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Part III

Statement of Program Service Accomplishments

Check if Schedule O contains a response to any question in this Part III

1

Briefly describe the organization's mission

COMMUNITY HOSPITALS OF INDIANA, INC ("CHI") IS A 501(C)(3) CORPORATION SERVING THE HEALTH RELATED NEEDS OF THE CITIZENS OF THE INDIANAPOLIS METROPOLITAN AREA AND CENTRAL INDIANA CHI OPERATES TWO GENERAL ACUTE CARE HOSPITALS AND PROVIDES INPATIENT, OUTPATIENT, EMERGENCY AND AMBULATORY HEALTH CARE SERVICES TO ALL PATIENTS REGARDLESS OF THEIR ABILITY TO PAY

2

Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ?

If "Yes," describe these new services on Schedule O

3

Did the organization cease conducting, or make significant changes in how it conducts, any program services?

If "Yes," describe these changes on Schedule O

4

Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses Section 501(c)(3) and 501(c)(4) organizations and section 4947(a)(1) trusts are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported

4a

(Code) (Expenses \$ 384,055,712 including grants of \$) (Revenue \$ 609,290,975)

COMMUNITY HOSPITALS OF INDIANA, INC OPERATES TWO ACUTE CARE FULL SERVICE HOSPITALS IN INDIANAPOLIS, INDIANA WITH 1,029 LICENSED BEDS IN 2011, COMMUNITY HOSPITALS SERVED 32,307 INPATIENTS FOR A TOTAL OF 149,793 INPATIENT DAYS OF SERVICE THE TWO HOSPITALS ALSO PROVIDED 938,906 OUTPATIENT VISITS, WHICH INCLUDED 110,927 EMERGENCY VISITS AND 481,624 MENTAL HEALTH VISITS COMMUNITY HOSPITALS OFFERS MANY PATIENT FOCUSED HEALTHCARE SERVICES THAT INCLUDE WOMEN AND CHILDREN SERVICES, PEDIATRICS, ONCOLOGY, MENTAL HEALTH SERVICES, NEUROSCIENCES, ORTHOPEDICS, JOINT REPLACEMENT, BREAST CARE SERVICES, SURGERY SERVICES, REHABILITATION SERVICES, HEALTH PROMOTION SERVICES, EMERGENCY SERVICES, AND TRAINING AND EDUCATION FOR HEALTH CARE PROFESSIONALS

4b

(Code) (Expenses \$ including grants of \$) (Revenue \$)

4c

(Code) (Expenses \$ including grants of \$) (Revenue \$)

4d

Other program services (Describe in Schedule O)


















(Expenses \$ including grants of \$) (Revenue \$)

4e

Total program service expenses \$ 384,055,712

Part IV

Checklist of Required Schedules

		Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A 	1	Yes
2	Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)? 	2	Yes
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I	3	No
4	Section 501(c)(3) organizations. Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II	4	No
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C, Part III	5	No
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I 	6	No
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas or historic structures? If "Yes," complete Schedule D, Part II 	7	No
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III 	8	No
9	Did the organization report an amount in Part X, line 21, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? If "Yes," complete Schedule D, Part IV 	9	No
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? If "Yes," complete Schedule D, Part V 	10	No
11	If the organization's answer to any of the following questions is 'Yes,' then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable		
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI. 	11a	Yes
b	Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII. 	11b	No
c	Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII. 	11c	Yes
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX. 	11d	Yes
e	Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X. 	11e	Yes
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X. 	11f	No
12a	Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI, XII, and XIII 	12a	No
b	Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered 'No' to line 12a, then completing Schedule D, Parts XI, XII, and XIII is optional 	12b	Yes
13	Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	13	No
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a	No
b	Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Part I	14b	No
15	Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or assistance to any organization or entity located outside the U S ? If "Yes," complete Schedule F, Part II and IV	15	No
16	Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or assistance to individuals located outside the U S ? If "Yes," complete Schedule F, Part III and IV	16	No
17	Did the organization report a total of more than \$15,000, of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I	17	No
18	Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II	18	No
19	Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III	19	No
20a	Did the organization operate one or more hospitals? If "Yes," complete Schedule H 	20a	Yes
b	If "Yes" to line 20a, did the organization attach its audited financial statement to this return? Note. All Form 990 filers that operated one or more hospitals must attach audited financial statements 	20b	Yes

Part IV

Checklist of Required Schedules (continued)

21	Did the organization report more than \$5,000 of grants and other assistance to governments and organizations in the United States on Part IX, column (A), line 1? <i>If "Yes," complete Schedule I, Parts I and II</i>	21		No
22	Did the organization report more than \$5,000 of grants and other assistance to individuals in the United States on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i>	22		No
23	Did the organization answer "Yes" to Part VII, Section A, questions 3, 4, or 5, about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? <i>If "Yes," complete Schedule J</i>	23	Yes	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? <i>If "Yes," answer questions 24b-24d and complete Schedule K. If "No," go to line 25</i>	24a	Yes	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		No
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		No
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		No
25a	Section 501(c)(3) and 501(c)(4) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i>	25a		No
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i>	25b		No
26	Was a loan to or by a current or former officer, director, trustee, key employee, highly compensated employee, or disqualified person outstanding as of the end of the organization's tax year? <i>If "Yes," complete Schedule L, Part II</i>	26		No
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor, or a grant selection committee member, or to a person related to such an individual? <i>If "Yes," complete Schedule L, Part III</i>	27		No
28	Was the organization a party to a business transaction with one of the following parties? (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)			
a	A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>	28a		No
b	A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>	28b	Yes	
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or owner? <i>If "Yes," complete Schedule L, Part IV</i>	28c	Yes	
29	Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i>	29		No
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i>	30		No
31	Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i>	31		No
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i>	32		No
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I</i>	33		No
34	Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Parts II, III, IV, and V, line 1</i>	34	Yes	
35a	Is any related organization a controlled entity of the filing organization within the meaning of section 512(b)(13)?	35a	Yes	
b	Did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i>	35b	Yes	
36	Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i>	36		No
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? <i>If "Yes," complete Schedule R, Part VI</i>	37		No
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11 and 19? Note. All Form 990 filers are required to complete Schedule O	38	Yes	

Part V Statements Regarding Other IRS Filings and Tax Compliance						
Check if Schedule O contains a response to any question in this Part V <input checked="" type="checkbox"/>						
		Yes	No			
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable. .	1a	229			
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable.	1b	0			
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c	Yes			
2a	Enter the number of employees reported on Form W-3, <i>Transmittal of Wage and Tax Statements</i> filed for the calendar year ending with or within the year covered by this return.	2a	4,781			
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions).	2b	Yes			
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?	3a				No
b	If "Yes," has it filed a Form 990-T for this year? If "No," provide an explanation in Schedule O.	3b				
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account or securities account)?	4a	Yes			
b	If "Yes," enter the name of the foreign country: CJ See instructions for filing requirements for Form TD F 90-22.1, Report of Foreign Bank and Financial Accounts.					
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a				No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b				No
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?	5c				
6a	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible?	6a				No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b				
7	Organizations that may receive deductible contributions under section 170(c).					
a	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?	7a				No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b				
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c				No
d	If "Yes," indicate the number of Forms 8282 filed during the year.	7d				
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e				No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f				No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g				
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h				
8	Sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations. Did the supporting organization, or a donor advised fund maintained by a sponsoring organization, have excess business holdings at any time during the year?	8				
9	Sponsoring organizations maintaining donor advised funds.					
a	Did the organization make any taxable distributions under section 4966?	9a				
b	Did the organization make a distribution to a donor, donor advisor, or related person?	9b				
10	Section 501(c)(7) organizations. Enter					
a	Initiation fees and capital contributions included on Part VIII, line 12.	10a				
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities.	10b				
11	Section 501(c)(12) organizations. Enter					
a	Gross income from members or shareholders.	11a				
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them).	11b				
12a	Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?	12a				
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year.	12b				
13	Section 501(c)(29) qualified nonprofit health insurance issuers.					
a	Is the organization licensed to issue qualified health plans in more than one state? Note. All 501(c)(29) organizations must list in Schedule O each state in which they are licensed to issue qualified health plans, the amount of reserves required by each state, and the amount of reserves the organization allocated to each state.	13a				
b	Enter the aggregate amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans.	13b				
c	Enter the aggregate amount of reserves on hand.	13c				
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a				No
b	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O.	14b				

Part VI

Governance, Management, and Disclosure

For each "Yes" response to lines 2 through 7b below, and for a "No" response to lines 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.
Check if Schedule O contains a response to any question in this Part VI

Section A. Governing Body and Management

		Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year		
1a	3		
b	Enter the number of voting members included in line 1a, above, who are independent	1b	2
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2	Yes
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	3	Yes
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4	No
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5	No
6	Did the organization have members or stockholders?	6	Yes
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a	Yes
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b	Yes
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following		
a	The governing body?	8a	Yes
b	Each committee with authority to act on behalf of the governing body?	8b	Yes
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O	9	No

Section B. Policies

(This Section B requests information about policies not required by the Internal Revenue Code.)

		Yes	No
10a	Did the organization have local chapters, branches, or affiliates?	10a	No
b	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	10b	
11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a	No
b	Describe in Schedule O the process, if any, used by the organization to review the Form 990		
12a	Did the organization have a written conflict of interest policy? If "No," go to line 13	12a	Yes
b	Were officers, directors or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	Yes
c	Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done	12c	Yes
13	Did the organization have a written whistleblower policy?	13	Yes
14	Did the organization have a written document retention and destruction policy?	14	Yes
15	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?		
a	The organization's CEO, Executive Director, or top management official	15a	Yes
b	Other officers or key employees of the organization	15b	Yes
	If "Yes," to line 15a or 15b, describe the process in Schedule O (see instructions)		
16a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a	Yes
b	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	16b	No

Section C. Disclosure

17	List the States with which a copy of this Form 990 is required to be filed	IN
18	Section 6104 requires an organization to make its Form 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply. <input type="checkbox"/> Own website <input type="checkbox"/> Another's website <input checked="" type="checkbox"/> Upon request	
19	Describe in Schedule O whether (and if so, how), the organization made its governing documents, conflict of interest policy, and financial statements available to the public. See Additional Data Table.	
20	State the name, physical address, and telephone number of the person who possesses the books and records of the organization.	
	JEFFERY KIRKHAM 1500 N RITTER AVENUE INDIANAPOLIS, IN 46219 (317) 355-5822	

Part VII

Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

Check if Schedule O contains a response to any question in this Part VII

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

- 1a** Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.
- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation, and **current** key employees. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
 - List all of the organization's **current** key employees, if any. See instructions for definition of "key employee."
 - List the organization's five **current** highest compensated employees (other than an officer, director, trustee or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations.
 - List all of the organization's **former** officers, key employees, or highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
 - List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.

List persons in the following order: individual trustees or directors; institutional trustees; officers; key employees; highest compensated employees; and former such persons.

Check this box if neither the organization nor any related organizations compensated any current or former officer, director, or trustee

(A) Name and Title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
(1) MICHAEL C BLANCHET DIRECTOR/CHI	40.00	X		X				500,069	0	350,826
(2) STEVEN R PLUMP CHAIRMAN	5.00	X		X				0	0	0
(3) KRISTIN T SHERMAN TREASURER/SE	5.00	X		X				0	0	0
(4) TONY LENNEN PRESIDENT -	5.00			X				0	328,925	133,178
(5) BARBARA SUMMERS PRESIDENT -	55.00			X				276,662	0	288,561
(6) JEFFERY KIRKHAM CFO - CHI	55.00			X				271,324	0	274,763
(7) ROBIN LEDYARD MD PRESIDENT -	55.00			X				271,179	0	140,472
(8) JOHN T CUMMINGS MD PHYSICIAN	50.00					X		1,266,628	0	525,218
(9) DAVID C HALL MD PHYSICIAN	50.00					X		1,016,195	0	184,196
(10) ROBERT B SLOAN JR MD PHYSICIAN	50.00					X		959,942	0	53,164
(11) JILL W DONALDSON MD PHYSICIAN	50.00					X		730,979	0	245,150
(12) ROSEMARIE JONES MD PHYSICIAN	50.00					X		686,607	0	487,101
(13) STEVE HULTGREN FORMER INTER	16.15						X	58,325	86,099	143,914

Part VII

1b	Sub-Total	▼			
c	Total from continuation sheets to Part VII, Section A	▼			
d	Total (add lines 1b and 1c)	▼	6,037,910	415,024	2,826,543

2 Total number of individuals (including but not limited to those listed in Item 1) who received more than \$100,000 of reportable compensation from the organization. 210

		Yes	No
3	Did the organization list any former officer, director or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i>	3 Yes	
4	For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? <i>If "Yes," complete Schedule J for such individual</i>	4 Yes	
5	Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? <i>If "Yes," complete Schedule J for such person</i>	5	No

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than \$100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation
CARDINAL HEALTH 2353 PROSPECT DRIVE AURORA, IL 60504	PHARMACEUTICALS	34,460,003
OWENS AND MINOR 12199 COLLECTION CENTER DRIVE CHICAGO, IL 60693	MEDICAL SUPPLY	20,724,239
MID AMERICA CLINICAL LABS 2560 NORTH SHADELAND AVENUE INDIANAPOLIS, IN 46219	LAB SERVICES	12,245,386
ROLLINS CONSTRUCTION 3024 N RIDGEVIEW DRIVE INDIANAPOLIS, IN 46226	CONSTRUCTION	11,512,771
COMMUNITY IMAGING ASSOCIATES 7205 SHADELAND STATION INDIANAPOLIS, IN 46256	X-RAY IMAGING	8,580,285

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization ▶301

Part VIII

Statement of Revenue

				(A)	(B)	(C)	(D)
				Total revenue	Related or exempt function revenue	Unrelated business revenue	Revenue excluded from tax under sections 512, 513, or 514
Contributions, gifts, grants and other similar amounts	1a	Federated campaigns . . .	1a				
	b	Membership dues	1b				
	c	Fundraising events	1c				
	d	Related organizations	1d	743,241			
	e	Government grants (contributions)	1e	4,435,391			
	f	All other contributions, gifts, grants, and similar amounts not included above	1f				
	g	Noncash contributions included in lines 1a-1f \$ _____					
	h	Total. Add lines 1a-1f			5,178,632		
Program Service Revenue			Business Code				
	2a	PATIENT SERVICES	900099	609,290,975	609,290,975		
	b						
	c						
	d						
	e						
	f	All other program service revenue					
	g	Total. Add lines 2a-2f			609,290,975		
Other Revenue	3	Investment income (including dividends, interest and other similar amounts)			21,702,645		21,702,645
	4	Income from investment of tax-exempt bond proceeds . .					
	5	Royalties					
			(i) Real	(ii) Personal			
	6a	Gross rents	5,438,874				
	b	Less rental expenses					
	c	Rental income or (loss)	5,438,874				
	d	Net rental income or (loss)			5,438,874		5,438,874
			(i) Securities	(ii) Other			
	7a	Gross amount from sales of assets other than inventory	148,450,625	540,387			
	b	Less cost or other basis and sales expenses	138,982,727				
	c	Gain or (loss)	9,467,898	540,387			
	d	Net gain or (loss)			10,008,285		10,008,285
	8a	Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18	a				
	b	Less direct expenses	b				
	c	Net income or (loss) from fundraising events . .					
	9a	Gross income from gaming activities See Part IV, line 19	a				
	b	Less direct expenses	b				
	c	Net income or (loss) from gaming activities . .					
	10a	Gross sales of inventory, less returns and allowances	a				
	b	Less cost of goods sold	b				
	c	Net income or (loss) from sales of inventory . .					
	Miscellaneous Revenue		Business Code				
11a	EQUITY INVESTMENT INCOME	900003	21,685,385	21,685,385			
b	LEASED EQUIPMENT	532420	8,330,534	8,330,534			
c	EHR/EPIC INCENTIVE PAYMENTS	900099	5,832,207	5,832,207			
d	All other revenue		21,065,073	21,348,648	-283,575		
e	Total. Add lines 11a-11d			56,913,199			
12	Total revenue. See Instructions			708,532,610	666,487,749	-283,575	37,149,804

Part IX

Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns

All other organizations must complete column (A) but are not required to complete columns (B), (C), and (D)

Check if Schedule O contains a response to any question in this Part IX

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.		(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1	Grants and other assistance to governments and organizations in the United States See Part IV, line 21				
2	Grants and other assistance to individuals in the United States See Part IV, line 22				
3	Grants and other assistance to governments, organizations, and individuals outside the United States See Part IV, lines 15 and 16				
4	Benefits paid to or for members				
5	Compensation of current officers, directors, trustees, and key employees	2,373,856	205,826	2,168,030	
6	Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7	Other salaries and wages	217,951,674	163,284,546	54,667,128	
8	Pension plan contributions (include section 401(k) and section 403(b) employer contributions)	5,255,398	235,980	5,019,418	
9	Other employee benefits	31,261,346	23,197,171	8,064,175	
10	Payroll taxes	14,276,276	10,729,908	3,546,368	
11	Fees for services (non-employees)				
a	Management				
b	Legal	2,513,142		2,513,142	
c	Accounting	754,534		754,534	
d	Lobbying				
e	Professional fundraising See Part IV, line 17				
f	Investment management fees	486,200		486,200	
g	Other	137,003,456	58,949,450	78,054,006	
12	Advertising and promotion	39,515	16,942	22,573	
13	Office expenses	105,068,773	99,327,602	5,741,171	
14	Information technology	5,480,816	2,345,598	3,135,218	
15	Royalties				
16	Occupancy	17,448,551	12,947,524	4,501,027	
17	Travel	721,285	449,458	271,827	
18	Payments of travel or entertainment expenses for any federal, state, or local public officials				
19	Conferences, conventions, and meetings	186,115	57,796	128,319	
20	Interest	9,445,340		9,445,340	
21	Payments to affiliates				
22	Depreciation, depletion, and amortization	32,616,633	11,120,202	21,496,431	
23	Insurance	3,078,680	57,723	3,020,957	
24	Other expenses Itemize expenses not covered above (List miscellaneous expenses in line 24f If line 24f amount exceeds 10% of line 25, column (A) amount, list line 24f expenses on Schedule O)				
a	PROPERTY TAX	1,631,734	698,325	933,409	
b	DUES & SUBSCRIPTIONS	618,956	238,891	380,065	
c	RECRUITMENT	118,256	50,609	67,647	
d	GRANT DISBURSEMENTS	112,426	48,114	64,312	
e					
f	All other expenses	219,764	94,047	125,717	
25	Total functional expenses. Add lines 1 through 24f	588,662,726	384,055,712	204,607,014	0
26	Joint costs. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720) Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation				

Part X

Balance Sheet

					(A)		(B)
					Beginning of year		End of year
Assets	1	Cash—non-interest-bearing			60,033,743	1	82,171,501
	2	Savings and temporary cash investments				2	
	3	Pledges and grants receivable, net				3	
	4	Accounts receivable, net			79,330,664	4	89,844,080
	5	Receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L				5	
	6	Receivables from other disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B). Complete Part II of Schedule L				6	
	7	Notes and loans receivable, net			461,344	7	402,230
	8	Inventories for sale or use			7,720,914	8	8,001,495
	9	Prepaid expenses and deferred charges			5,870,391	9	7,463,136
	10a	Land, buildings, and equipment—cost or other basis. Complete Part VI of Schedule D	10a	837,879,928			
	b	Less—accumulated depreciation	10b	458,318,642	381,852,222	10c	379,561,286
	11	Investments—publicly traded securities			336,322,921	11	335,152,652
	12	Investments—other securities. See Part IV, line 11				12	
	13	Investments—program-related. See Part IV, line 11			166,595,042	13	340,237,782
	14	Intangible assets			204,916	14	12,387,312
	15	Other assets. See Part IV, line 11			132,547,503	15	228,453,109
	16	Total assets. Add lines 1 through 15 (must equal line 34)			1,170,939,660	16	1,483,674,583
Liabilities	17	Accounts payable and accrued expenses			158,412,594	17	146,059,884
	18	Grants payable				18	
	19	Deferred revenue				19	
	20	Tax-exempt bond liabilities			419,603,642	20	405,863,554
	21	Escrow or custodial account liability. Complete Part IV of Schedule D				21	
	22	Payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L				22	
	23	Secured mortgages and notes payable to unrelated third parties				23	
	24	Unsecured notes and loans payable to unrelated third parties			5,146,206	24	29,646,206
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D			36,166,158	25	298,767,408
26	Total liabilities. Add lines 17 through 25			619,328,600	26	880,337,052	
Net Assets or Fund Balances	Organizations that follow SFAS 117, check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.						
	27	Unrestricted net assets			551,611,060	27	603,337,531
	28	Temporarily restricted net assets				28	
	29	Permanently restricted net assets				29	
	Organizations that do not follow SFAS 117, check here <input type="checkbox"/> and complete lines 30 through 34.						
	30	Capital stock or trust principal, or current funds				30	
	31	Paid-in or capital surplus, or land, building or equipment fund				31	
	32	Retained earnings, endowment, accumulated income, or other funds				32	
	33	Total net assets or fund balances			551,611,060	33	603,337,531
34	Total liabilities and net assets/fund balances			1,170,939,660	34	1,483,674,583	

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response to any question in this Part XI

1	Total revenue (must equal Part VIII, column (A), line 12)	1	708,532,610
2	Total expenses (must equal Part IX, column (A), line 25)	2	588,662,726
3	Revenue less expenses Subtract line 2 from line 1	3	119,869,884
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	551,611,060
5	Other changes in net assets or fund balances (explain in Schedule O)	5	-68,143,413
6	Net assets or fund balances at end of year Combine lines 3, 4, and 5 (must equal Part X, line 33, column (B))	6	603,337,531

Part XII Financial Statements and Reporting

Check if Schedule O contains a response to any question in this Part XII

		Yes	No
1	Accounting method used to prepare the Form 990 <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O		
2a	Were the organization's financial statements compiled or reviewed by an independent accountant?		No
b	Were the organization's financial statements audited by an independent accountant?	Yes	
c	If "Yes," to 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O	Yes	
d	If "Yes" to line 2a or 2b, check a box below to indicate whether the financial statements for the year were issued on a separate basis, consolidated basis, or both <input checked="" type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separated basis		
3a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	Yes	
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	Yes	

SCHEDULE A
(Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

▶ Attach to Form 990 or Form 990-EZ. ▶ See separate instructions.

OMB No 1545-0047

2011

Open to Public
Inspection

Name of the organization COMMUNITY HOSPITALS OF INDIANA INC	Employer identification number 35-0983617
----------------------------------------------------------------	--------------------------------------------------

Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions

The organization is not a private foundation because it is (For lines 1 through 11, check only one box)

- 1

☐

A church, convention of churches, or association of churches **section 170(b)(1)(A)(i).**
- 2

☐

A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E)
- 3

☒

A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4

☐

A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state
- 5

☐

An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II)
- 6

☐

A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7

☐

An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi)** (Complete Part II)
- 8

☐

A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II)
- 9

☐

An organization that normally receives (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2).** (Complete Part III)
- 10

☐

An organization organized and operated exclusively to test for public safety Se**section 509(a)(4).**
- 11

☐

An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2) See **section 509(a)(3).** Check the box that describes the type of supporting organization and complete lines 11e through 11h

a

☐

Type I

b

☐

Type II

c

☐

Type III - Functionally integrated

d

☐

Type III - Other

e

☐

By checking this box, I certify that the organization is not controlled directly or indirectly by one or more disqualified persons other than foundation managers and other than one or more publicly supported organizations described in section 509(a)(1) or section 509(a)(2)

f

☐

If the organization received a written determination from the IRS that it is a Type I, Type II or Type III supporting organization, check this box

g

☐

Since August 17, 2006, has the organization accepted any gift or contribution from any of the following persons?

(i)

a person who directly or indirectly controls, either alone or together with persons described in (ii) and (iii) below, the governing body of the the supported organization?

(ii)

a family member of a person described in (i) above?

(iii)

a 35% controlled entity of a person described in (i) or (ii) above?

h

☐

Provide the following information about the supported organization(s)

	Yes	No
11g(i)		
11g(ii)		
11g(iii)		

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1- 9 above or IRC section (see instructions))	(iv) Is the organization in col (i) listed in your governing document?		(v) Did you notify the organization in col (i) of your support?		(vi) Is the organization in col (i) organized in the U S ?		(vii) Amount of support?
			Yes	No	Yes	No	Yes	No	
Total									

Part II

Support Schedule for Organizations Described in IRC 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)
(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support						
Calendar year	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 Public Support. Subtract line 5 from line 4						

Section B. Total Support						
Calendar year	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income (Explain in Part IV) Do not include gain or loss from the sale of capital assets						
11 Total support (Add lines 7 through 10)						
12 Gross receipts from related activities, etc (See instructions)					12	
13 First Five Years If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a 501(c)(3) organization, check this box and stop here						

Section C. Computation of Public Support Percentage						
14 Public Support Percentage for 2011 (line 6 column (f) divided by line 11 column (f))		14				
15 Public Support Percentage for 2010 Schedule A, Part II, line 14		15				
16a 33 1/3% support test—2011. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization						
b 33 1/3% support test—2010. If the organization did not check the box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization						
17a 10%-facts-and-circumstances test—2011. If the organization did not check a box on line 13, 16a, or 16b and line 14 is 10% or more, and if the organization meets the "facts and circumstances" test, check this box and stop here. Explain in Part IV how the organization meets the "facts and circumstances" test The organization qualifies as a publicly supported organization						
b 10%-facts-and-circumstances test—2010. If the organization did not check a box on line 13, 16a, 16b, or 17a and line 15 is 10% or more, and if the organization meets the "facts and circumstances" test, check this box and stop here. Explain in Part IV how the organization meets the "facts and circumstances" test The organization qualifies as a publicly supported organization						
18 Private Foundation If the organization did not check a box on line 13, 16a, 16b, 17a or 17b, check this box and see instructions						

Part IIIPart III

Support Schedule for Organizations Described in IRC 509(a)(2)
(Complete only if you checked the box on line 9 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support						
Calendar year (or fiscal year beginning in)	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 Public Support (Subtract line 7c from line 6)						

Section B. Total Support						
Calendar year (or fiscal year beginning in)	(a) 2007	(b) 2008	(c) 2009	(d) 2010	(e) 2011	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part IV.)						
13 Total support (Add lines 9, 10c, 11 and 12.)						
14 First Five Years If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a 501(c)(3) organization, check this box and stop here						

Section C. Computation of Public Support Percentage		
15 Public Support Percentage for 2011 (line 8 column (f) divided by line 13 column (f))	15	
16 Public support percentage from 2010 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage		
17 Investment income percentage for 2011 (line 10c column (f) divided by line 13 column (f))	17	
18 Investment income percentage from 2010 Schedule A, Part III, line 17	18	
19a 33 1/3% support tests—2011. If the organization did not check the box on line 14, and line 15 is more than 33 1/3% and line 17 is not more than 33 1/3%, check this box and stop here. The organization qualifies as a publicly supported organization		
b 33 1/3% support tests—2010. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and stop here. The organization qualifies as a publicly supported organization		
20 Private Foundation If the organization did not check a box on line 14, 19a or 19b, check this box and see instructions		

Part IV **Supplemental Information.** Supplemental Information. Complete this part to provide the explanation required by Part II, line 10; Part II, line 17a or 17b; or Part III, line 12. Also complete this part for any additional information. (See instructions).

Facts And Circumstances Test

Explanation

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

► Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b
► Attach to Form 990. ► See separate instructions.

OMB No 1545-0047

2011

Open to Public Inspection

Name of the organization
COMMUNITY HOSPITALS OF INDIANA INC

Employer identification number
35-0983617

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" to Form 990, Part IV, line 6.

	(a) Donor advised funds	(b) Funds and other accounts
1	Total number at end of year	
2	Aggregate contributions to (during year)	
3	Aggregate grants from (during year)	
4	Aggregate value at end of year	
5	Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? <div><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	
6	Did the organization inform all grantees, donors, and donor advisors in writing that grant funds may be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit <div><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</div>	

Part II Conservation Easements. Complete if the organization answered "Yes" to Form 990, Part IV, line 7.

1

Purpose(s) of conservation easements held by the organization (check all that apply)

☐ Preservation of land for public use (e g , recreation or pleasure)☐ Preservation of an historically importantly land area
☐ Protection of natural habitat☐ Preservation of a certified historic structure
☐ Preservation of open space

2

Complete lines 2a–2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year

	Held at the End of the Year
a	Total number of conservation easements
b	Total acreage restricted by conservation easements
c	Number of conservation easements on a certified historic structure included in (a)
d	Number of conservation easements included in (c) acquired after 8/17/06

3

Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the taxable year ► _____

4

Number of states where property subject to conservation easement is located ► _____

5

Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?

☐ Yes ☒ No

6

Staff and volunteer hours devoted to monitoring, inspecting and enforcing conservation easements during the year ► _____

7

Amount of expenses incurred in monitoring, inspecting, and enforcing conservation easements during the year
► \$ _____

8

Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and 170(h)(4)(B)(ii)?

☐ Yes ☒ No

9

In Part XIV, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets. Complete if the organization answered "Yes" to Form 990, Part IV, line 8.

1a

If the organization elected, as permitted under SFAS 116, not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education or research in furtherance of public service, provide, in Part XIV, the text of the footnote to its financial statements that describes these items

b

If the organization elected, as permitted under SFAS 116, to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items

(i) Revenues included in Form 990, Part VIII, line 1

► \$ _____

(ii) Assets included in Form 990, Part X

► \$ _____

2

If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 relating to these items

a

Revenues included in Form 990, Part VIII, line 1

► \$ _____

b

Assets included in Form 990, Part X

► \$ _____

For Privacy Act and Paperwork Reduction Act Notice, see the Intructions for Form 990

Cat No 52283D

Schedule D (Form 990) 2011

Part III

Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets (continued)

3

Using the organization's accession and other records, check any of the following that are a significant use of its collection items (check all that apply)

a

☐ Public exhibition

b

☐ Scholarly research

c

☐ Preservation for future generations

d

☐ Loan or exchange programs

e

☐ Other

4

Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIV

5

During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection?

☐ Yes☒ No

Part IV

Escrow and Custodial Arrangements. Complete if the organization answered "Yes" to Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

1a

Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?

☐ Yes☒ No

b

If "Yes," explain the arrangement in Part XIV and complete the following table

	Amount
1c	
1d	
1e	
1f	

2a

Did the organization include an amount on Form 990, Part X, line 21?

☐ Yes☒ No

b

If "Yes," explain the arrangement in Part XIV

Part V

Endowment Funds. Complete if the organization answered "Yes" to Form 990, Part IV, line 10.

	(a)Current Year	(b)Prior Year	(c)Two Years Back	(d)Three Years Back	(e)Four Years Back
1a	Beginning of year balance				
b	Contributions				
c	Investment earnings or losses				
d	Grants or scholarships				
e	Other expenditures for facilities and programs				
f	Administrative expenses				
g	End of year balance				

2

Provide the estimated percentage of the year end balance held as

a

Board designated or quasi-endowment ▶

b

Permanent endowment ▶

c

Term endowment ▶

3a

Are there endowment funds not in the possession of the organization that are held and administered for the organization by

(i)

unrelated organizations

3a(i)

Yes

No

(ii)

related organizations

3a(ii)

Yes

No

b

If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?

3b

Yes

No

4

Describe in Part XIV the intended uses of the organization's endowment funds

Part VI

Land, Buildings, and Equipment. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b)Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		4,916,784		4,916,784
b Buildings		448,727,175	174,220,212	274,506,963
c Leasehold improvements		19,617,388	7,137,834	12,479,554
d Equipment		357,105,330	269,922,236	87,183,094
e Other		7,513,251	7,038,360	474,891
Total. Add lines 1a-1e (Column (d) should equal Form 990, Part X, column (B), line 10(c).) ▶				379,561,286

Part XI

Reconciliation of Change in Net Assets from Form 990 to Financial Statements

1	Total revenue (Form 990, Part VIII, column (A), line 12)	1	
2	Total expenses (Form 990, Part IX, column (A), line 25)	2	
3	Excess or (deficit) for the year Subtract line 2 from line 1	3	
4	Net unrealized gains (losses) on investments	4	
5	Donated services and use of facilities	5	
6	Investment expenses	6	
7	Prior period adjustments	7	
8	Other (Describe in Part XIV)	8	
9	Total adjustments (net) Add lines 4 - 8	9	
10	Excess or (deficit) for the year per financial statements Combine lines 3 and 9	10	

Part XII

Reconciliation of Revenue per Audited Financial Statements With Revenue per Return

1	Total revenue, gains, and other support per audited financial statements	1	
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12		
a	Net unrealized gains on investments	2a	
b	Donated services and use of facilities	2b	
c	Recoveries of prior year grants	2c	
d	Other (Describe in Part XIV)	2d	
e	Add lines 2a through 2d	2e	
3	Subtract line 2e from line 1	3	
4	Amounts included on Form 990, Part VIII, line 12, but not on line 1		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	
b	Other (Describe in Part XIV)	4b	
c	Add lines 4a and 4b	4c	
5	Total Revenue Add lines 3 and 4c. (This should equal Form 990, Part I, line 12)	5	

Part XIII

Reconciliation of Expenses per Audited Financial Statements With Expenses per Return

1	Total expenses and losses per audited financial statements	1	
2	Amounts included on line 1 but not on Form 990, Part IX, line 25		
a	Donated services and use of facilities	2a	
b	Prior year adjustments	2b	
c	Other losses	2c	
d	Other (Describe in Part XIV)	2d	
e	Add lines 2a through 2d	2e	
3	Subtract line 2e from line 1	3	
4	Amounts included on Form 990, Part IX, line 25, but not on line 1:		
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a	
b	Other (Describe in Part XIV)	4b	
c	Add lines 4a and 4b	4c	
5	Total expenses Add lines 3 and 4c. (This should equal Form 990, Part I, line 18)	5	

Part XIV

Supplemental Information

Complete this part to provide the descriptions required for Part II, lines 3, 5, and 9, Part III, lines 1a and 4, Part IV, lines 1b and 2b, Part V, line 4, Part X, Part XI, line 8, Part XII, lines 2d and 4b, and Part XIII, lines 2d and 4b. Also complete this part to provide any additional information.

Identifier	Return Reference	Explanation
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Additional Data

Software ID:

Software Version:

EIN: 35-0983617

Name: COMMUNITY HOSPITALS OF INDIANA INC

Form 990, Schedule D, Part IX, - Other Assets

(a) Description	(b) Book value
DUE FROM AFFILIATED ENTITIES	180,516,620
FUNDS HELD BY TRUSTEE	19,185,980
THIRD PARTY RECEIVABLE	8,825,768
OTHER RECEIVABLES	7,699,413
DEFERRED FINANCING COSTS	6,647,140
CHN ASSURANCE PREMIUM	3,111,119
OTHER ASSETS	1,507,823
OVERFUNDED PENSION/RTRMT	959,246

SCHEDULE H
(Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No 1545-0047

2011

Open to Public Inspection

Name of the organization
COMMUNITY HOSPITALS OF INDIANA INC

Employer identification number
35-0983617

Part I

Charity Care and Certain Other Community Benefits at Cost

		Yes	No	
1a	Did the organization have a charity care policy? If "No," skip to question 6a	1a	Yes	
b	If "Yes," is it a written policy?	1b	Yes	
2	If the organization had multiple hospitals, indicate which of the following best describes application of the charity care policy to the various hospitals <div><input checked="" type="checkbox"/> Applied uniformly to all hospitals <input type="checkbox"/> Generally tailored to individual hospitals</div> <div><input type="checkbox"/> Applied uniformly to most hospitals</div>			
3	Answer the following based on the charity care eligibility criteria that applies to the largest number of the organization's patients during the tax year a Did the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing <i>free</i> care? If "Yes," indicate which of the following is the FPG family income limit for eligibility for free care <div><input type="checkbox"/> 100%<input type="checkbox"/> 150%<input checked="" type="checkbox"/> 200%<input type="checkbox"/> Other _____%</div> b Did the organization use FPG to determine eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following is the family income limit for eligibility for discounted care <div><input type="checkbox"/> 200%<input type="checkbox"/> 250%<input checked="" type="checkbox"/> 300%<input type="checkbox"/> 350%<input type="checkbox"/> 400%<input type="checkbox"/> Other _____%</div> c If the organization did not use FPG to determine eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care Include in the description whether the organization uses an asset test or other threshold, regardless of income, to determine eligibility for free or discounted care	3a	Yes	
4	Did the organization's policy provide free or discounted care to the "medically indigent"?	4	Yes	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	Yes	
b	If "Yes," did the organization's charity care expenses exceed the budgeted amount?	5b		No
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?	5c		
6a	Did the organization prepare a community benefit report during the tax year?	6a	Yes	
6b	If "Yes," did the organization make it available to the public?	6b	Yes	
	Complete the following table using the worksheets provided in the Schedule H instructions Do not submit these worksheets with the Schedule H			

7 Charity Care and Certain Other Community Benefits at Cost						
Charity Care 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 Charity care at cost (from Worksheet 1)		29,531	15,481,960		15,481,960	2 630 %
b Medicaid (from Worksheet 3, column a)		53,873	83,789,720	62,815,169	20,974,551	3 560 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Charity Care and Means-Tested Government Programs		83,404	99,271,680	62,815,169	36,456,511	6 190 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	16	674	9,353,853	1,572,848	7,781,005	1 320 %
f Health professions education (from Worksheet 5)	7	887	9,315,203	2,040,279	7,274,924	1 240 %
g Subsidized health services (from Worksheet 6)	2	587	123		123	
h Research (from Worksheet 7)	2		1,065,025		1,065,025	0 180 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)	2		3,520		3,520	
j Total Other Benefits	29	2,148	19,737,724	3,613,127	16,124,597	2 740 %
k Total. Add lines 7d and 7j	29	85,552	119,009,404	66,428,296	52,581,108	8 930 %

Part IICommunity Building Activities

Complete this table if the organization conducted any community building activities.

	(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
1Physical improvements and housing	1	6	1,698		1,698	
2Economic development						
3Community support	13	13,044	9,238		9,238	
4Environmental improvements						
5Leadership development and training for community members	1		84,794	28,895	55,899	0 010 %
6Coalition building	6	1,097	12,904	1,000	11,904	
7Community health improvement advocacy	32	75,342	4,406,168	408,510	3,997,658	0 680 %
8Workforce development	11	603	1,020,906	128,442	892,464	0 150 %
9Other						
10Total	64	90,092	5,535,708	566,847	4,968,861	0 840 %

Part IIIBad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

		Yes	No
1Did the organization report bad debt expense in accordance with Heathcare Financial Management Association Statement No 15?	1	Yes	
2Enter the amount of the organization's bad debt expense	211,635,273		
3Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's charity care policy	3		
4Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense. In addition, describe the costing methodology used in determining the amounts reported on lines 2 and 3, and rationale for including a portion of bad debt amounts as community benefit			

Section B. Medicare

5Enter total revenue received from Medicare (including DSH and IME)	5124,042,757		
6Enter Medicare allowable costs of care relating to payments on line 5	6133,161,155		
7Subtract line 6 from line 5. This is the surplus or (shortfall)	7-9,118,398		
8Describe 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: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other			

Section C. Collection Practices

9aDid the organization have a written debt collection policy during the tax year?	9a	Yes	
bIf "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	Yes	

Part IVManagement Companies and Joint Ventures (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 %
1NORTHPOINT PEDIATRIC	PROVIDE PHYSICIANS SERVICES	49 000 %		51 000 %
2COMMUNITY IMAGING	PROVIDE MEDICAL IMAGING SERVICES	50 000 %		50 000 %
3IN SPECIALTY GROUP	PROVIDE SPECIALTY PHYSICIAN SERVICES	70 000 %		30 000 %
4EAST CAMPUS SURG CTR	PROVIDE OUTPATIENT SURGERY SERVICES	51 000 %		49 000 %
5MID AM CLINCIAL LABS	PROVIDE LABORATORY SERVICES	22 000 %		
6NORTH CAMPUS SURG	PROVIDE OUTPATIENT SURGERY SERVICES	49 000 %		
7MICHIGAN SURGERY INV	PROVIDE OUTPATIENT SURGERY SERVICES	40 000 %		
8UNITED HOSPITAL SERV	PROVIDE LINEN SERVICES	13 000 %		
9HAMILTON SURGERY CTR	PROVIDE OUTPATIENT SURGERY SERVICES	11 000 %		49 000 %
10INDPLS ENDOSCOPY CTR	PROVIDE MEDICAL SERVICES	19 000 %		49 000 %
11				
12				
13				

Section A. Hospital Facilities

(list in order of size from largest to smallest)

How many hospital facilities did the organization operate during the tax year? 2

Name and address

[illegible]

Part V Facility Information (continued)

Section B. Facility Policies and Practices.

(Complete a separate Section B for each of the hospital facilities listed in Part V, Section A.)

COMMUNITY HOSPITAL NORTH

Name of Hospital Facility:_____

Line Number of Hospital Facility (from Schedule H, Part V, Section A):_____1_____

	Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2011)		
1 During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment ("Needs Assessment")? If "No," skip to question 8 If "Yes," indicate what the Needs Assessment 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 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 those needs h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests i <input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs j <input checked="" type="checkbox"/> Other (describe in Part VI)	1 Yes	
2 Indicate the tax year the hospital facility last conducted a Needs Assessment 20 <u>11</u>		
3 In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3 Yes	
4 Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4 Yes	
5 Did the hospital facility make its Needs Assessment widely available to the public? If "Yes," indicate how the Needs Assessment was made widely available (check all that apply) a <input checked="" type="checkbox"/> Hospital facility's website b <input checked="" type="checkbox"/> Available upon request from the hospital facility c <input checked="" type="checkbox"/> Other (describe in Part VI)	5 Yes	
6 If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply) a <input checked="" type="checkbox"/> Adoption of an implementation strategy to address the health needs of the hospital facility's community b <input checked="" type="checkbox"/> Execution of the implementation strategy c <input checked="" type="checkbox"/> Development of a community-wide community benefit plan for the facility d <input checked="" type="checkbox"/> Participation in community-wide community benefit plan e <input checked="" type="checkbox"/> Inclusion of a community benefit section in operational plans f <input checked="" type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the CHNA g <input checked="" type="checkbox"/> Prioritization of health needs in the community h <input checked="" type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community i <input checked="" type="checkbox"/> Other (describe in Part VI)		
7 Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed together with the reasons why it has not addressed such needs	7	No
Financial Assistance Policy		
Did the hospital facility have in place during the tax year a written financial assistance policy that		
8 Explains eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8 Yes	
9 Used federal poverty guidelines (FPG) to determine eligibility for providing free care? If "Yes," indicate the FPG family income limit for eligibility for free care <u>200</u> 0% If "No," explain in Part VI the criteria the hospital facility used	9 Yes	

Part V

Facility Information (continued)

		Yes	No	
10	Used FPG to determine eligibility for providing discounted care? If "Yes," indicate the FPG family income limit for eligibility for discounted care <u>300 0</u> % If "No," explain in Part VI the criteria the hospital facility used	10	Yes	
11	Explained the basis for calculating amounts charged to patients? If "Yes," indicate the factors used in determining such amounts (check all that apply) a <input checked="" type="checkbox"/> Income level b <input type="checkbox"/> Asset level c <input checked="" type="checkbox"/> Medical indigency d <input type="checkbox"/> Insurance status e <input type="checkbox"/> Uninsured discount f <input type="checkbox"/> Medicaid/Medicare g <input type="checkbox"/> State regulation h <input type="checkbox"/> Other (describe in Part VI)	11	Yes	
12	Explained the method for applying for financial assistance?	12	Yes	
13	Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply) a <input checked="" type="checkbox"/> The policy was posted at all times on the hospital facility's web site b <input checked="" type="checkbox"/> The policy was attached to all billing invoices c <input checked="" type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms d <input checked="" type="checkbox"/> The policy was posted in the hospital facility's admissions offices e <input type="checkbox"/> The policy was provided, in writing, to patients upon admission to the hospital facility f <input checked="" type="checkbox"/> The policy was available upon request g <input type="checkbox"/> Other (describe in Part VI)	13	Yes	

Billing and Collections

14	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment?	14	Yes	
15	Check all of the following collection actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP a <input checked="" type="checkbox"/> Reporting to credit agency b <input checked="" type="checkbox"/> Lawsuits c <input type="checkbox"/> Liens on residences d <input type="checkbox"/> Body attachments or arrests e <input type="checkbox"/> Other similar actions (describe in Part VI)			
16	Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged a <input type="checkbox"/> Reporting to credit agency b <input type="checkbox"/> Lawsuits c <input type="checkbox"/> Liens on residences d <input type="checkbox"/> Body attachments e <input type="checkbox"/> Other similar actions (describe in Part VI)	16		No
17	Indicate which efforts the hospital facility made before initiating any of the actions checked in question 16 (check all that apply) a <input type="checkbox"/> Notified patients of the financial assistance policy upon admission b <input type="checkbox"/> Notified patients of the financial assistance policy prior to discharge c <input type="checkbox"/> Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills d <input type="checkbox"/> Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy e <input type="checkbox"/> Other (describe in Part VI)			

Part V

Facility Information (continued)

Policy Relating to Emergency Medical Care

		Yes	No
18	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? If "No," indicate why	Yes	
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 Part VI)		
d	<input type="checkbox"/> Other (describe in Part VI)		

Individuals Eligible for Financial Assistance

19	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	<input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged		
b	<input type="checkbox"/> The hospital facility used the average of it's three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged		
c	<input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged		
d	<input checked="" type="checkbox"/> Other (describe in Part VI)		
20	Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Part VI	20	No
21	Did the hospital facility charge any of its FAP-eligible patients an amount equal to the gross charge for services provided to that patient? If "Yes," explain in Part VI	21	No

Part V

Facility Information (continued)

Section B. Facility Policies and Practices.

(Complete a separate Section B for each of the hospital facilities listed in Part V, Section A.)

COMMUNITY HOSPITAL EAST

Name of Hospital Facility:_____

Line Number of Hospital Facility (from Schedule H, Part V, Section A):_____2_____

		Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2011)			
1 During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment ("Needs Assessment")? If "No," skip to question 8 If "Yes," indicate what the Needs Assessment 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 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 those needs h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests i <input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs j <input checked="" type="checkbox"/> Other (describe in Part VI)	1	Yes	
2 Indicate the tax year the hospital facility last conducted a Needs Assessment 20 11			
3 In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3	Yes	
4 Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4	Yes	
5 Did the hospital facility make its Needs Assessment widely available to the public? If "Yes," indicate how the Needs Assessment was made widely available (check all that apply) a <input checked="" type="checkbox"/> Hospital facility's website b <input checked="" type="checkbox"/> Available upon request from the hospital facility c <input checked="" type="checkbox"/> Other (describe in Part VI)	5	Yes	
6 If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply) a <input checked="" type="checkbox"/> Adoption of an implementation strategy to address the health needs of the hospital facility's community b <input checked="" type="checkbox"/> Execution of the implementation strategy c <input checked="" type="checkbox"/> Development of a community-wide community benefit plan for the facility d <input checked="" type="checkbox"/> Participation in community-wide community benefit plan e <input checked="" type="checkbox"/> Inclusion of a community benefit section in operational plans f <input checked="" type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the CHNA g <input checked="" type="checkbox"/> Prioritization of health needs in the community h <input checked="" type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community i <input checked="" type="checkbox"/> Other (describe in Part VI)			
7 Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed together with the reasons why it has not addressed such needs	7		No
Financial Assistance Policy			
Did the hospital facility have in place during the tax year a written financial assistance policy that			
8 Explains eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	8	Yes	
9 Used federal poverty guidelines (FPG) to determine eligibility for providing free care? If "Yes," indicate the FPG family income limit for eligibility for free care 200 0% If "No," explain in Part VI the criteria the hospital facility used	9	Yes	

Part V

Facility Information (continued)

		Yes	No	
10	Used FPG to determine eligibility for providing discounted care? If "Yes," indicate the FPG family income limit for eligibility for discounted care <u>300 0</u> % If "No," explain in Part VI the criteria the hospital facility used	10	Yes	
11	Explained the basis for calculating amounts charged to patients? If "Yes," indicate the factors used in determining such amounts (check all that apply) a <input checked="" type="checkbox"/> Income level b <input type="checkbox"/> Asset level c <input checked="" type="checkbox"/> Medical indigency d <input type="checkbox"/> Insurance status e <input type="checkbox"/> Uninsured discount f <input type="checkbox"/> Medicaid/Medicare g <input type="checkbox"/> State regulation h <input type="checkbox"/> Other (describe in Part VI)	11	Yes	
12	Explained the method for applying for financial assistance?	12	Yes	
13	Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply) a <input checked="" type="checkbox"/> The policy was posted at all times on the hospital facility's web site b <input checked="" type="checkbox"/> The policy was attached to all billing invoices c <input checked="" type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms d <input checked="" type="checkbox"/> The policy was posted in the hospital facility's admissions offices e <input type="checkbox"/> The policy was provided, in writing, to patients upon admission to the hospital facility f <input checked="" type="checkbox"/> The policy was available upon request g <input type="checkbox"/> Other (describe in Part VI)	13	Yes	

Billing and Collections

14	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained actions the hospital facility may take upon non-payment?	14	Yes	
15	Check all of the following collection actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP a <input checked="" type="checkbox"/> Reporting to credit agency b <input checked="" type="checkbox"/> Lawsuits c <input type="checkbox"/> Liens on residences d <input type="checkbox"/> Body attachments or arrests e <input type="checkbox"/> Other similar actions (describe in Part VI)			
16	Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged a <input type="checkbox"/> Reporting to credit agency b <input type="checkbox"/> Lawsuits c <input type="checkbox"/> Liens on residences d <input type="checkbox"/> Body attachments e <input type="checkbox"/> Other similar actions (describe in Part VI)	16		No
17	Indicate which efforts the hospital facility made before initiating any of the actions checked in question 16 (check all that apply) a <input type="checkbox"/> Notified patients of the financial assistance policy upon admission b <input type="checkbox"/> Notified patients of the financial assistance policy prior to discharge c <input type="checkbox"/> Notified patients of the financial assistance policy in communications with the patients regarding the patients' bills d <input type="checkbox"/> Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy e <input type="checkbox"/> Other (describe in Part VI)			

Part V

Facility Information (continued)

Policy Relating to Emergency Medical Care

		Yes	No
18	Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? If "No," indicate why	Yes	
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 Part VI)		
d	<input type="checkbox"/> Other (describe in Part VI)		

Individuals Eligible for Financial Assistance

19	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	<input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged		
b	<input type="checkbox"/> The hospital facility used the average of it's three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged		
c	<input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged		
d	<input checked="" type="checkbox"/> Other (describe in Part VI)		
20	Did the hospital facility charge any of its patients who were eligible for assistance under the hospital facility's financial assistance policy, and to whom the hospital facility provided emergency or other medically necessary services, more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Part VI	20	No
21	Did the hospital facility charge any of its FAP-eligible patients an amount equal to the gross charge for services provided to that patient? If "Yes," explain in Part VI	21	No

Part V

Facility Information (continued)

Section C. Other 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 facilities did the organization operate during the tax year? 67

Name and address	Type of Facility (Describe)
1 See Additional Data Table	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Part VI

Supplemental Information

Complete this part to provide the following information

- 1
- Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7, Part II, Part III, lines 4, 8, and 9b, and Part V, Section B, lines 1j, 3, 4, 5c, 6l, 7, 9, 10, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21
- 2
- Community health needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any community health needs assessments reported in Part V, Section B
- 3
- Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy
- 4
- Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves
- 5
- Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e g , open medical staff, community board, use of surplus funds, etc)
- 6
- Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served
- 7
- State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report

Identifier	ReturnReference	Explanation
RELATED ORGANIZATION INFORMATION	PART I LINE 6A	A COMMUNITY BENEFIT REPORT IS COMPLETED FOR THE COMMUNITY HEALTH NETWORK AS A WHOLE COMMUNITY HOSPITALS OF INDIANA INC IS INCLUDED WITHIN THE NETWORK COMMUNITY BENEFIT REPORT

Identifier	ReturnReference	Explanation
COSTING METHODOLOGY EXPLANATION	PART I LINE 7	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 I LINE 7G SUBSIDIZED HEALTH SERVICES EXPLANATION SUBSIDIZED HEALTH CARE REPORTED DOES NOT INCLUDE COSTS ATTRIBUTABLE TO PHYSICIAN CLINICS

Identifier	ReturnReference	Explanation
BAD DEBT EXPENSE EXPLANATION	PART III LINE 4	THE COST TO CHARGE RATIO UTILIZED FOR PURPOSES OF REPORTING BAD DEBT COSTS WAS DERIVED FROM WORKSHEET 2 AND IS BASED ON THE ORGANIZATIONS AUDITED FINANCIAL STATEMENTS COMMUNITY HOSPITALS OF INDIANA INC UTILIZES AN AUTOMATED SOFTWARE SOLUTION TO ASSIST IN DETERMINING PATIENTS ELIGIBLE FOR FREE CARE AS A RESULT OF THE IMPLEMENTATION OF THIS AUTOMATED SOLUTION THERE IS VERY LITTLE BAD DEBT RECORDED FOR PATIENTS WHO WOULD BE ELIGIBLE FOR FREE CARE UNDER THE NETWORK POLICY THE AUDITED FINANCIAL STATEMENTS CONTAIN THE FOLLOWING TEXT WITHIN THE FOOTNOTES TO DESCRIBE BAD DEBT EXPENSE THE NETWORKS ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR DOUBTFUL ACCOUNTS IN EVALUATING THE COLLECTABILITY OF ACCOUNTS RECEIVABLE THE NETWORK ANALYZES ITS PAST HISTORY AND IDENTIFIES TRENDS FOR EACH OF ITS MAJOR PAYOR SOURCES OF REVENUE TO ESTIMATE THE APPROPRIATE ALLOWANCE FOR DOUBTFUL ACCOUNTS PROVISION FOR BAD DEBTS AND PROVISION FOR CHARITY MANAGEMENT REGULARLY REVIEWS DATA ABOUT THESE MAJOR PAYOR SOURCES OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD PARTY COVERAGE THE NETWORK ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR DOUBTFUL ACCOUNTS PROVISION FOR BAD DEBTS AND CHARITY FOR EXPECTED UNCOLLECTIBLE DEDUCTIBLES AND COINSURANCES FOR RECEIVABLES ASSOCIATED WITH SELFPAY PATIENTS THE NETWORK RECORDS A PROVISION FOR BAD DEBTS AND CHARITY 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 ALL REASONABLE COLLECTION EFFORTS HAVE BEEN EXHAUSTED IS CHARGED OFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS FOR CHNW CHS VEI AND IHH ACCOUNTS THAT ARE SENT TO COLLECTION COMPANIES THE ACCOUNTS REMAIN AS ACCOUNTS RECEIVABLE ON THE BALANCE SHEET THESE ACCOUNTS ARE NOT WRITTEN OFF UNLESS RETURNED FROM THE COLLECTION COMPANY AS SUCH THE ALLOWANCE FOR DOUBTFUL ACCOUNTS IS SIGNIFICANT FOR THIS COMPONENT OF THE ACCOUNTS RECEIVABLE THE NETWORKS ALLOWANCE FOR DOUBTFUL ACCOUNTS INCREASED BY 956 IN FISCAL YEAR 2011 FROM FISCAL YEAR 2010 THIS INCREASE IS THE RESULT OF ACCOUNTS THAT WERE TRANSFERRED TO THE COLLECTION COMPANY DURING FISCAL YEAR 2011 FOR CHNW CHS VEI AND IHH ACCOUNTS TRANSFERRED TO COLLECTIONS DURING FISCAL YEAR 2011 REPRESENTED 1086 OF THE TOTAL GROSS ACCOUNTS RECEIVABLE IN FISCAL YEAR 2011 WESTVIEW WAS CONSOLIDATED ONTO THE NETWORK FINANCIAL STATEMENTS WHICH ATTRIBUTED TO 2985000 OF THE OVERALL INCREASE FROM FISCAL YEAR 2010 THE NETWORK HAS NOT CHANGED ITS CHARITY CARE OR UNINSURED DISCOUNT POLICIES DURING FISCAL YEARS 2011 OR 2010 THE NETWORK RECOGNIZES PATIENT SERVICE REVENUE ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRDPARTY PAYOR 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 POLICY ON THE BASIS OF HISTORICAL EXPERIENCE A PORTION OF THE NETWORKS UNINSURED PATIENTS WILL BE UNABLE OR UNWILLING TO PAY FOR THE SERVICES PROVIDED THUS THE NETWORK RECORDS A PROVISION FOR BAD DEBTS AND CHARITY RELATED TO UNINSURED PATIENTS IN THE PERIOD THE SERVICES ARE PROVIDED 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 WRITTENOFF AGAINST THE ALLOWANCE FOR DOUBTFUL ACCOUNTS AFTER EXHAUSTING COLLECTION EFFORTS ANY SUBSEQUENT RECOVERIES ARE RECORDED AGAINST THE PROVISION FOR BAD DEBTS THE NETWORK MAINTAINS RECORDS TO IDENTIFY AND MONITOR THE LEVEL OF CHARITY CARE IT PROVIDES THE NETWORK PROVIDES CHARITY CARE TO PATIENTS WHOSE INCOME LEVEL IS BELOW 200 OF THE FEDERAL POVERTY LEVEL EFFECTIVE JANUARY 1 2010 THE NETWORK EARLY ADOPTED ACCOUNTING STANDARDS UPDATE ASU NO 201023 HEALTH CARE ENTITIES TOPIC 954 MEASURING CHARITY CARE FOR DISCLOSURE AS A RESULT OF ASU NO 201023 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 INCLUDES THE AMOUNT OF COSTS FORGONE FOR SERVICES AND SUPPLIES FURNISHED UNDER ITS CHARITY CARE POLICY AND WAS 26939000 AND 25693000 FOR THE YEARS ENDED DECEMBER 31 2011 AND 2010 RESPECTIVELY CHARITY CARE COST WAS DETERMINED ON THE APPLICATION OF THE ASSOCIATED COSTTO CHARGE RATIOS

Identifier	ReturnReference	Explanation
MEDICARE EXPLANATION	PART III LINE 8	PER THE 990 INSTRUCTIONS THE MEDICARE COST REPORT WAS UTILIZED TO DETERMINE THE MEDICARE SHORTFALL HOWEVER THE MEDICARE COST REPORT IS NOT REFLECTIVE OF ALL COSTS ASSOCIATED WITH MEDICARE PROGRAMS SUCH AS PHYSICIAN SERVICES AND SERVICES BILLED VIA FREE STANDING CLINICS FURTHER THE MEDICARE COST REPORT EXCLUDES REVENUES AND COSTS OF MEDICARE PART C AND D THE MEDICARE SHORTFALL ATTRIBUTED TO THOSE AREAS NOT INCLUDED ON THE MEDICARE COST REPORT IS 15514536 AS SUCH THE TOTAL MEDICARE SHORTFALL FOR ALL MEDICARE PROGRAMS IS 24632934 MEDICARE SHORTFALLS SHOULD BE CONSIDERED AS COMMUNITY BENEFIT BECAUSE MEDICARE REPRESENTS 3021 OF THE OVERALL PAYER MIX FOR COMMUNITY HOSPITALS OF INDIANA INC

Identifier	ReturnReference	Explanation
COLLECTION PRACTICES EXPLANATION	PART III LINE 9B	SEE ATTACHED FINANCIAL ASSISTANCE POLICY

Identifier	ReturnReference	Explanation
ADDITIONAL INFORMATION	PART VI	PART VI ITEMS 2 THROUGH 5 ARE DISCUSSED WITHIN THE ATTACHED IRS 990 SCHEDULE H SUPPLEMENTAL INFORMATION REPORT FOR A COPY OF THIS REPORT PLEASE CONTACT HOLLY MILLARD AT 317 3555860 PART VI ITEM 6 AFFILIATED HEALTH CARE SYSTEM COMMUNITY HOSPITALS OF INDIANA INC CHI IS PART OF AN AFFILIATED HEALTH CARE SYSTEM SEE THE ATTACHED IRS 990 SCHEDULE H SUPPLEMENTAL INFORMATION REPORT FOR HOW CHI IS INVOLVED IN PROMOTING THE HEALTH OF THE COMMUNITY IT SERVES PART VI ITEM 7 STATE FILING OF COMMUNITY BENEFIT REPORT INDIANA

Identifier	ReturnReference	Explanation
COMMUNITY HOSPITAL NORTH LINE NUMBER 1 PART V LINE 1J	PART V LINE 1J	SEE ATTACHED IRS 990 SCHEDULE H SUPPLEMENTAL INFORMATION REPORT

Identifier	ReturnReference	Explanation
COMMUNITY HOSPITAL NORTH LINE NUMBER 1 PART V LINE 3	PART V LINE 3	SEE ATTACHED IRS 990 SCHEDULE H SUPPLEMENTAL INFORMATION REPORT

Identifier	ReturnReference	Explanation
COMMUNITY HOSPITAL NORTH LINE NUMBER 1 PART V LINE 4	PART V LINE 4	SEE ATTACHED IRS 990 SCHEDULE H SUPPLEMENTAL INFORMATION REPORT

Identifier	ReturnReference	Explanation
COMMUNITY HOSPITAL NORTH LINE NUMBER 1 PART V LINE 5C	PART V LINE 5C	SEE ATTACHED IRS 990 SCHEDULE H SUPPLEMENTAL INFORMATION REPORT

Identifier	ReturnReference	Explanation
COMMUNITY HOSPITAL NORTH LINE NUMBER 1 PART V LINE 6I	PART V LINE 6I	SEE ATTACHED IRS 990 SCHEDULE H SUPPLEMENTAL INFORMATION REPORT

Identifier	ReturnReference	Explanation
COMMUNITY HOSPITAL NORTH LINE NUMBER 1 PART V LINE 7	PART V LINE 7	SEE ATTACHED IRS 990 SCHEDULE H SUPPLEMENTAL INFORMATION REPORT

Identifier	ReturnReference	Explanation
COMMUNITY HOSPITAL NORTH LINE NUMBER 1 PART V LINE 19D	PART V LINE 19D	THE UNINSURED DISCOUNT WAS DETERMINED UTILIZING THE NETWORKS TOP COMMERCIAL PAYORS PER THE NETWORKS AUDITED FINANCIAL STATEMENTS REGARDING UNINSURED DISCOUNTS COSTS FORGONE FOR SERVICES AND SUPPLIES FURNISHED UNDER THE NETWORKS UNINSURED DISCOUNT POLICY APPROXIMATED 6956000 AND 5417000 FOR THE YEARS ENDED DECEMBER 31 2011 AND 2010 RESPECTIVELY UNINSURED DISCOUNTS REPRESENT A STANDARD DISCOUNT ON CHARGES AS IT RELATES TO PATIENTS WHO HAVE NO INSURANCE COVERAGE UNINSURED DISCOUNT COST WAS DETERMINED BASED ON THE APPLICATION OF THE ASSOCIATED COSTTOCHARGE RATIOS TO CHARGES

Identifier	ReturnReference	Explanation
COMMUNITY HOSPITAL EAST LINE NUMBER 2 PART V LINE 1J	PART V LINE 1J	SEE ATTACHED IRS 990 SCHEDULE H SUPPLEMENTAL INFORMATION REPORT

Identifier	ReturnReference	Explanation
COMMUNITY HOSPITAL EAST LINE NUMBER 2 PART V LINE 3	PART V LINE 3	SEE ATTACHED IRS 990 SCHEDULE H SUPPLEMENTAL INFORMATION REPORT

Identifier	ReturnReference	Explanation
COMMUNITY HOSPITAL EAST LINE NUMBER 2 PART V LINE 4	PART V LINE 4	SEE ATTACHED IRS 990 SCHEDULE H SUPPLEMENTAL INFORMATION REPORT

Identifier	ReturnReference	Explanation
COMMUNITY HOSPITAL EAST LINE NUMBER 2 PART V LINE 5C	PART V LINE 5C	SEE ATTACHED IRS 990 SCHEDULE H SUPPLEMENTAL INFORMATION REPORT

Identifier	ReturnReference	Explanation
COMMUNITY HOSPITAL EAST LINE NUMBER 2 PART V LINE 6I	PART V LINE 6I	SEE ATTACHED IRS 990 SCHEDULE H SUPPLEMENTAL INFORMATION REPORT

Identifier	ReturnReference	Explanation
COMMUNITY HOSPITAL EAST LINE NUMBER 2 PART V LINE 7	PART V LINE 7	SEE ATTACHED IRS 990 SCHEDULE H SUPPLEMENTAL INFORMATION REPORT

Identifier	ReturnReference	Explanation
COMMUNITY HOSPITAL EAST LINE NUMBER 2 PART V LINE 19D	PART V LINE 19D	THE UNINSURED DISCOUNT WAS DETERMINED UTILIZING THE NETWORKS TOP COMMERCIAL PAYORS PER THE NETWORKS AUDITED FINANCIAL STATEMENTS REGARDING UNINSURED DISCOUNTS COSTS FORGONE FOR SERVICES AND SUPPLIES FURNISHED UNDER THE NETWORKS UNINSURED DISCOUNT POLICY APPROXIMATED 6956000 AND 5417000 FOR THE YEARS ENDED DECEMBER 31 2011 AND 2010 RESPECTIVELY UNINSURED DISCOUNTS REPRESENT A STANDARD DISCOUNT ON CHARGES AS IT RELATES TO PATIENTS WHO HAVE NO INSURANCE COVERAGE UNINSURED DISCOUNT COST WAS DETERMINED BASED ON THE APPLICATION OF THE ASSOCIATED COSTTOCHARGE RATIOS TO CHARGES

Additional Data

Software ID:	
Software Version:	
EIN:	33
Name:	C

Software Version:**Name:** COMMUNITY HOSPITALS OF INDIANA INC

Name: COMMUNITY HOSPITALS OF INDIANA INC

Form 990 Schedule H, Part V Section C. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

[illegible]

Schedule J

(Form 990)

Compensation Information

OMB No 1545-0047

2011

Open to Public Inspection

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

▶ Complete if the organization answered "Yes" to Form 990, Part IV, question 23.

▶ Attach to Form 990. ▶ See separate instructions.

Department of the Treasury

Internal Revenue Service

Name of the organization

COMMUNITY HOSPITALS OF INDIANA INC

Employer identification number

35-0983617

Part I

Questions Regarding Compensation

- 1a

Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.

☐ First-class or charter travel

☐ Travel for companions

☐ Tax idemnification and gross-up payments

☐ Discretionary spending account

☐ Housing allowance or residence for personal use

☐ Payments for business use of personal residence

☐ Health or social club dues or initiation fees

☐ Personal services (e g , maid, chauffeur, chef)
- b

If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all the expenses described above? If "No," complete Part III to explain.
- 2

Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all officers, directors, trustees, and the CEO/Executive Director, regarding the items checked in line 1a?
- 3

Indicate which, if any, of the following the organization uses to establish the compensation of the organization's CEO/Executive Director. Check all that apply.

☐ Compensation committee

☐ Independent compensation consultant

☐ Form 990 of other organizations

☐ Written employment contract

☐ Compensation survey or study

☐ Approval by the board or compensation committee
- 4

During the year, did any person listed in Form 990, Part VII, Section A, line 1a with respect to the filing organization or a related organization:

a

Receive a severance payment or change-of-control payment?

b

Participate in, or receive payment from, a supplemental nonqualified retirement plan?

c

Participate in, or receive payment from, an equity-based compensation arrangement?

If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.

Only 501(c)(3) and 501(c)(4) organizations only must complete lines 5-9.

5

For persons listed in form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:

a

The organization?

b

Any related organization?

If "Yes," to line 5a or 5b, describe in Part III.

6

For persons listed in form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:

a

The organization?

b

Any related organization?

If "Yes," to line 6a or 6b, describe in Part III.

7

For persons listed in Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III.

8

Were any amounts reported in Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regs. section 53.4958-4(a)(3)? If "Yes," describe in Part III.

9

If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?

Yes

No

1b

2

4a

No

4b

No

4c

No

5a

Yes

5b

No

6a

No

6b

No

7

Yes

8

No

9

For Privacy Act and Paperwork Reduction Act Notice, see the Instructions for Form 990.

Cat No 50053T

Schedule J (Form 990) 2011

Part II Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees. Use Schedule J-1 if additional space needed.

For each individual whose compensation must be reported in Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions on row (ii) Do not list any individuals that are not listed on Form 990, Part VII

Note. The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, columns (D) and (E) for that individual

(A) Name		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported in prior Form 990 or Form 990-EZ
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) MICHAEL C BLANCHET	(i) (ii)	489,882		10,187	343,806	7,020	850,895	
(2) TONY LENNEN	(i) (ii)	327,130		1,795	108,763	24,415	462,103	
(3) BARBARA SUMMERS	(i) (ii)	275,590		1,072	268,066	20,495	565,223	
(4) JEFFERY KIRKHAM	(i) (ii)	269,875		1,449	252,298	22,465	546,087	
(5) ROBIN LEDYARD MD	(i) (ii)	269,713		1,466	117,759	22,713	411,651	
(6) JOHN T CUMMINGS MD	(i) (ii)	788,638	160,775	317,215	497,412	27,806	1,791,846	315,993
(7) DAVID C HALL MD	(i) (ii)	892,508	105,600	18,087	151,039	33,157	1,200,391	57,017
(8) ROBERT B SLOAN JR MD	(i) (ii)	894,645		65,297	31,813	21,351	1,013,106	
(9) JILL W DONALDSON MD	(i) (ii)	651,815	45,995	33,169	223,602	21,548	976,129	
(10) ROSEMARIE JONES MD	(i) (ii)	563,482	76,317	46,808	487,101		1,173,708	
(11) STEVE HULTGREN	(i) (ii)	57,901 85,499		424 600	49,717 76,892	7,080 10,225	115,122 173,216	

Part III **Supplemental Information**

Complete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 4c, 5a, 5b, 6a, 6b, 7, and 8. Also complete this part for any additional information.

Identifier	Return Reference	Explanation
RELATED ORG METHODS USED FOR COMPENSATION EXPLANATION	SCHEDULE J, PAGE 1, PART I, LINE 3	COMMUNITY HOSPITALS OF INDIANA, INC. ("CHI") CEO/EXECUTIVE DIRECTOR IS PAID BY COMMUNITY HEALTH NETWORK, INC. ("CHNW"), A RELATED 501(C)(3) ORGANIZATION. CHNW USES THE FOLLOWING IN DETERMINING THE CEO'S COMPENSATION: 1) COMPENSATION COMMITTEE, 2) INDEPENDENT COMPENSATION CONSULTANT, 3) COMPENSATION SURVEY OR STUDY, AND 4) APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE.
COMPENSATION CONTINGENT UPON REVENUES OF ORGANIZATION	SCHEDULE J, PAGE 1, PART I, LINE 5A	DR. JOHN CUMMINGS, DR. DAVID HALL, DR. JILL DONALDSON, AND DR. ROSEMARIE JONES ARE ELIGIBLE TO PARTICIPATE IN CHI'S INCENTIVE COMPENSATION PLAN. CHI DEVELOPED ITS COMPENSATION PLAN IN CONJUNCTION WITH AN INDEPENDENT COMPENSATION CONSULTANT. IN ADDITION, THE PLAN WAS APPROVED BY THE NETWORK EXECUTIVE COMPENSATION COMMITTEE, COMPOSED OF INDEPENDENT OUTSIDE DIRECTORS. IN ADOPTING ITS INCENTIVE BASED COMPENSATION PLAN, CHI (TOGETHER WITH ITS INDEPENDENT COMPENSATION CONSULTANT, ITS EXTERNAL LEGAL COUNSEL, AND THE NETWORK EXECUTIVE COMPENSATION COMMITTEE) CONSIDERED AND APPLIED THE PROVISIONS OF CODE SECTION 4958 AND THE CORRESPONDING TREASURY REGULATIONS TO ENSURE THAT ITS COMPENSATION DECISIONS REFLECT ARMS LENGTH, FAIR MARKET TERMS.
NON-FIXED PAYMENTS PROVIDED	SCHEDULE J, PAGE 1, PART I, LINE 7	COMMUNITY HOSPITALS OF INDIANA, INC. PARTICIPATES IN THE NETWORK'S SENIOR LEADERSHIP INCENTIVE PROGRAM. CERTAIN INDIVIDUALS OF THE LEADERSHIP TEAM PARTICIPATE IN THIS PROGRAM. THE PROGRAM WAS ADOPTED BY THE EXECUTIVE COMPENSATION COMMITTEE, AND IS INTENDED TO INFLUENCE OUTSTANDING PERFORMANCE BY THE SENIOR LEADERS, AS MEASURED AGAINST BOTH ORGANIZATIONAL AND INDIVIDUAL PERFORMANCE. THE PROGRAM IS REVIEWED ANNUALLY BY THE EXECUTIVE COMPENSATION COMMITTEE, WHICH IS COMPOSED ENTIRELY OF INDEPENDENT COMMUNITY MEMBERS. THE INCENTIVE COMPENSATION THAT IS AWARDED IS INCLUDED IN TOTAL COMPENSATION TO THE EXECUTIVE. THE TOTAL COMPENSATION (INCLUDING ANY PAYMENTS UNDER THE PROGRAM) IS SUBJECT TO THE REVIEW AND APPROVAL OF THE EXECUTIVE COMPENSATION COMMITTEE AND INDEPENDENT COMPENSATION CONSULTANT, IN CONSIDERATION OF CODE SECTION 4958 (AND THE CORRESPONDING TREASURY REGULATIONS) TO ENSURE THAT IT REFLECTS ARMS LENGTH, FAIR MARKET TERMS.

Schedule K
(Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Schedule O (Form 990).
▶ Attach to Form 990. ▶ See separate instructions.

OMB No 1545-0047

2011

Open to Public
Inspection

Name of the organization
COMMUNITY HOSPITALS OF INDIANA INC

Employer identification number
35-0983617

Part I Bond Issues

	(a) Issuer Name	(b) Issuer EIN	(c) CUSIP #	(d) Date Issued	(e) Issue Price	(f) Description of Purpose	(g) Defeased		(h) On Behalf of Issuer		(i) Pool financing	
							Yes	No	Yes	No	Yes	No
A	IN HLTH FACILITY FINANCING AUTHORIT	35-1611409	45479QAU3	05-04-2005	157,491,981	NORTH HOSP EXPANSION		X		X		X
B	IN HLTH FACILITY FINANCING AUTHORIT	35-1611409	45479QAY5	05-04-2005	37,500,000	NORTH HOSP EXPANSION		X		X		X
C	INDIANA FINANCE AUTHORITY	35-1602316	45471AAM4	06-30-2009	100,000,000	SOUTH HOSP EXPANSION		X		X		X

Part II Proceeds

		A		B		C		D	
1	Amount of bonds retired	11,335,000		3,500,000		2,060,000			
2	Amount of bonds defeased								
3	Total proceeds of issue	159,591,906		37,500,020		100,013,940			
4	Gross proceeds in reserve funds	10,229,475							
5	Capitalized interest from proceeds	11,119,328		1,838,231					
6	Proceeds in refunding escrow								
7	Issuance costs from proceeds	1,453,597		345,682		842,000			
8	Credit enhancement from proceeds	3,768,763		216,893		499,875			
9	Working capital expenditures from proceeds								
10	Capital expenditures from proceeds	133,020,743		35,099,214		98,672,065			
11	Other spent proceeds								
12	Other unspent proceeds								
13	Year of substantial completion	2007		2007		2010			
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue?		X		X		X		
15	Were the bonds issued as part of an advance refunding issue?		X		X		X		
16	Has the final allocation of proceeds been made?	X		X		X			
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X			

Part III Private Business Use

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X		X		X		
2	Are there any lease arrangements that may result in private business use of bond-financed property?	X		X		X			

Part III

Private Business Use (Continued)

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
3a	Are there any management or service contracts that may result in private business use?	X		X		X			
b	If 'Yes' to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?	X		X		X			
c	Are there any research agreements that may result in private business use of bond-financed property?	X		X		X			
d	If 'Yes' to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?	X		X		X			
4	Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government	1 440 %		1 440 %		0 840 %			
5	Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government								
6	Total of lines 4 and 5	1 440 %		1 440 %		0 840 %			
7	Has the organization adopted management practices and procedures to ensure the post-issuance compliance of its tax-exempt bond liabilities?	X		X		X			

Part IV

Arbitrage

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Has a Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate, been filed with respect to the bond issue?		X		X		X		
2	Is the bond issue a variable rate issue?		X	X		X			
3a	Has the organization or the governmental issuer entered into a hedge with respect to the bond issue?		X		X		X		
b	Name of provider								
c	Term of hedge								
d	Was the hedge superintegrated?								
e	Was a hedge terminated?								
4a	Were gross proceeds invested in a GIC ?	X		X			X		
b	Name of provider	FSA CAPITAL		FSA CAPITAL					
c	Term of GIC	2 3		2 3					
d	Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?	X		X					
5	Were any gross proceeds invested beyond an available temporary period?	X		X			X		
6	Did the bond issue qualify for an exception to rebate?		X		X	X			

Part V

Procedures To Undertake Corrective Action

Check the box if the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations ☒ Yes ☐ No

Part VI

Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule K (see instructions)

Identifier	Return Reference	Explanation
DIFFERENCES IN ISSUE PRICE EXPLANATION	SCHEDULE K	IN HLTH FACILITY FINANCING AUTHORIT PART II LINE 3A ISSUE PRICE 157491981 INTEREST EARNED 2099925 IN HLTH FACILITY FINANCING AUTHORIT PART II LINE 3B ISSUE PRICE 37500000 INTEREST EARNED 20 INDIANA FINANCE AUTHORITY PART II LINE 3C ISSUE PRICE 100000000 INTEREST EARNED 13940

Schedule L
(Form 990 or 990-EZ)

Transactions with Interested Persons

OMB No 1545-0047

2011

Open to Public Inspection

Name of the organization
COMMUNITY HOSPITALS OF INDIANA INC

Employer identification number

35-0983617

Part I

Excess Benefit Transactions (section 501(c)(3) and section 501 (c)(4) organizations only).

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b

1	(a) Name of disqualified person	(b) Description of transaction	(c) Corrected?	
			Yes	No

2 Enter the amount of tax imposed on the organization managers or disqualified persons during the year under section 4958 ► \$

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization ► \$

Part II

Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 26, or Form 990-EZ, Part V, line 38a

(a) Name of interested person and purpose	(b) Loan to or from the organization?		(c)Original principal amount	(d)Balance due	(e) In default?		(f) Approved by board or committee?		(g)Written agreement?	
	To	From			Yes	No	Yes	No	Yes	No
Total ► \$										

Part III

Grants or Assistance Benefitting Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(a) Name of interested person	(b)Relationship between interested person and the organization	(c)Amount of grant or type of assistance

Part IV

Business Transactions Involving Interested Persons.
Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) THOMAS LEDYARD MD	FAMILY MEMBER	184,018	WAGES		No
(2) INDIANA PROHEALTH NETWORK INC	SHARE BD MEMBER	85,547,201	SERVICE REVENUE		No

Part V

Supplemental Information
Complete this part to provide additional information for responses to questions on Schedule L (see instructions)

Identifier	Return Reference	Explanation
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SCHEDULE O

(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on
Form 990 or to provide any additional information.
▶ Attach to Form 990 or 990-EZ.

OMB No 1545-0047

2011

Open to Public
Inspection

Name of the organization COMMUNITY HOSPITALS OF INDIANA INC	Employer identification number 35-0983617
----------------------------------------------------------------	--------------------------------------------------

Identifier	Return Reference	Explanation
ORGANIZATION'S MISSION	FORM 990 - ORGANIZATION'S MISSION	COMMUNITY HOSPITALS OF INDIANA, INC ("CHI") IS A 501(C)(3) CORPORATION SERVING THE HEALTH RELATED NEEDS OF THE CITIZENS OF THE INDIANAPOLIS METROPOLITAN AREA AND CENTRAL INDIANA. CHI OPERATES TWO GENERAL ACUTE CARE HOSPITALS AND PROVIDES INPATIENT, OUTPATIENT, EMERGENCY AND AMBULATORY HEALTH CARE SERVICES TO ALL PATIENTS REGARDLESS OF THEIR ABILITY TO PAY.

Identifier	Return Reference	Explanation
ADDITIONAL INFORMATION	FORM 990	<p>FORM 990, PART I, LINE 4 - INDEPENDENT VOTING MEMBERS CHI IS AN AFFILIATE OF COMMUNITY HEALTH NETWORK ("THE NETWORK"), AN INTEGRATED HEALTH DELIVERY SYSTEM CHI, TOGETHER WITH THE OTHER TAX-EXEMPT AFFILIATES OF THE NETWORK, IS CONTROLLED BY A TAX-EXEMPT PARENT ORGANIZATION, COMMUNITY HEALTH NETWORK, INC ("CHNW") CHNW EXERCISES CONTROL OVER CHI THROUGH A SERIES OF GOVERNANCE RIGHTS A) CHNW IS THE SOLE MEMBER OF CHI, B) CHNW HAS THE AUTHORITY TO APPROVE THREE-FOURTHS OF THE DIRECTORS THAT ARE ELECTED TO CHI'S BOARD OF DIRECTORS, C) CHI HAS DELEGATED EXCLUSIVE AUTHORITY TO CHNW, ACTING THROUGH CHNW'S BOARD OF DIRECTORS, IN THE FOLLOWING SUBSTANTIVE AREAS STRATEGIC PLANNING, CAPITAL ACCESS, BUDGETING AND ALLOCATION, AUDIT AND COMPLIANCE, EXECUTIVE COMPENSATION, AND DISPUTE RESOLUTION, D) CHNW MUST APPROVE ANY MODIFICATION, REPEAL, AMENDMENT, OR RESTATEMENT OF CHI'S ARTICLES OF INCORPORATION, AND E) CHNW MUST APPROVE ANY CLOSURE OF A HOSPITAL THAT IS OWNED BY CHI OR THE SALE OR DISPOSITION OF SUBSTANTIALLY ALL OF CHI'S ASSETS WITH REGARD TO EXECUTIVE COMPENSATION, CHNW HAS DELEGATED AUTHORITY TO REVIEW AND APPROVE EXECUTIVE COMPENSATION, INCLUDING CHI'S EXECUTIVES, TO A NETWORK EXECUTIVE COMPENSATION COMMITTEE COMPOSED OF INDEPENDENT OUTSIDE DIRECTORS IN SUM, CHI HAS REMOVED ANY RISK OF INAPPROPRIATE RELATED PARTY TRANSACTIONS BY DELEGATING (THROUGH CHNW) ITS EXECUTIVE COMPENSATION DECISIONS TO A NETWORK EXECUTIVE COMPENSATION COMMITTEE AND ITS CONFLICT OF INTEREST DECISIONS TO A NETWORK AUDIT COMMITTEE, WITH EACH COMMITTEE COMPOSED OF INDEPENDENT OUTSIDE DIRECTORS CHI'S PHYSICIANS CONSTITUTE A SECOND CLASS OF MEMBERS AS A CLASS, THE PHYSICIANS HAVE THE FOLLOWING RIGHTS A) TO ELECT ONE-FOURTH OF THE BOARD OF DIRECTORS OF CHI, B) TO APPROVE ANY MODIFICATION, REPEAL, AMENDMENT, OR RESTATEMENT OF CHI'S ARTICLES OF INCORPORATION, AND C) TO APPROVE ANY CLOSURE OF A HOSPITAL THAT IS OWNED BY CHI OR THE SALE OR DISPOSITION OF SUBSTANTIALLY ALL OF CHI'S ASSETS FORM 990, PART I, LINE 5 - NUMBER OF EMPLOYEES CHI EMPLOYEES ARE LEASED FROM COMMUNITY HEALTH NETWORK, INC</p>

Identifier	Return Reference	Explanation
ADDITIONAL INFORMATION	FORM 990, PART V	FORM 990, PART V, LINE 3B - FILING FORM 990-T FORM 990-T IS BEING FILED TO SUPPORT THE NET OPERATING LOSS DEDUCTION

Identifier	Return Reference	Explanation
FINANCIAL ACCOUNTS IN FOREIGN COUNTRIES	FORM 990, PART V, LINE 4B	CAYMAN ISLANDS

Identifier	Return Reference	Explanation
ADDITIONAL INFORMATION	FORM 990, PART VI	FORM 990, PART VI, LINE 1B - VOTING MEMBERS THAT ARE INDEPENDENT SEE FORM 990, PART I, LINE 4 REFERENCE ON SCHEDULE O ABOVE FORM 990, PART VI, LINE 2 - RELATED PARTY INFORMATION AMONG OFFICERS MANY OF CHI'S DIRECTORS, OFFICERS, AND KEY EMPLOYEES SERVE IN AN EXECUTIVE ROLE FOR OTHER TAX-EXEMPT AND TAXABLE AFFILIATES THROUGHOUT THE NETWORK ALL CHI'S DIRECTORS AND/OR OFFICERS ALSO SERVE AS DIRECTORS AND/OR OFFICERS OF COMMUNITY HOSPITAL SOUTH, INC IN ADDITION, THE FOLLOWING DIRECTORS AND/OR OFFICERS SERVE AS DIRECTORS AND/OR OFFICERS OF THE FOLLOWING ORGANIZATIONS MICHAEL C BLANCHET - COMMUNITY HEALTH NETWORK, INC - COMMUNITY HOME HEALTH SERVICES, INC - INDIANA PROHEALTH NETWORK, INC STEVEN R PLUMP - COMMUNITY HEALTH NETWORK, INC KRISTIN T SHERMAN - COMMUNITY HEALTH NETWORK, INC

Identifier	Return Reference	Explanation
MANAGEMENT DELEGATED	FORM 990, PAGE 6, PART VI, LINE 3	CHI HAS DELEGATED EXCLUSIVE AUTHORITY TO CHNW, ACTING THROUGH CHNW'S BOARD OF DIRECTORS, IN THE FOLLOWING SUBSTANTIVE AREAS: STRATEGIC PLANNING, CAPITAL ACCESS, BUDGETING AND ALLOCATION, AUDIT AND COMPLIANCE, EXECUTIVE COMPENSATION, AND DISPUTE RESOLUTION

Identifier	Return Reference	Explanation
CLASSES OF MEMBERS OR STOCKHOLDERS	FORM 990, PAGE 6, PART VI, LINE 6	SEE FORM 990, PART I, LINE 4 REFERENCE ON SCHEDULE O ABOVE

Identifier	Return Reference	Explanation
ELECTION OF MEMBERS AND THEIR RIGHTS	FORM 990, PAGE 6, PART VI, LINE 7A	SEE FORM 990, PART I, LINE 4 REFERENCE ON SCHEDULE O ABOVE

Identifier	Return Reference	Explanation
DECISIONS SUBJECT TO APPROVAL OF MEMBERS	FORM 990, PAGE 6, PART VI, LINE 7B	SEE FORM 990, PART I, LINE 4 REFERENCE ON SCHEDULE O ABOVE

Identifier	Return Reference	Explanation
ORGANIZATION'S PROCESS USED TO REVIEW FORM 990	FORM 990, PAGE 6, PART VI, LINE 11B	AS DISCUSSED IN PART I, LINE 4, CHI HAS DELEGATED AUTHORITY FOR AUDIT, COMPLIANCE, AND EXECUTIVE COMPENSATION TO CHNW. CHNW'S BOARD OF DIRECTORS HAS DELEGATED AUTHORITY FOR THE REVIEW OF CHI'S FORM 990 TO TWO COMMITTEES COMPOSED OF INDEPENDENT OUTSIDE DIRECTORS. A) THE NETWORK EXECUTIVE COMPENSATION COMMITTEE REVIEWED THE COMPENSATION ASPECTS OF CHI'S FORM 990, AND B) THE NETWORK FINANCE COMMITTEE REVIEWED THE REMAINDER OF THE CHI'S FORM 990. IN ADDITION, CHI'S OUTSIDE ACCOUNTING FIRM AND LAW FIRM REVIEWED THE FORM 990 PRIOR TO FILING. CHI AND CHNW UTILIZED THIS PROCESS TO ENSURE THAT CHI'S FORM 990 RECEIVED SUBSTANTIVE REVIEW BY DIRECTORS AND PROFESSIONALS WITH SPECIFIC KNOWLEDGE OF CHI'S ACTIVITIES AND EXTENSIVE FINANCIAL, ACCOUNTING, AND TAX EXPERTISE.

Identifier	Return Reference	Explanation
ENFORCEMENT OF CONFLICTS POLICY	FORM 990, PAGE 6, PART VI, LINE 12C	<p>AS DISCUSSED IN PART I, LINE 4, CHI HAS DELEGATED AUTHORITY FOR AUDIT AND COMPLIANCE TO CHNW. CHNW HAS ADOPTED A CONFLICT OF INTEREST POLICY THAT APPLIES TO EVERY TAX-EXEMPT ORGANIZATION WITHIN THE NETWORK, INCLUDING CHI. THE CONFLICT OF INTEREST POLICY REQUIRES DIRECTORS, OFFICERS, AND KEY EMPLOYEES TO SUBMIT AN ANNUAL CONFLICT OF INTEREST DISCLOSURE. THE ANNUAL DISCLOSURE REQUIRES DIRECTORS, OFFICERS, AND KEY EMPLOYEES TO DISCLOSE, IN WRITING, ANY KNOWN FINANCIAL INTEREST THAT THE INDIVIDUAL (TOGETHER WITH FAMILY MEMBERS) HAS IN ANY BUSINESS ENTITY THAT TRANSACTS BUSINESS WITH CHI. IN ADDITION, DIRECTORS, OFFICERS, AND KEY EMPLOYEES ARE REQUIRED TO IMMEDIATELY DISCLOSE ANY POSSIBLE CONFLICT OF INTEREST THAT ARISES MID-YEAR IN RELATION TO A PROPOSED TRANSACTION. THE CONFLICT OF INTEREST POLICY REQUIRES THAT ANY INDIVIDUAL WITH A CONFLICT BE RECUSED FROM THE DECISION MAKING PROCESS, THAT INDEPENDENT DIRECTORS OR COMMITTEE MEMBERS DETERMINE THAT THE PROPOSED TRANSACTION IS IN THE BEST INTEREST OF CHI, AND THE TRANSACTION MUST BE APPROVED BY A VOTE OF INDEPENDENT DIRECTORS OR COMMITTEE MEMBERS WITHOUT THE PARTICIPATION OF ANY INTERESTED INDIVIDUAL. THE ANNUAL CONFLICT DISCLOSURE STATEMENTS ARE SUBMITTED TO, AND REVIEWED BY, CHNW'S AUDIT COMMITTEE, COMPOSED OF INDEPENDENT DIRECTORS. IN ADDITION, THE EXECUTIVE STAFF AND GENERAL COUNSEL OF THE NETWORK ARE RESPONSIBLE FOR MONITORING ANY POSSIBLE CONFLICT TRANSACTIONS THAT ARISE AND MANAGING THEM TO ENSURE THAT ALL TRANSACTIONS REPRESENT ARMS LENGTH, FAIR MARKET VALUE TERMS FOR THE BENEFIT OF CHI.</p>

Identifier	Return Reference	Explanation
COMPENSATION PROCESS FOR TOP OFFICIAL	FORM 990, PAGE 6, PART VI, LINE 15A	<p>AS DISCUSSED IN PART I, LINE 4, CHI HAS DELEGATED AUTHORITY FOR EXECUTIVE COMPENSATION TO CHNW. CHNW HAS ADOPTED AN EXECUTIVE COMPENSATION AND INTERMEDIATE SANCTIONS POLICY THAT APPLIES TO CHI. THE PURPOSE OF THE POLICY IS TO ENSURE THAT CHI'S COMPENSATION ARRANGEMENTS WITH RELATED PARTIES ARE EVALUATED AND ENTERED AT ARMS LENGTH AND THAT ANY COMPENSATION THAT IS PAID TO A RELATED PARTY IS REASONABLE AND REFLECTS FAIR MARKET VALUE. THIS POLICY ENCOURAGES THE APPLICATION OF THE REBUTTABLE PRESUMPTION STANDARD OF CODE SECTION 4958 AND THE RELATED TREASURY REGULATIONS BY:</p> <ul style="list-style-type: none"> A) EXCLUDING ANY INTERESTED PARTY FROM THE DECISION MAKING PROCESS, B) REQUIRING DISINTERESTED BOARD OR COMMITTEE MEMBERS TO OBTAIN AND RELY UPON COMPARABILITY DATA WHEN SETTING THE PROPOSED COMPENSATION TERMS, C) REQUIRING APPROVAL OF THE TRANSACTION IN ADVANCE BY DISINTERESTED DIRECTORS OR COMMITTEE MEMBERS, AND D) REQUIRING CONTEMPORANEOUS DOCUMENTATION (I.E. MINUTES) REFLECTING THE DECISION AND THE PROCESS BY WHICH IT WAS MADE. <p>CHNW ALSO DELEGATED AUTHORITY REGARDING CHI'S EXECUTIVE COMPENSATION TO:</p> <ul style="list-style-type: none"> A) THE NETWORK EXECUTIVE COMPENSATION COMMITTEE, COMPOSED OF INDEPENDENT OUTSIDE DIRECTORS, WHICH IS RESPONSIBLE FOR APPLYING THE TERMS AND PROCESS OF THE EXECUTIVE COMPENSATION AND INTERMEDIATE SANCTIONS POLICY AS OUTLINED ABOVE, AND B) THE NETWORK VICE PRESIDENT OF HUMAN RESOURCES WHO IS RESPONSIBLE FOR OBTAINING COMPARATIVE SALARY MARKET DATA FOR THE CHIEF EXECUTIVE OFFICER, OFFICERS, AND KEY EMPLOYEES, PERIODICALLY ENGAGING AN INDEPENDENT COMPENSATION CONSULTANT TO ESTABLISH REASONABLE COMPENSATION, AND PROVIDING STAFF SUPPORT TO THE NETWORK EXECUTIVE COMPENSATION COMMITTEE. <p>DURING 2011, THE NETWORK EXECUTIVE COMPENSATION COMMITTEE FOLLOWED THIS PROCESS FOR ALL CHIEF EXECUTIVE OFFICERS FOR ALL NETWORK ENTITIES, THE NETWORK CHIEF FINANCIAL OFFICER, THE NETWORK VICE PRESIDENT OF HUMAN RESOURCES, THE NETWORK VICE PRESIDENT OF MEDICAL AND ACADEMIC AFFAIRS, THE NETWORK VICE PRESIDENT OF LEGAL SERVICES, THE NETWORK CHIEF INFORMATION OFFICER, AND THE VICE PRESIDENT OF BUSINESS DEVELOPMENT AND MARKETING. FOR ALL POSITIONS REPRESENTING MANAGER AND ABOVE, THE CHIEF EXECUTIVE OFFICERS, CHIEF FINANCIAL OFFICERS, AND HUMAN RESOURCES REPRESENTATIVES FOR ALL NETWORK ENTITIES FOLLOWED A PROCESS WHEREBY SALARIES WERE COMPARED AGAINST COMPARATIVE SALARY MARKET DATA.</p>

Identifier	Return Reference	Explanation
COMPENSATION PROCESS FOR OFFICERS	FORM 990, PAGE 6, PART VI, LINE 15B	SEE LINE 15A ABOVE

Identifier	Return Reference	Explanation
GOVERNING DOCUMENTS DISCLOSURE EXPLANATION	FORM 990, PAGE 6, PART VI, LINE 19	A) THE ARTICLES OF INCORPORATION AND CERTIFICATE OF EXISTENCE ARE ON FILE WITH THE INDIANA SECRETARY OF STATE AND ARE AVAILABLE TO THE PUBLIC UPON REQUEST TO THE INDIANA SECRETARY OF STATE OR FREE OF CHARGE ON THE SECRETARY OF STATE'S WEBSITE B) AS A SUBSIDIARY OF CHNW, CHI HAS ADOPTED THE NETWORK CONFLICT OF INTEREST POLICY WHILE THIS POLICY IS NOT AVAILABLE TO THE PUBLIC, THE NETWORK'S DEFINITION OF CONFLICT OF INTEREST AND HOW TO REPORT SUCH AN INCIDENT IS DESCRIBED IN THE NETWORK RESPONSIBILITY AND COMPLIANCE PROGRAM ("NRCP") MANUAL WHICH IS POSTED ON THE NETWORK'S WEBSITE, ECOMMUNITY.COM THIS MANUAL IS AVAILABLE FOR THE PUBLIC TO REVIEW C) CHI DOES NOT HAVE INDIVIDUALLY AUDITED FINANCIAL STATEMENTS ITS FINANCIAL RESULTS ARE INCLUDED IN THE CONSOLIDATED FINANCIAL STATEMENTS OF CHNW AND AFFILIATES AS SUCH, THERE ARE NO INDIVIDUAL FINANCIAL STATEMENTS TO POST CHI DOES FILE THE 990 TAX RETURN ON AN ANNUAL BASIS WHICH IS AVAILABLE UPON REQUEST AND/OR AVAILABLE ON A DELAYED BASIS ON GUIDESTAR.COM

Identifier	Return Reference	Explanation
ADDITIONAL INFORMATION	FORM 990, PART VII	FORM 990, PART VII - AVERAGE HOURS WORKED FOR RELATED ORGANIZATION MICHAEL C BLANCHET - 20 STEVE HULTGREN - 23 85 JEFFERY KIRKHAM - 10 TONY LENNEN - 50

Identifier	Return Reference	Explanation
OTHER CHANGES IN NET ASSETS EXPLANATION	FORM 990, PART XI, LINE 5	UNDERFUNDED PENSION LIABILITY (102,506,524) INVESTMENT MARKET VALUE (41,226,210) EQUITY INVESTMENT NON-CONTROLLING INTEREST (248,414) EQUITY CONTRIBUTION (18,100,000) TRANSFER OF FUND BALANCE FROM MERGER OF COMMUNITY HEALTH NETWORK, INC ("CHNW") 93,937,735 TOTAL (68,143,413) EFFECTIVE DECEMBER 31, 2011, CHNW WAS MERGED INTO CHI

SCHEDULE R
(Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 33, 34, 35, 36, or 37.
▶ Attach to Form 990. ▶ See separate instructions.

OMB No 1545-0047

2011

Open to Public Inspection

Name of the organization
COMMUNITY HOSPITALS OF INDIANA INC

Employer identification number
35-0983617

Part I

Identification of Disregarded Entities (Complete if the organization answered "Yes" on Form 990, Part IV, line 33.)

(a) Name, address, and EIN of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity

Part II

Identification of Related Tax-Exempt Organizations (Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.)

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled organization	
						Yes	No
See Additional Data Table							

Part III

Identification of Related Organizations Taxable as a Partnership (Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a partnership during the tax year.)

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512- 514)	(f) Share of total income	(g) Share of end-of- year assets	(h) Disproportionate allocations?		(i) Code V—UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
See Additional Data Table												

Part IV

Identification of Related Organizations Taxable as a Corporation or Trust (Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.)

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership
See Additional Data Table							

Part V

Transactions With Related Organizations (Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35, 35A, or 36.)

Note. Complete line 1 if any entity is listed in Parts II, III or IV

1

During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?

a

Receipt of (i) interest (ii) annuities (iii) royalties (iv) rent from a controlled entity

b

Gift, grant, or capital contribution to related organization(s)

c

Gift, grant, or capital contribution from related organization(s)

d

Loans or loan guarantees to or for related organization(s)

e

Loans or loan guarantees by related organization(s)

f

Sale of assets to related organization(s)

g

Purchase of assets from related organization(s)

h

Exchange of assets with related organization(s)

i

Lease of facilities, equipment, or other assets to related organization(s)

j

Lease of facilities, equipment, or other assets from related organization(s)

k

Performance of services or membership or fundraising solicitations for related organization(s)

l

Performance of services or membership or fundraising solicitations by related organization(s)

m

Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)

n

Sharing of paid employees with related organization(s)

o

Reimbursement paid to related organization(s) for expenses

p

Reimbursement paid by related organization(s) for expenses

q

Other transfer of cash or property to related organization(s)

r

Other transfer of cash or property from related organization(s)

Yes

No

1a

Yes

1b

Yes

1c

Yes

1d

No

1e

No

1f

No

1g

Yes

1h

No

1i

Yes

1j

Yes

1k

No

1l

No

1m

No

1n

No

1o

Yes

1p

Yes

1q

Yes

1r

Yes

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds

(a) Name of other organization	(b) Transaction type(a-r)	(c) Amount involved	(d) Method of determining amount involved
(1) See Additional Data Table			
(2)			
(3)			
(4)			
(5)			
(6)			

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

[illegible]

Part VII

Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule R (see instructions)

Identifier	Return Reference	Explanation	
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Software ID:

Software Version:

EIN: 35-0983617

Name: COMMUNITY HOSPITALS OF INDIANA INC

Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations

(a) Name, address, and EIN of related organization	(b) Primary Activity	(c) Legal Domicile (State or Foreign Country)	(d) Exempt Code section	(e) Public charity status (if 501(c)(3))	(f) Direct Controlling Entity	(g) Section 512 (b)(13) controlled organization	
COMMUNITY HEALTH NETWORK INC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 31-1038302	PARENT	IN	501C3	11B	NA		No
COMMUNITY HEALTH NETWORK FOUNDATION 1500 NORTH RITTER AVENUE INDIANAPOLIS, IN 46219 51-0181688	SUPPORT	IN	501C3	11B	CHNW	Yes	
COMMUNITY HOME HEALTH SERVICES INC 9894 EAST 121ST STREET FISHERS, IN 46037 35-0953467	HLTH CARE	IN	501C3	9	CHNW	Yes	
COMM HOSP OF ANDERSON & MADISON CTY 1515 NORTH MADISON AVENUE ANDERSON, IN 46011 35-1069822	HOSPITAL	IN	501C3	3	CHI	Yes	
COMMUNITY HOSP ANDERSON FDN INC 1515 NORTH MADISON AVENUE ANDERSON, IN 46011 86-1053152	SUPPORT	IN	501C3	7	CHA	Yes	
COMMUNITY LTC INC 1031 MONTICELLO DRIVE ANDERSON, IN 46011 35-1877441	HLTH CARE	IN	501C3	9	CHA	Yes	
COMMUNITY HOSPITAL SOUTH INC 1402 E COUNTY LINE ROAD SOUTH INDIANAPOLIS, IN 46227 35-1088640	HOSPITAL	IN	501C3	3	CHI	Yes	
COMMUNITY PHYSICIANS OF IN INC 7240 SHADELAND STATION SUITE 300 INDIANAPOLIS, IN 46256 20-5392766	PHY SRV	IN	501C3	9	CHI	Yes	
INDIANA HEART HOSPITAL LLC 8075 NORTH SHADELAND AVENUE INDIANAPOLIS, IN 46250 35-2123783	HOSPITAL	IN	501C3	3	CHI	Yes	
INDIANAPOLIS OSTEOPATHIC HOSPITAL 3630 GUION ROAD INDIANAPOLIS, IN 46222 35-1094734	HOSPITAL	IN	501C3	3	CHNW	Yes	
WESTVIEW HOSPITAL FOUNDATION INC 3630 GUION ROAD INDIANAPOLIS, IN 46222 31-1036451	SUPPORT	IN	501C3	11B	IOH	Yes	
HEALTH INSTITUTE OF INDIANA INC 3660 GUION ROAD INDIANAPOLIS, IN 46222 35-2022402	FITNESS	IN	501C3	9	IOH	Yes	

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal Domicile (State or Foreign Country)	(d) Direct Controlling Entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income (\$)	(g) Share of end- of-year assets (\$)	(h) Disproportionate allocations?		(i) Code V- UBI amount on Box 20 of K-1 (\$)	(j) General or Managing Partner?		(k) Percentage ownership
							Yes	No		Yes	No	
EAST CAMPUS SURGERY CENTER LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-2028517	SURGERY	IN	NA	RELATED	6,135,388	7,926,970		No			No	51 000 %
INDIANA SPECIALTY GROUP LLC 7240 SHADELAND STATION SUITE 300 INDIANAPOLIS, IN 46256 35-1976258	HLTH CARE	IN	NA	RELATED	3,961	3,197,205		No			No	70 000 %
MICHIGAN SURGERY INVESTMENT LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 32-0147008	SURG CTRS	IN	N/A					No			No	
NORTH CAMPUS OFFICE ASSOCIATES LP 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-1808625	RNTL PROP	IN	N/A					No			No	
NORTH CAMPUS SURGERY CENTER LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-2147088	SURGERY	IN	N/A					No			No	
SURGICARE LLC 2907 MCINTIRE DRIVE BLOOMINGTON, IN 47403 35-1975122	SURGERY	IN	N/A					No			No	
EAST CAMPUS SURGERY CENTER LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-2028517	SURGERY	IN	NA	RELATED	6,135,388	7,926,970		No			No	51 000 %
INDIANA SPECIALTY GROUP LLC 7240 SHADELAND STATION SUITE 300 INDIANAPOLIS, IN 46256 35-1976258	HLTH CARE	IN	NA	RELATED	3,961	3,197,205		No			No	70 000 %
MICHIGAN SURGERY INVESTMENT LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 32-0147008	SURG CTRS	IN	N/A					No			No	
NORTH CAMPUS OFFICE ASSOCIATES LP 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-1808625	RNTL PROP	IN	N/A					No			No	
NORTH CAMPUS SURGERY CENTER LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-2147088	SURGERY	IN	N/A					No			No	
SURGICARE LLC 2907 MCINTIRE DRIVE BLOOMINGTON, IN 47403 35-1975122	SURGERY	IN	N/A					No			No	

Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal Domicile (State or Foreign Country)	(d) Direct Controlling Entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income (\$)	(g) Share of end-of-year assets (\$)	(h) Percentage ownership
CHN ASSURANCE COMPANY LTD PO BOX 1051GT GRAND CAYMAN CJ 98-0418913	INSURANCE	CJ	NA	C CORP		13,387,873	100 000 %
INDIANA PROHEALTH NETWORK INC 8180 CLEARVISTA PARKWAY SUITE 230 INDIANAPOLIS, IN 46256 35-1614719	INSURANCE	IN	NA	C CORP	34,266,540	14,229,891	100 000 %
VISIONARY ENTERPRISES INC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-1538433	MGMT SRVS	IN	N/A				
VEI MICHIGAN INC 940 N MAIN STREET ANN HARBOR, MI 48104 30-0097377	MGMT SRVS	IN	N/A				
VEI-PRO HEALTH INC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 45-4037444	INSURANCE	IN	N/A				
WESTVIEW DELIVERY SYSTEM INC 3630 GUION ROAD INDIANAPOLIS, IN 46222 35-1910292	MGMT SRVS	IN	N/A				
CHN ASSURANCE COMPANY LTD PO BOX 1051GT GRAND CAYMAN CJ 98-0418913	INSURANCE	CJ	NA	C CORP		13,387,873	100 000 %
INDIANA PROHEALTH NETWORK INC 8180 CLEARVISTA PARKWAY SUITE 230 INDIANAPOLIS, IN 46256 35-1614719	INSURANCE	IN	NA	C CORP	34,266,540	14,229,891	100 000 %
VISIONARY ENTERPRISES INC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-1538433	MGMT SRVS	IN	N/A				
VEI MICHIGAN INC 940 N MAIN STREET ANN HARBOR, MI 48104 30-0097377	MGMT SRVS	IN	N/A				
VEI-PRO HEALTH INC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 45-4037444	INSURANCE	IN	N/A				
WESTVIEW DELIVERY SYSTEM INC 3630 GUION ROAD INDIANAPOLIS, IN 46222 35-1910292	MGMT SRVS	IN	N/A				

Form 990, Schedule R, Part V - Transactions With Related Organizations

(a) Name of other organization	(b) Transaction type(a-r)	(c) Amount Involved (\$)	(d) Method of determining amount involved
(1) COMMUNITY HEALTH NETWORK FOUNDATION	C	743,241	BOOK VALUE
(2) COMMUNITY HEALTH NETWORK FOUNDATION	G	182,000	BOOK VALUE
(3) COMMUNITY HEALTH NETWORK FOUNDATION	R	1,474,915	BOOK VALUE
(4) COMMUNITY HEALTH NETWORK FOUNDATION	J	39,234	BOOK VALUE
(5) COMMUNITY HOME HEALTH SERVICES INC	O	261,620	BOOK VALUE
(6) COMMUNITY HOME HEALTH SERVICES INC	P	694,551	BOOK VALUE
(7) COMMUNITY HOME HEALTH SERVICES INC	Q	96,781	BOOK VALUE
(8) COMMUNITY HOME HEALTH SERVICES INC	R	130,000	BOOK VALUE
(9) COMM HOSP OF ANDERSON & MADISON CTY	P	1,636,650	BOOK VALUE
(10) COMM HOSP OF ANDERSON & MADISON CTY	Q	210,682	BOOK VALUE
(11) COMMUNITY HOSPITAL SOUTH INC	R	66,016,487	BOOK VALUE
(12) COMMUNITY PHYSICIANS OF IN INC	B	30,564,245	BOOK VALUE
(13) COMMUNITY PHYSICIANS OF IN INC	R	23,216,298	BOOK VALUE
(14) CHN ASSURANCE COMPANY LTD	O	1,336,435	BOOK VALUE
(15) CHN ASSURANCE COMPANY LTD	Q	1,593,040	BOOK VALUE
(16) EAST CAMPUS SURGERY CENTER LLC	Q	189,360	BOOK VALUE
(17) INDIANA HEART HOSPITAL LLC	A	3,971,634	BOOK VALUE
(18) INDIANA HEART HOSPITAL LLC	O	1,210,748	BOOK VALUE
(19) INDIANA HEART HOSPITAL LLC	P	3,228,168	BOOK VALUE
(20) INDIANA HEART HOSPITAL LLC	R	106,267,331	BOOK VALUE

Form 990, Schedule R, Part V - Transactions With Related Organizations

(a) Name of other organization		(b) Transaction type(a-r)	(c) Amount Involved (\$)	(d) Method of determining amount involved
(21)	INDIANA PROHEALTH NETWORK INC	O	26,852,919	BOOK VALUE
(22)	INDIANA PROHEALTH NETWORK INC	P	49,777,094	BOOK VALUE
(23)	INDIANA PROHEALTH NETWORK INC	R	8,917,188	BOOK VALUE
(24)	MICHIGAN SURGERY INVESTMENT LLC	A	261,538	BOOK VALUE
(25)	NORTH CAMPUS SURGERY CENTER LLC	Q	338,959	BOOK VALUE
(26)	NORTH CAMPUS SURGERY CENTER LLC	R	479,122	BOOK VALUE
(27)	VISIONARY ENTERPRISES INC	A	1,094,287	BOOK VALUE
(28)	VISIONARY ENTERPRISES INC	J	3,829,958	BOOK VALUE
(29)	VISIONARY ENTERPRISES INC	O	12,545,439	BOOK VALUE
(30)	VISIONARY ENTERPRISES INC	P	2,132,371	BOOK VALUE
(31)	VISIONARY ENTERPRISES INC	Q	481,589	BOOK VALUE
(32)	VISIONARY ENTERPRISES INC	R	1,117,125	BOOK VALUE
(33)	INDIANAPOLIS OSTEOPATHIC HOSPITAL	P	65,216	BOOK VALUE
(34)	COMMUNITY HEALTH NETWORK FOUNDATION	C	743,241	BOOK VALUE
(35)	COMMUNITY HEALTH NETWORK FOUNDATION	G	182,000	BOOK VALUE
(36)	COMMUNITY HEALTH NETWORK FOUNDATION	R	1,474,915	BOOK VALUE
(37)	COMMUNITY HEALTH NETWORK FOUNDATION	J	39,234	BOOK VALUE
(38)	COMMUNITY HOME HEALTH SERVICES INC	O	261,620	BOOK VALUE
(39)	COMMUNITY HOME HEALTH SERVICES INC	P	694,551	BOOK VALUE
(40)	COMMUNITY HOME HEALTH SERVICES INC	Q	96,781	BOOK VALUE

Form 990, Schedule R, Part V - Transactions With Related Organizations

(a) Name of other organization		(b) Transaction type(a-r)	(c) Amount Involved (\$)	(d) Method of determining amount involved
(41)	COMMUNITY HOME HEALTH SERVICES INC	R	130,000	BOOK VALUE
(42)	COMM HOSP OF ANDERSON & MADISON CTY	P	1,636,650	BOOK VALUE
(43)	COMM HOSP OF ANDERSON & MADISON CTY	Q	210,682	BOOK VALUE
(44)	COMMUNITY HOSPITAL SOUTH INC	R	66,016,487	BOOK VALUE
(45)	COMMUNITY PHYSICIANS OF IN INC	B	30,564,245	BOOK VALUE
(46)	COMMUNITY PHYSICIANS OF IN INC	R	23,216,298	BOOK VALUE
(47)	CHN ASSURANCE COMPANY LTD	O	1,336,435	BOOK VALUE
(48)	CHN ASSURANCE COMPANY LTD	Q	1,593,040	BOOK VALUE
(49)	EAST CAMPUS SURGERY CENTER LLC	Q	189,360	BOOK VALUE
(50)	INDIANA HEART HOSPITAL LLC	A	3,971,634	BOOK VALUE
(51)	INDIANA HEART HOSPITAL LLC	O	1,210,748	BOOK VALUE
(52)	INDIANA HEART HOSPITAL LLC	P	3,228,168	BOOK VALUE
(53)	INDIANA HEART HOSPITAL LLC	R	106,267,331	BOOK VALUE
(54)	INDIANA PROHEALTH NETWORK INC	O	26,852,919	BOOK VALUE
(55)	INDIANA PROHEALTH NETWORK INC	P	49,777,094	BOOK VALUE
(56)	INDIANA PROHEALTH NETWORK INC	R	8,917,188	BOOK VALUE
(57)	MICHIGAN SURGERY INVESTMENT LLC	A	261,538	BOOK VALUE
(58)	NORTH CAMPUS SURGERY CENTER LLC	Q	338,959	BOOK VALUE
(59)	NORTH CAMPUS SURGERY CENTER LLC	R	479,122	BOOK VALUE
(60)	VISIONARY ENTERPRISES INC	A	1,094,287	BOOK VALUE

Form 990, Schedule R, Part V - Transactions With Related Organizations

(a) Name of other organization		(b) Transaction type(a-r)	(c) Amount Involved (\$)	(d) Method of determining amount involved
(61)	VISIONARY ENTERPRISES INC	J	3,829,958	BOOK VALUE
(62)	VISIONARY ENTERPRISES INC	O	12,545,439	BOOK VALUE
(63)	VISIONARY ENTERPRISES INC	P	2,132,371	BOOK VALUE
(64)	VISIONARY ENTERPRISES INC	Q	481,589	BOOK VALUE
(65)	VISIONARY ENTERPRISES INC	R	1,117,125	BOOK VALUE
(66)	INDIANAPOLIS OSTEOPATHIC HOSPITAL	P	65,216	BOOK VALUE
(67)	COMMUNITY HEALTH NETWORK FOUNDATION	C	743,241	BOOK VALUE
(68)	COMMUNITY HEALTH NETWORK FOUNDATION	G	182,000	BOOK VALUE
(69)	COMMUNITY HEALTH NETWORK FOUNDATION	R	1,474,915	BOOK VALUE
(70)	COMMUNITY HEALTH NETWORK FOUNDATION	J	39,234	BOOK VALUE
(71)	COMMUNITY HOME HEALTH SERVICES INC	O	261,620	BOOK VALUE
(72)	COMMUNITY HOME HEALTH SERVICES INC	P	694,551	BOOK VALUE
(73)	COMMUNITY HOME HEALTH SERVICES INC	Q	96,781	BOOK VALUE
(74)	COMMUNITY HOME HEALTH SERVICES INC	R	130,000	BOOK VALUE
(75)	COMM HOSP OF ANDERSON & MADISON CTY	P	1,636,650	BOOK VALUE
(76)	COMM HOSP OF ANDERSON & MADISON CTY	Q	210,682	BOOK VALUE
(77)	COMMUNITY HOSPITAL SOUTH INC	R	66,016,487	BOOK VALUE
(78)	COMMUNITY PHYSICIANS OF IN INC	B	30,564,245	BOOK VALUE
(79)	COMMUNITY PHYSICIANS OF IN INC	R	23,216,298	BOOK VALUE
(80)	CHN ASSURANCE COMPANY LTD	O	1,336,435	BOOK VALUE

Form 990, Schedule R, Part V - Transactions With Related Organizations

(a) Name of other organization		(b) Transaction type(a-r)	(c) Amount Involved (\$)	(d) Method of determining amount involved
(81)	CHN ASSURANCE COMPANY LTD	Q	1,593,040	BOOK VALUE
(82)	EAST CAMPUS SURGERY CENTER LLC	Q	189,360	BOOK VALUE
(83)	INDIANA HEART HOSPITAL LLC	A	3,971,634	BOOK VALUE
(84)	INDIANA HEART HOSPITAL LLC	O	1,210,748	BOOK VALUE
(85)	INDIANA HEART HOSPITAL LLC	P	3,228,168	BOOK VALUE
(86)	INDIANA HEART HOSPITAL LLC	R	106,267,331	BOOK VALUE
(87)	INDIANA PROHEALTH NETWORK INC	O	26,852,919	BOOK VALUE
(88)	INDIANA PROHEALTH NETWORK INC	P	49,777,094	BOOK VALUE
(89)	INDIANA PROHEALTH NETWORK INC	R	8,917,188	BOOK VALUE
(90)	MICHIGAN SURGERY INVESTMENT LLC	A	261,538	BOOK VALUE
(91)	NORTH CAMPUS SURGERY CENTER LLC	Q	338,959	BOOK VALUE
(92)	NORTH CAMPUS SURGERY CENTER LLC	R	479,122	BOOK VALUE
(93)	VISIONARY ENTERPRISES INC	A	1,094,287	BOOK VALUE
(94)	VISIONARY ENTERPRISES INC	J	3,829,958	BOOK VALUE
(95)	VISIONARY ENTERPRISES INC	O	12,545,439	BOOK VALUE
(96)	VISIONARY ENTERPRISES INC	P	2,132,371	BOOK VALUE
(97)	VISIONARY ENTERPRISES INC	Q	481,589	BOOK VALUE
(98)	VISIONARY ENTERPRISES INC	R	1,117,125	BOOK VALUE
(99)	INDIANAPOLIS OSTEOPATHIC HOSPITAL	P	65,216	BOOK VALUE
(100)	COMMUNITY HEALTH NETWORK FOUNDATION	C	743,241	BOOK VALUE

Form 990, Schedule R, Part V - Transactions With Related Organizations

(a) Name of other organization		(b) Transaction type(a-r)	(c) Amount Involved (\$)	(d) Method of determining amount involved
(101)	COMMUNITY HEALTH NETWORK FOUNDATION	G	182,000	BOOK VALUE
(102)	COMMUNITY HEALTH NETWORK FOUNDATION	R	1,474,915	BOOK VALUE
(103)	COMMUNITY HEALTH NETWORK FOUNDATION	J	39,234	BOOK VALUE
(104)	COMMUNITY HOME HEALTH SERVICES INC	O	261,620	BOOK VALUE
(105)	COMMUNITY HOME HEALTH SERVICES INC	P	694,551	BOOK VALUE
(106)	COMMUNITY HOME HEALTH SERVICES INC	Q	96,781	BOOK VALUE
(107)	COMMUNITY HOME HEALTH SERVICES INC	R	130,000	BOOK VALUE
(108)	COMM HOSP OF ANDERSON & MADISON CTY	P	1,636,650	BOOK VALUE
(109)	COMM HOSP OF ANDERSON & MADISON CTY	Q	210,682	BOOK VALUE
(110)	COMMUNITY HOSPITAL SOUTH INC	R	66,016,487	BOOK VALUE
(111)	COMMUNITY PHYSICIANS OF IN INC	B	30,564,245	BOOK VALUE
(112)	COMMUNITY PHYSICIANS OF IN INC	R	23,216,298	BOOK VALUE
(113)	CHN ASSURANCE COMPANY LTD	O	1,336,435	BOOK VALUE
(114)	CHN ASSURANCE COMPANY LTD	Q	1,593,040	BOOK VALUE
(115)	EAST CAMPUS SURGERY CENTER LLC	Q	189,360	BOOK VALUE
(116)	INDIANA HEART HOSPITAL LLC	A	3,971,634	BOOK VALUE
(117)	INDIANA HEART HOSPITAL LLC	O	1,210,748	BOOK VALUE
(118)	INDIANA HEART HOSPITAL LLC	P	3,228,168	BOOK VALUE
(119)	INDIANA HEART HOSPITAL LLC	R	106,267,331	BOOK VALUE
(120)	INDIANA PROHEALTH NETWORK INC	O	26,852,919	BOOK VALUE

Form 990, Schedule R, Part V - Transactions With Related Organizations

(a) Name of other organization		(b) Transaction type(a-r)	(c) Amount Involved (\$)	(d) Method of determining amount involved
(121)	INDIANA PROHEALTH NETWORK INC	P	49,777,094	BOOK VALUE
(122)	INDIANA PROHEALTH NETWORK INC	R	8,917,188	BOOK VALUE
(123)	MICHIGAN SURGERY INVESTMENT LLC	A	261,538	BOOK VALUE
(124)	NORTH CAMPUS SURGERY CENTER LLC	Q	338,959	BOOK VALUE
(125)	NORTH CAMPUS SURGERY CENTER LLC	R	479,122	BOOK VALUE
(126)	VISIONARY ENTERPRISES INC	A	1,094,287	BOOK VALUE
(127)	VISIONARY ENTERPRISES INC	J	3,829,958	BOOK VALUE
(128)	VISIONARY ENTERPRISES INC	O	12,545,439	BOOK VALUE
(129)	VISIONARY ENTERPRISES INC	P	2,132,371	BOOK VALUE
(130)	VISIONARY ENTERPRISES INC	Q	481,589	BOOK VALUE
(131)	VISIONARY ENTERPRISES INC	R	1,117,125	BOOK VALUE
(132)	INDIANAPOLIS OSTEOPATHIC HOSPITAL	P	65,216	BOOK VALUE
(133)	COMMUNITY HEALTH NETWORK FOUNDATION	C	743,241	BOOK VALUE
(134)	COMMUNITY HEALTH NETWORK FOUNDATION	G	182,000	BOOK VALUE
(135)	COMMUNITY HEALTH NETWORK FOUNDATION	R	1,474,915	BOOK VALUE
(136)	COMMUNITY HEALTH NETWORK FOUNDATION	J	39,234	BOOK VALUE
(137)	COMMUNITY HOME HEALTH SERVICES INC	O	261,620	BOOK VALUE
(138)	COMMUNITY HOME HEALTH SERVICES INC	P	694,551	BOOK VALUE
(139)	COMMUNITY HOME HEALTH SERVICES INC	Q	96,781	BOOK VALUE
(140)	COMMUNITY HOME HEALTH SERVICES INC	R	130,000	BOOK VALUE

Form 990, Schedule R, Part V - Transactions With Related Organizations

(a) Name of other organization		(b) Transaction type(a-r)	(c) Amount Involved (\$)	(d) Method of determining amount involved
(141)	COMM HOSP OF ANDERSON & MADISON CTY	P	1,636,650	BOOK VALUE
(142)	COMM HOSP OF ANDERSON & MADISON CTY	Q	210,682	BOOK VALUE
(143)	COMMUNITY HOSPITAL SOUTH INC	R	66,016,487	BOOK VALUE
(144)	COMMUNITY PHYSICIANS OF IN INC	B	30,564,245	BOOK VALUE
(145)	COMMUNITY PHYSICIANS OF IN INC	R	23,216,298	BOOK VALUE
(146)	CHN ASSURANCE COMPANY LTD	O	1,336,435	BOOK VALUE
(147)	CHN ASSURANCE COMPANY LTD	Q	1,593,040	BOOK VALUE
(148)	EAST CAMPUS SURGERY CENTER LLC	Q	189,360	BOOK VALUE
(149)	INDIANA HEART HOSPITAL LLC	A	3,971,634	BOOK VALUE
(150)	INDIANA HEART HOSPITAL LLC	O	1,210,748	BOOK VALUE
(151)	INDIANA HEART HOSPITAL LLC	P	3,228,168	BOOK VALUE
(152)	INDIANA HEART HOSPITAL LLC	R	106,267,331	BOOK VALUE
(153)	INDIANA PROHEALTH NETWORK INC	O	26,852,919	BOOK VALUE
(154)	INDIANA PROHEALTH NETWORK INC	P	49,777,094	BOOK VALUE
(155)	INDIANA PROHEALTH NETWORK INC	R	8,917,188	BOOK VALUE
(156)	MICHIGAN SURGERY INVESTMENT LLC	A	261,538	BOOK VALUE
(157)	NORTH CAMPUS SURGERY CENTER LLC	Q	338,959	BOOK VALUE
(158)	NORTH CAMPUS SURGERY CENTER LLC	R	479,122	BOOK VALUE
(159)	VISIONARY ENTERPRISES INC	A	1,094,287	BOOK VALUE
(160)	VISIONARY ENTERPRISES INC	J	3,829,958	BOOK VALUE

Form 990, Schedule R, Part V - Transactions With Related Organizations

(a) Name of other organization		(b) Transaction type(a-r)	(c) Amount Involved (\$)	(d) Method of determining amount involved
(161)	VISIONARY ENTERPRISES INC	O	12,545,439	BOOK VALUE
(162)	VISIONARY ENTERPRISES INC	P	2,132,371	BOOK VALUE
(163)	VISIONARY ENTERPRISES INC	Q	481,589	BOOK VALUE
(164)	VISIONARY ENTERPRISES INC	R	1,117,125	BOOK VALUE
(165)	INDIANAPOLIS OSTEOPATHIC HOSPITAL	P	65,216	BOOK VALUE
(166)	COMMUNITY HEALTH NETWORK FOUNDATION	C	743,241	BOOK VALUE
(167)	COMMUNITY HEALTH NETWORK FOUNDATION	G	182,000	BOOK VALUE
(168)	COMMUNITY HEALTH NETWORK FOUNDATION	R	1,474,915	BOOK VALUE
(169)	COMMUNITY HEALTH NETWORK FOUNDATION	J	39,234	BOOK VALUE
(170)	COMMUNITY HOME HEALTH SERVICES INC	O	261,620	BOOK VALUE
(171)	COMMUNITY HOME HEALTH SERVICES INC	P	694,551	BOOK VALUE
(172)	COMMUNITY HOME HEALTH SERVICES INC	Q	96,781	BOOK VALUE
(173)	COMMUNITY HOME HEALTH SERVICES INC	R	130,000	BOOK VALUE
(174)	COMM HOSP OF ANDERSON & MADISON CTY	P	1,636,650	BOOK VALUE
(175)	COMM HOSP OF ANDERSON & MADISON CTY	Q	210,682	BOOK VALUE
(176)	COMMUNITY HOSPITAL SOUTH INC	R	66,016,487	BOOK VALUE
(177)	COMMUNITY PHYSICIANS OF IN INC	B	30,564,245	BOOK VALUE
(178)	COMMUNITY PHYSICIANS OF IN INC	R	23,216,298	BOOK VALUE
(179)	CHN ASSURANCE COMPANY LTD	O	1,336,435	BOOK VALUE
(180)	CHN ASSURANCE COMPANY LTD	Q	1,593,040	BOOK VALUE

Form 990, Schedule R, Part V - Transactions With Related Organizations

(a) Name of other organization		(b) Transaction type(a-r)	(c) Amount Involved (\$)	(d) Method of determining amount involved
(181)	EAST CAMPUS SURGERY CENTER LLC	Q	189,360	BOOK VALUE
(182)	INDIANA HEART HOSPITAL LLC	A	3,971,634	BOOK VALUE
(183)	INDIANA HEART HOSPITAL LLC	O	1,210,748	BOOK VALUE
(184)	INDIANA HEART HOSPITAL LLC	P	3,228,168	BOOK VALUE
(185)	INDIANA HEART HOSPITAL LLC	R	106,267,331	BOOK VALUE
(186)	INDIANA PROHEALTH NETWORK INC	O	26,852,919	BOOK VALUE
(187)	INDIANA PROHEALTH NETWORK INC	P	49,777,094	BOOK VALUE
(188)	INDIANA PROHEALTH NETWORK INC	R	8,917,188	BOOK VALUE
(189)	MICHIGAN SURGERY INVESTMENT LLC	A	261,538	BOOK VALUE
(190)	NORTH CAMPUS SURGERY CENTER LLC	Q	338,959	BOOK VALUE
(191)	NORTH CAMPUS SURGERY CENTER LLC	R	479,122	BOOK VALUE
(192)	VISIONARY ENTERPRISES INC	A	1,094,287	BOOK VALUE
(193)	VISIONARY ENTERPRISES INC	J	3,829,958	BOOK VALUE
(194)	VISIONARY ENTERPRISES INC	O	12,545,439	BOOK VALUE
(195)	VISIONARY ENTERPRISES INC	P	2,132,371	BOOK VALUE
(196)	VISIONARY ENTERPRISES INC	Q	481,589	BOOK VALUE
(197)	VISIONARY ENTERPRISES INC	R	1,117,125	BOOK VALUE
(198)	INDIANAPOLIS OSTEOPATHIC HOSPITAL	P	65,216	BOOK VALUE



Community

Health Network

IRS 990 Schedule H
Supplemental Information
Fiscal Year 2011

Table of Contents

Part I: 6 a & b	3
Part II: Community Building Activities (described in Part VI)	6
1. Physical Improvements and Housing.....	8
2. Economic Development.....	12
3. Community Support.....	16
4. Environmental Improvements.....	19
5. Leadership Development and Training for Community Partners.....	21
6. Coalition Building.....	22
7. Community Health Improvement Advocacy.....	23
8. Workforce Development.....	26
9. Other.....	28
Part V: Facility Information - Community Health Needs Assessment	29
2. Needs Assessment	30
4. Community Information.....	32
5. Promotion of Community Health.....	66
Part VI Supplemental Information	69
7. State filing of a community benefit report.....	69

SCHEDULE H
(Form 990)

Hospitals

OMB No. 1545-0047

2011

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

Name of the organization

Employer identification number

Part I Financial Assistance and Certain Other Community Benefits at Cost

Yes No

- 6a** Did the organization prepare a community benefit report during the tax year?
- b** If "Yes," did the organization make it available to the public?
- Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

6a	✓	
6b	✓	

2011 Community Benefit Report

The 2011 Community Health Network Community Benefit Report prepared for the tax year describes the organizations programs and services that promote the health of the community and the communities served by our health network. The report is made available to the public through the website. The website can also serve as a vehicle to distribute hard copies of the report to the public by clicking the Community Benefit Report icon or hyperlink for a copy of the report. There are several other hyperlinks that lead the reader through many of the parts of the organization and stories on their contribution to the community outside of the limits of the Community Benefit Report. For example, we describe the benefits of our collaboration to assist in the development of the Jane Pauley Community Health Center in the online Community Benefit Report but it also contains a hyperlink and icon that takes the reader to the Jane Pauley Community Health Center website so they can register to be a patient or learn about the sliding fee scale and who may qualify for services. Hence giving the online Community Benefit Report an "actionable" aspect that paper copies would never be able to replicate. See below for website illustration.



Financial Assistance and Certain Other Community Benefit at Cost

6b Continued

“Actionable” hyperlinks give immediate access to resources.

Giving everyone access to healthcare



In 2016, Community Health Network (CHN) launched a new initiative to help low-income, uninsured, and underinsured individuals and families access the care and services they need. The initiative is called the Community Health Network (CHN) Health Equity Fund (HEF). The HEF is a new fund that provides financial assistance to individuals and families who are unable to pay for the care and services they need. The HEF is a new fund that provides financial assistance to individuals and families who are unable to pay for the care and services they need.

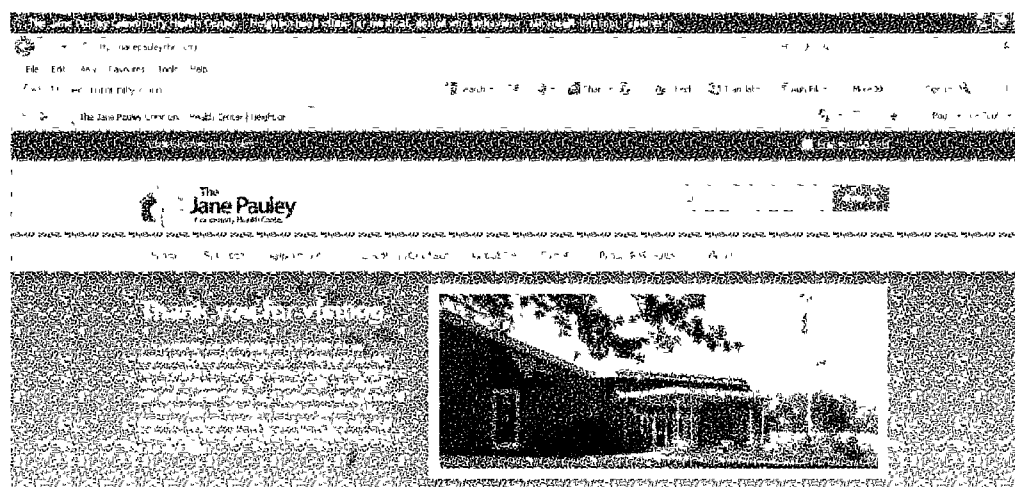


The Jane Pauley Health Equity Fund (HEF) was launched in 2016 to help low-income, uninsured, and underinsured individuals and families access the care and services they need. The HEF is a new fund that provides financial assistance to individuals and families who are unable to pay for the care and services they need. The HEF is a new fund that provides financial assistance to individuals and families who are unable to pay for the care and services they need.

The HEF is a new fund that provides financial assistance to individuals and families who are unable to pay for the care and services they need. The HEF is a new fund that provides financial assistance to individuals and families who are unable to pay for the care and services they need. The HEF is a new fund that provides financial assistance to individuals and families who are unable to pay for the care and services they need.

The HEF is a new fund that provides financial assistance to individuals and families who are unable to pay for the care and services they need. The HEF is a new fund that provides financial assistance to individuals and families who are unable to pay for the care and services they need. The HEF is a new fund that provides financial assistance to individuals and families who are unable to pay for the care and services they need.

Clicking on hyperlink sends viewer to actual website for appointment information and printable forms to fill out before arriving at appointment.



Part II Community Building Activities

Understanding Community Benefit

Community Health Network has adopted the Catholic Health Association/VHA definitions of community benefit from “A Guide for Planning and Reporting Community Benefit.” All data is collected using the Community Benefit Inventory for Social Accountability (CBISA) database developed by Lyon Software and recognized as the “gold standard” for collecting and reporting data. CBISA/Lyon Software was used by Sen. Chuck Grassley when adopting the guidelines for the new IRS Form 990 Schedule H.

Community benefit programs or activities provide treatment and/or promote health and healing as a response to identified community needs. A community benefit must meet at least one of the following criteria:

- *Generates a low or negative margin.*
- *Responds to needs of special populations, such as persons living in poverty and other disenfranchised persons.*
- *Supplies services or programs that would likely be discontinued – or would need to be provided by another not-for-profit or government provider – if the decision was made on a purely financial basis.*
- *Responds to public health needs.*
- *Involves education or research that improves overall community health.*

There are six foundational beliefs upon which these definitions are based:

- *Those who live in poverty and at all margins of our society have a moral priority for services.*
- *Not-for-profit mission-driven health care organizations have a responsibility to work toward improved health in the communities they serve.*
- *Community members and organizations must become actively involved in the health care facility’s community benefit programs.*
- *Health care organizations must demonstrate the value of their community services.*
- *Community benefit programs must be integrated throughout health care organizations.*
- *Leadership commitment is required for successful community benefit programs.*

Adopting standardized methods for accountability**Standardized software**

The software used to collect community benefit activities is called the *Community Benefit Inventory for Social Accountability (CBISA)*. The software has been helping hospitals, health systems, long term care communities and state hospital associations tell their community benefit story for more than 20 years. The CBISA software allows us to show in a national standardized format, how we are accountable to the community through our continued commitment to our mission and values. CBISA is compliant with the Catholic Health Association/VHA guidelines, used to develop the IRS 990 Schedule H form. It is currently the most effective and accepted tool for IRS 990 Schedule H reporting.

CBISA is a comprehensive web-based software program designed to meet all of our community benefit needs—tracking, reporting and evaluating.

Standardized policy

Patient Education of Eligibility For Assistance is an area of great concern for the IRS 990 Schedule H. One of the biggest hurdles in the national and local debate on community benefit is the definition and application of charity care vs. bad debt. In the past, reporting charity care also included for some organizations a percentage of bad debt, as it would seem logical that some of bad debt would indeed fall under the terms of charity care. The new reporting does not consider any part of bad debt to be charity care and has language that requires an organization to be proactive and prescriptive in developing policy and procedures for standardized methods of collecting and reporting charity care amounts.

The Financial Assistance Policy (see Appendix III) complies with all national and state standards for community benefit laws and recommendations. The policy also includes: the purpose for the policy, how we communicate the policy to the patients, and how the patient applies. Most important is the proactive measure taken to inform patients throughout the billing process, rather than waiting until a patient gets a final notice of collections.

Community benefit—national and state of Indiana issues

Nationally, several groups have invested significant time and resources to better define what community benefit is and how it should be evaluated. Each group has different motivations for its research and education, and the groups range from consumer organizations, labor unions and private payers/insurers to several federal government agencies including Congress, the Internal Revenue Service and Health & Human Services' Office of Inspector General (OIG). Together, they scrutinize the not-for-profit status of hospitals while also focusing on several areas of reform:

- *Charity care-community benefit*
- *Governance (board duties, composition, prudent investor rules)*
- *Filing of the 990 (requires CEO signature, independent audits, disclosure)*
- *Enforcement (three-year review of tax-exempt status noted in health care reform bill)*

As the courts, Congress and the IRS have focused on these areas they are looking toward a community benefit standard and charity care standard to use as a measure for an appropriate amount which would justify the call for federal income tax exemptions.

Community benefit standardized reporting categories

1. Traditional charity care and other financial assistance on behalf of uninsured and low-income persons.
2. Government-sponsored means tested health care.
3. Community health and supportive services provided for low income persons and for the broader community.
4. Health professions education and training programs.
5. Subsidized health services that are provided despite a financial loss.

6. Research activities that are community benefits.
7. Cash and in-kind contributions.
8. Community-building and leadership activities.
9. Community benefit operations and activities.

Community Benefit Program Highlights

The VHA Community Benefit Award for Excellence recognizes organizations for their focus and commitment to community benefit and the effective strategies used to tell their community benefit story. Community Health Network was one of the recipients of the award in 2009. We were one of only five health networks in the United States to be recognized. The following community benefit highlights demonstrate the reasons we won the award, with initiatives designed to meet the unique needs of the local community. We do it as part of our mission; we do it as part of our commitment. And we do it because it's the right thing to do.

This list is structured in the format provided by the IRS Form 990 rather than the previous mentioned "five key areas" needed to succeed in creating and sustaining a healthy community and illustrated with the five pillars. Some examples throughout this report were extracted from materials used preceding or during the time of the given event.

1. Physical Improvements and housing

In communities across our service areas, we see deteriorating neighborhoods of every shape and size. It is hard to miss the graffiti-laced walls, the broken windows, the caved in roofs. It is equally hard to dismiss the unknown health hazards these properties can pose. Disrepair often spreads beyond the boundary of one property to blight an entire neighborhood or community. Surrounding streets become stagnant and unsafe. Concerns about safety and crime rates increase. Residents and businesses move out. Property values decline. Retirees, residents, business owners, and employees that remain behind may need to go further to access goods or services. The inspiration and creativity that formed the neighborhood's original vibrancy can fade away.

In 2006, Community Health Network (CHN) began to look at the provision of rehabilitation of housing for vulnerable populations, working to reclaim a few of the neighborhoods in the communities we serve. CHN embarked on an experiment in environmental and economic development, to address the growing challenge of cleaning up and revitalizing properties in the communities we serve. We began to understand our role in the maintenance of parks and playgrounds to promote physical activity. We built coalitions and rallied to reverse the decline of our neighborhoods.

Community's most recent 2011 Habitat for Humanity build on the eastside is a strong example of the network's commitment to encouraging employee volunteerism and supporting economic development for the past five years. The goal of building homes in blighted areas or challenged neighborhoods started in the Windsor Village neighborhood on Catherwood Avenue.

Windsor Village had become a worn down eastside neighborhood dotted with homes and foreclosed properties and we took the worst house on Catherwood Avenue to rebuild. Our hope was to foster a sense of rebirth for the neighborhood and for the eastside of Indianapolis. It worked. The completion of the home - making it the best on the street rather than the worst - triggered home repairs by nearby neighbors and encouraged private investment of run down homes in the neighborhood. Home prices on the street rose \$20,000. The effort also brought together a coalition of businesses, neighborhood groups, churches and government entities to assist in the project. The original home was purchased by the CHN Foundation and renovated by a number of firms that donated in-kind services. The Indianapolis Neighborhood Partnership and the Century 21 Foundation helped the homeowner through the home buying process.

In 2008, Community Health Network, in partnership with Habitat for Humanity, built two homes on a property not far from the first home and close to the network's east hospital facility. The deed to the property, donated to the CHN Foundation, was combined with Foundation funds for making the land build ready. The project was then turned over to the Habitat for Humanity for the collaborative process of the build. Parcel builds on the Community North campus preceded the onsite project. Some 310 onsite volunteers clocked more than 700 volunteer hours during the six weeks of building. With the 2011 Habitat Home complete, the total number of homes that the network has built or rehabbed is seven.

These initiatives have been successful in sparking dialogue among the stakeholders in the neighborhoods and the community engagement it creates enhances the new residents care and commitment to the property and the long term success of the project. Individuals and organizations also have built lasting working relationships and stronger community ties. CHN recognizes that community engagement is a vital process to help alleviate environmental and economic concerns for citizens in economically disadvantaged areas and give them a voice in their community's future. The relationship and goodwill with the community, the connection of health outcomes and healthy communities is reinforced with every activity we continue to provide in these neighborhoods. Success is more likely with any intervention once a trusting foundation is developed with the community.

Community Hospital South features xeriscaping, an environmentally-friendly landscaping practice. Perennials and native plants are more cost efficient and conserve water.

Community Hospital South doesn't need an irrigation system to water the flowers and plants on campus. The landscaping is carefully planned with selections that are compatible with the soil and weather conditions in central Indiana, in a practice known as xeriscaping.

"Aside from a couple of planters at the front of the facility, most of the plants and flowers you'll see on our campus are perennials," said Mitchell Breeze, director of general support services at

Community South. "It's one of many ways we're working to conserve resources, but we're still able to create a pleasant healing environment for patients and visitors."

Breeze has selected a variety of plants and flowers for the Community South campus that are well-suited to the region. Among them:

- Liriope
- Coreopsis
- Pardon Me Daylily
- Ice Follies Daffodils
- Blue Wonder Catmint
- Saybrook Gold Juniper
- Red Prince Weigela
- Hamlen Dwarf Fountain Grass
- Gro-Low Sumac
- Royal Star Magnolia

In addition to focusing on xeriscaping, Breeze has been committed to preserving resources through the hospital's recent expansion project. Plants that were displaced during construction were preserved off-site and have since been reintroduced to beds around the campus.

Xeriscaping is one of the many aspects of Community Hospital South's commitment to environmentally-friendly practices. The hospital's emergency department was the first building project in the state of Indiana to be awarded LEED® Gold Certification by the U.S. Green Building Council, and the patient tower that opened in July 2010 is registered with the Green Guide for Health Care.

"We feel that doing our part to make our building and grounds more environmentally friendly has a healthy impact on the community and the people who live and work here," added Breeze.

Fishers have 12 playgrounds in its municipal parks, and until recently none of the children's areas could be accessed by the disabled.

Two years ago, families approached city officials about the need. The town pursued the project, and recently commemorated its new Americans with Disabilities Act (ADA)-inclusive playground at Brooks School Park.

"A couple families with children with physical disabilities approached me and informed me there was no place in Fishers where kids could be actively engaged at a park," said Scott Faultless, Town Council president.

"They could walk and push kids in a wheelchair on a trail, but they could not be engaged in activities that most kids can. They did not have the same opportunity." Faultless talked to the council about it right away, and members got to work.

"The council made a decision that they wanted to make sure all kids in the community had a place to play, no matter their abilities," he said. The council began pursuing designs, locations and securing money. The council chose to build the playground at Brooks School Park, 11780 Brooks School Road, because geographically it is closest to the center of town and more people could access it, Faultless said. The town awarded the contract to Miracle of Michigan & Indiana, a company based in Okemos, Mich., that builds playground structures, park shelters and more. Construction on the \$350,000 playground began in the spring. The town's general fund and some park impact fees paid for expenses, which covered design, construction and equipment purchase, Faultless said. The playground opened Saturday with an All Play Inspiration Celebration that drew about 500 people. The Fishers Junior High jazz band, the New Britton Elementary choir and the Fishers Police Department color guard performed. Indianapolis Colts community spokesman Josh Bleill, an Iraq war veteran who lost both legs, spoke at the event. The playground has areas geared toward ages 2-5 and 5-12.

Community Health Network participated in the renovation of the park and is supplying a new shelter and other amenities. The equipment includes five Big Timber Toppers that offer shade and feature 21 activities including nine slides, five climbers, stepping stones, bridges, climbing rocks and a sensory area that includes drums, chimes, bells and xylophones, according to park director Barry Russell. The play equipment includes six swings -- two for toddlers, two regular-size and two wheelchair-accessible sets, he said.

"There is a ramping system incorporated into the structure that a wheelchair-bound individual can use to access, including slides and climbing pieces," said Maura Leon-Barber, spokeswoman for the town.

"It is also possible for a wheelchair to move around the play equipment to access climbing apparatus or transfer stations and the sensory play area as the surface is rubberized.

"ADA does not just mean wheelchair bound. The equipment also allows those that have other physical and mental disabilities to access all of the play elements, although some may need a caregiver to assist them."

The rubberized surface helps protect children from injuries, Faultless said. This playground is the first in the town's parks to incorporate that type of floor design. Faultless said that in the future, the town may consider remodeling playgrounds to be ADA-inclusive, but it depends on funding. The turnout at the celebration and the responses he has gotten from the community show that families appreciate the new playground. "Several (disabled) kids for the first time in Fishers had a chance to play alongside with others," he said.

More than 250 employee volunteers from Community Health Network will give of their time and money when they descend on IPS School #14 (Washington Irving Elementary School) on August 26-27, as part of the United Way's annual Day of Caring.

Besides basic clean up in the school yard, Community volunteers will create shade on the playground, paint playground equipment, as well as the playground itself, and install benches and metal basketball nets. Inside the largest IPS elementary school, Community employees will paint one entry wall with a mural depicting the students and the school's mascot, a hornet. In addition, the volunteers will repair and improve the school's family resource center and the teachers' lounge, outfitting the rooms with a new washer, dryer, refrigerator and microwave. Finally, Community will supply school uniforms and supplies to students. "The start of school this year was the best one we've had in a while, thanks to Community Health Network," said Josette Jackson, a social worker at the school. "Many of our students do not have the resources they need, and many parents were very relieved that the staff at Community will donate school uniforms and supplies. They were also comforted to know that a new washer and dryer were in place if they need to have uniforms cleaned," Jackson added. "For some parents, the start of a new school year can be stressful, but this year Community Health Network brought smiles to the faces of teachers, students and their families, with their plans to improve the school."

Community Health Network employees who are volunteering at School #14 are part of a major network employee volunteerism initiative recently launched, called Serve 360°. It grew out of the hospital's mission statement, which focuses on a lifelong commitment to the community-at-large. "Volunteering and sharing our time with others is about doing good for people, providing for those who are in need," said Linda Hajduk, Serve360° leader and vice president of organizational effectiveness at Community. "Our work at School #14 is an example of how, in just a few hours of focus, we can change the lives of 600 students." Community also has stationed bins at each of its hospitals, professional buildings and pharmacies to collect uniforms and school supplies, so members of the public can also donate to the school.

2. Economic Development

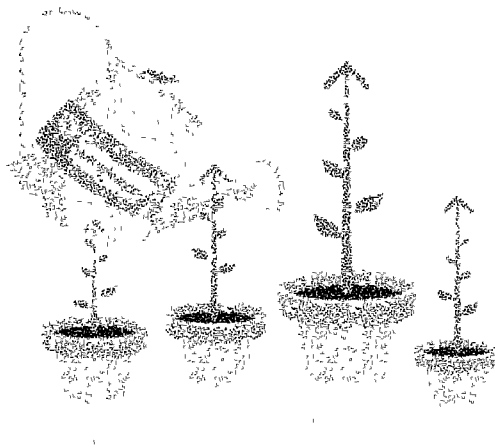
COMMUNITY'S INDIANA IMPACT

Community Health Network is among central Indiana's largest employers and the region's second largest locally based healthcare provider. With a total of 10,523 employees delivering quality care to more than 328,872 patients annually,



Community employs 5,254 people who live in Marion County. These employees earn an average annual salary of \$42,052 and pay \$3.2 million in annual county taxes.

With a mission to enhance the health and well-being of the communities we serve, in 2011 we provided \$66 million in charity care.



Community believes in the power of the people of the central Indiana business region. Each day we typically invest more than \$100,000 in high-charitable contributions attributed to the Indianapolis Super Bowl host corporation and made a significant investment in the construction of new facilities. Community Medical Center, for example, has opened over 50,000 with the help of partnership since 2000.

Ranked among the nation's most integrated healthcare systems, Community is a central Indiana leader in providing access to innovative and compassionate healthcare services, where and when patients need them—in hospitals, at convenient health pavilions and doctor's offices, in the workplace, at schools, in the home and online.

Community Health Network spent more than \$100 million with 217 local County residents in 2010.



Annually, Community contributes more than \$600,000 in sponsorship support to local races and organizations that help us fund our mission. Some of the important partnerships include:

- (B)Scape Indiana Health and Wellness Fair
- Boys and Girls Club of Indianapolis
- Habitat for Humanity of Greater Indianapolis
- Indiana Food Development and Growth
- YouthLink Indiana
- Various health fairs, farmers' markets and local celebrations throughout Marion County

Community Health Network Partnership a partner with Marian University to build College of Osteopathic Medicine which will add \$44 million a year to local economy.

Marian University will spend more than \$32 million to build a facility for its new college of osteopathic medicine and expects the school to add \$44 million a year to the Indianapolis-area economy.

The small Catholic college south of the Indianapolis Museum of Art will open the medical school in the fall of 2012. It will be the state's second such program, joining the Indiana University School of Medicine. Marian intends to enroll 150 students in each of four classes, topping out at a student body of 600. The school will directly employ more than 350, including many scientific and medical researchers. The economic impact estimate comes from a study commissioned by Marian and conducted by the Indianapolis-based Center for Urban Policy and the Environment. Once the school is operating at full capacity, Marian will spend \$18.5 million a year to run it, including \$13.2 million on wages, according to the study. Students will spend another \$8 million per year, the study estimated.

The study assumed the impact of those dollars would be multiplied as they ricochet in the local economy. The total economic impact will be more than \$44 million, which will support about 450 total jobs. "We wanted people to see that this is a game changer," Marian President Dan Elsener said, explaining why Marian commissioned the study.

Elsener hopes the economic impact numbers help as Marian seeks to raise more money to fund the medical school and several interrelated projects on its campus. Those projects include new facilities to support the doubling of math and science undergraduate students, which Elsener expects as a result of the medical school opening. Marian also is expanding graduate nurse training, and it will need more

housing and parking to accommodate the additional students. In all, those projects will cost \$200 million. Marian has so far raised \$130 million toward that goal.

The medical school by itself was initially projected to cost \$75 million. Marian announced its plans to start the school early this year after it secured a \$30 million gift from an anonymous donor. Elsener hopes the new medical school will help produce more family doctors for Indiana. More than half the counties in the state suffer from a shortage of primary care doctors. Last month, Marian hired Dr. Paul Evans as dean of the new medical school. Evans, who started work Sept. 1, spent the previous six years launching a new osteopathic medical school in Atlanta. "This is a unique opportunity," Evans said. "It's a new medical school that has absolutely no restrictions. All the knowledge I've gained over my career, here's a good opportunity to make it happen."

Marian has established partnerships with local hospitals—such as St. Vincent Health, Community Health Network and Westview Hospital—and is working on more to help its students finish their training.

Community Health Network announced a \$12 million construction project at I-465 and Washington Street that will improve access to health care and support economic development on Indianapolis' east side.

Located on six acres at 7910 East Washington Street, construction will soon begin on Community Health Pavilion, a three-story medical building that will house a variety of health care services in 55,000 square feet of space.

When completed in early 2012, the new Community Health Pavilion will offer convenient access to the primary care physicians from Community Physicians of Indiana; specialty physicians; advanced imaging services; Mid America Clinical Labs; rehab and sports medicine, and other health-related services. It will house a community room dedicated to patient education and health screenings. Existing MedCheck and Community Occupational Health Services offices, located at 17th and Post Road, will relocate to the new pavilion.

Jon Fohrer, CEO of Community Health Network's ambulatory division, said the pavilion is an important investment in the development of the city's east side, occupying property left undeveloped since the closing and subsequent demolition of Laughner's Cafeteria. "This health care facility will showcase Community's commitment to caring for east side residents and positively contribute to the neighborhood's economy," Fohrer said. "More than 100 employees will work at the new site, with nearly half of those positions being new jobs."

Fohrer said the Laughner family name will continue to be attached to the property. The pavilion's 'Laughner Community Room' will celebrate a generous donation, which Charles Laughner made to Community during the sale of the property.

Robin Ledyard, M.D. and president of Community Hospital East, said the pavilion will be the newest addition to a growing east side network of health care services anchored by Community Hospital East. "Community Health Network is committed to providing the best care possible to the residents of the

east side,” Leary said. “This pavilion will be a state-of-the-art medical home for our patients, allowing us to deliver quality care closer to where residents live, work and play.”

Several east side organizations, including the Warren Township Trustee’s Office, the Eastgate Neighborhood Association, and the Warren Township Development Association supported this project by writing letters to the Indianapolis Metropolitan Development Commission. “Community Health Network has deep roots in our east side community,” said Warren Township Trustee Jeff Bennett. “This project represents a substantial economic investment. It will be a positive redevelopment to a long vacant site and an important gateway to I 465.”

3. Community Support

Community Health Network and the Fishers Fire Department partner on campaign to lower incidents of senior citizen falls.

In a recent analysis of data for all emergency medical incidents handled by the Fishers Fire Department, injuries as a result of falls was second only to injuries from motor vehicle accidents. Armed with these statistics, the Fishers Fire Department and Community Health Network have launched a campaign to reduce falls in the Fishers area by 35 percent over the next two years.

As a part of the campaign, the Community Hospital North emergency department, Community Home Health Services, Community’s Touchpoint Senior Services program, and the Fishers Fire Department, are implementing a fall prevention program for senior citizens. The program will include several components, such as:

- Fall risk assessment
- Education
- Exercise
- Medication review
- Vision check
- Home safety assessment

“Records show that 741 injuries in a two year period occurred as a result of falls, and 623 of those injured required hospitalization,” said Steve Davison, division chief, emergency medical services for the Fishers Fire Department. “Many of those injured are senior citizens, so we decided to develop a comprehensive plan to help seniors avoid hospitalization and live comfortably and safely in their own homes.”

Of the 741 falls recorded, more than 400 were people over the age of 50, and the largest number of falls occurred in the 81-90 age group, which experienced 131 falls. In addition to the fall prevention program, the Fishers Fire Department will conduct a follow-up evaluation for every person who is 60 years or older and has a history of falls. Common conditions in older adults increase the risk of falls:

- Heart disease, stroke, Parkinson's and low blood pressure can cause dizziness, balance problems and fatigue
- Diabetes can cause a loss of sensation in the feet, leading to a reduced "sense of place"
- Arthritis results in loss of flexibility and increased difficulty maintaining balance
- Chronic obstructive pulmonary disease and heart failure result in breathing difficulties, weakness and fatigue, even with slight exertion
- Vision problems, such as glaucoma and cataracts, decreased visual function
- Medications, particularly sleeping medications, anti-depressants or anti-anxiety drugs and heart medication

"We are excited to partner with the Fishers Fire Department Emergency Medical Services to improve the health and well-being of Fishers residents," said Shelley O'Connell, director of Community's Touchpoint Senior Services program.

To see a copy of the Fall Risk Assessment or to learn more about senior services, visit www.eCommunity.com/seniorcare or call 800-777-7775.

Community Hospital South to host Oh Baby! Showcase on October 19; Free event for new and expectant parents features helpful information, giveaways, and a chance to win a \$100 gift card.

Community Hospital South, located at 1402 E. County Line Rd., invites new and expectant parents to Oh Baby! Showcase on Wednesday, October 19, from 6:30 to 8:30 p.m. The free event will offer valuable information for pregnancy and beyond, and attendees will have the opportunity to win prizes, including a \$100 gift card. **Registration is required for this event. Please call 800-777-7775 or visit eCommunity.com/ohbaby to reserve space.**

The Oh Baby! Showcase brings together relevant resources for individuals who are already pregnant, planning to become pregnant, or have recently welcomed a new baby. Attendees will have the opportunity to meet south side pediatricians, obstetricians and family practice physicians. Additionally, information will be available on the following topics:

- Maternity and children's services at Community Hospital South
- Doula and breastfeeding support
- Nutrition during pregnancy and losing baby fat
- Prenatal and newborn care
- Dealing with lower back pain
- Car seats and infant safety
- Pregnancy and parenting classes

Several local businesses will showcase services designed to make life easier for new and expectant parents, and each will offer door prizes. Community Physicians of Indiana will give away a \$100 gift

card to help parents prepare for their new arrival. Attendees will also enjoy light refreshments and free chair massages.

Community Health Network Foundation awarded grant to educate new mothers.

Community Health Network Foundation has been awarded a \$30,000 grant from the Nina Mason Pulliam Charitable Trust to launch educational programming at Community Hospital East that will annually teach 500 new mothers how to best care for their babies.

The grant will support one-time costs associated with the installation of the GetWellNetwork, a series of television-based patient education programs that will be available in 15 renovated maternity suites at the hospital.

Funds will transform televisions in the patient rooms into interactive learning tools, offering access to on-demand educational programming and resources that teach patients how to care for themselves, and their children, once discharged.

The educational program complements a \$400,000 renovation of Community East's maternity unit that was completed in 2010. The maternity unit now features an updated healing environment and technology to support the delivery of high-quality care.

"At Community Hospital East, we are committed to serving the east side community and this grant will help increase our offerings to women and families who choose our family rooms to begin a new family," said Robin Ledyard, M.D., and president of Community Hospital East. She also said she plans to add GetWellNetwork technology and programming to all of the hospital's inpatient rooms in 2011.

Additional support for this educational project comes from an in-kind gift from GetWellNetwork, Inc. The Nina Mason Pulliam Charitable Trust and the GetWellNetwork is providing helps educate patients, teaching them best practices for caring for their children. Their investments will impact the lives of entire families, giving them tools needed to live healthy, productive lives.

Joint Pain 101 class: End your joint pain in 2012.

Is hip, knee or shoulder pain keeping you from doing the things you love? Is the pain keeping you from getting a good night's sleep? Does it affect the way you walk or limit the things you can reach or carry?

If you're affected by joint pain, it's important to know you have options. You don't have to live in pain.

Please join us at one of our **free** classes, taught by orthopedic surgeons and team members. Here, you'll discover simple things you can do to minimize the pain. You'll also learn about the

different medical treatment options available to you, including medications, injections and physical therapy. And we'll talk about the latest in hip and knee replacement surgery, our Center for Joint Health, and answer your questions, too.

4. Environmental Improvements

Community Health Network employees plant trees for Super Bowl Legacy Project; 160 volunteers expected to plant hundreds of trees at Interstate 70-Emerson Avenue interchange

About 160 Community Health Network employees created a Super Bowl legacy by planting 400 trees, contributing toward the 2012 Indianapolis Super Bowl Host Committee's goal of planting 2,012 trees before Super Bowl XLVI. In partnership with Keep Indianapolis Beautiful (KIB) and volunteers completing Eli Lilly and Company Global Day of Service projects, Community volunteers helped transform the barren Interstate 70-Emerson Avenue interchange, near Community Hospital East.

Community joined 30 other organizations for the 2011 Lilly Global Day of Service event. Four Indianapolis corridors were revitalized during the one-day project, which aims to beautify Indianapolis, improve community spaces and promote wellness. Community's volunteers dug and moved dirt, put trees in place and moved mulch in the areas around the exit ramps. With support from Brickman Group, a national landscaping company with a strong Indiana presence, Community has also made a commitment to water and maintain the trees once they are in the ground.

The 2,012th tree was planted October 6 during the Global Day of Service at Pogues Run Art and Nature Park. This will help two community organizations meet long-term goals.

- The 2,012th tree planted in the "2,012 Trees by 2012" tree-planting initiative –a partnership between KIB and the 2012 Indianapolis Super Bowl Host Committee
- The 30,000th tree planted by KIB in the NeighborWoods program, which has the goal of planting 100,000 trees in Indianapolis by 2017

"This is a great opportunity to bring our employees together to help beautify Indianapolis and promote green space for healthy living," said Bryan Mills, president and CEO of Community Health Network. "While helping create a welcoming environment for visitors to the city, our employees will permanently transform a large outdoor space, which is so important to our east side neighbors, as many of them live and work close to this interchange."

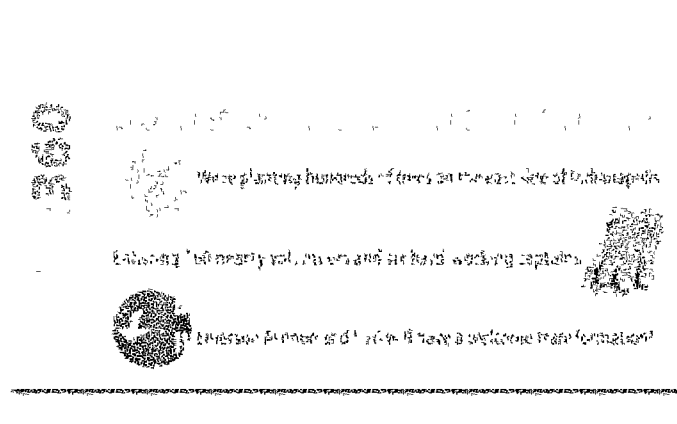
The green space will foster healthy outdoor living and have a lasting community and environmental impact for years to come. Being in a natural environment for as little as 10 minutes daily can reduce stress, blood pressure and improve mental health. In addition, living near parks or woodlands

improves health and extends life span, regardless of a person's social class or income. Community is committed to improving the health and well-being of Central Indiana residents.

"Without partners, such as Community Health Network, it wouldn't be possible to complete such a tremendous amount of work in a single day," said Rob Smith, president, Lilly Foundation. "It's impressive—and fun—to have hundreds of employees from two of the area's largest employers working together to improve public spaces in our city."

The tree planting project supports Community Health Network's Serve360° employee volunteerism initiative, launched this past summer. Serve360° was named to reflect Community's way of completing the circle, collectively giving back to the people and neighborhoods that gave birth to the network and continue to support it. The effort offers Community employees a way to live the network's mission, demonstrating a deep commitment to the communities they serve, enhancing health and well-being while cultivating the spirit of volunteer service.

Plant trees for the Super Bowl Legacy Project



Join us as we continue to Serve360° with the chance to make a lasting change to the landscape of our community... literally

As part of the Super Bowl Legacy Project, we'll be planting hundreds of trees at the Interstate 70-Emerson Avenue interchange near Community Hospital East

We need more "tree captains" plus about 160 volunteers on Thursday, October 6 from noon to 4 p.m.

With the expertise of Keep Indianapolis Beautiful and alongside volunteers from Eli Lilly & Co., we'll be digging and moving dirt, pulling trees in place and moving mulch in the areas around the exit ramps. With the support of our vendor partner, Brckman Group, Community Health Network has also made a commitment to maintain the trees once they are in the ground.

If you don't mind dirt and a little bit of hard labor, we hope you'll sign up for this Serve360 opportunity!

5. Leadership Development/Training for Community Members

Community EMS director has statewide responsibilities

John Zartman, director of emergency medical services and EMS education, has been named vice chairman of the Indiana EMS Commission Technical Advisory Committee (TAC), state coordinator for all Prehospital Trauma Life Support (PHTLS) courses and national registry representative for the National Registry of EMTs (NREMT).

“John has dedicated his career to the education and delivery of EMS care,” says Randy Wright, vice president of emergency services. “His engagement with state and national EMS organizations enhances Community’s relationships with local EMS teams and ensures that we are offering patients the best possible coordination of care when they arrive in our emergency departments.”

As vice chairman of the TAC, Zartman reports to the Indiana EMS Commission on all projects affecting roles and responsibilities of EMS operations and educational issues. An appointee of the governor’s office, Zartman develops and issues recommendations along with other members for system changes and modifications.

Zartman also serves as a state representative and coordinator for the National Association of EMTs (NAEMT). He coordinates all Indiana PHTLS courses, which are designed to train emergency personnel to deliver all levels of prehospital care for patients with minor to severe trauma. He monitors and approves all courses for the state of Indiana, including emergency medical responder, emergency medical technician (EMT), advanced EMT and paramedic. He also monitors the instructors who provide training and reviews core material.

In addition to ensuring that EMS personnel have proper training to provide patient care, Zartman administers statewide EMT and paramedic exams. These tests are the final step for students wishing to become nationally certified for EMS work. Zartman supervises the examinations and submits reports to NREMT for the processing of certifications.

As director of emergency medical services and EMS education for the network, Zartman supervises and sponsors many levels of EMS providers in Marion, Johnson, Hamilton, Madison and Hancock counties. Community Health Network’s EMS department also conducts multiple educational programs to all levels of EMS services, nursing, physicians and the general public.

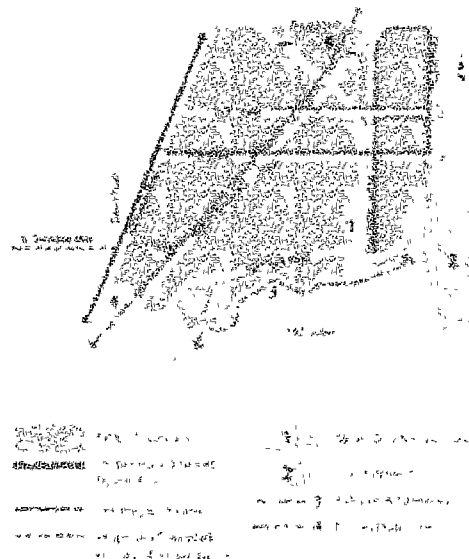
6. Coalition Building

Binford Redevelopment and Growth (BRAG)

In Fall 2006, the BRAG area was selected as a GINI (Great Indy Neighborhoods Initiative) recipient with the collaborative grant writing and support of Community Health Network. GINI made funding and

technical assistance available for three years to plan and implement quality of life enhancements. A Quality of Life Plan was prepared by working groups that formed as a result of a 2007 community wide visioning meeting. Today the coalition remains and is stronger than ever. Community Health Network is a proud sponsor of this successful community organization.

INSTEPP - Indy Northside Sidewalks and Trails Engaging People with Places



The initiative to develop multi-use trails came about from the surveys and community gatherings BRAG conducted during the three year GINI (Great Indy Neighborhoods Initiative) study. Survey results indicated that area residents thought that the lack of community connectivity was a significant concern. The INSTEPP committee was formed to address the issue.

Much of the BRAG area was built at a time when everything was designed around the automobile, so these destinations are safely accessible only by driving. Sidewalks and bike trails are virtually non-existent on our major thoroughfares. The Indianapolis Department of Public Works (DPW) has received \$1.2 million in federal funding to construct a multi-use path along 71st street from Binford Boulevard to Hague Road. The trail will increase pedestrian and bike safety and provide connectivity for area businesses and neighborhoods. We expect construction to begin in 2013.

The long term goal of INSTEPP is to build sidewalks and multi-use trails throughout the BRAG community, connecting neighborhoods both east and west of Binford Boulevard, and to provide safe crossings at all major intersections. The pathways identified in the INSTEPP plan are included in the Indianapolis Metropolitan Planning Organization Regional Pedestrian Plan (2006) and are also listed under the "recommendations for pedestrian pathways" in that plan.

Irvington Innovation Zone

"Forged by History, Powering Creative Prosperity"

Community Meetings

The Irvington Innovation Zone (IIZ) is a community based economic development program that is seeking to enhance a once vibrant area on the eastside of Indianapolis that has been a victim of the recent economic downturn. The IIZ is in the process of developing an economic development master plan for the greater Irvington area that is focused around advance manufacturing, motorsports, and logistics. The overall plan is intended to create a sustainable economy for the businesses, workers and residents on the east side of Indianapolis.

The plan will center on five key economic clusters: Advanced Manufacturing, Logistics, Motorsports, Life Sciences, and Education.

7. Community Health Improvement Advocacy

School Based Health Services

Background:

Today, all children and families have routine, significant contact with two social systems; school systems and health care systems. These are times that both systems are operating under many new financial constraints that demand fundamental transformations of their structures. At the same time these organizations are being changed, the public's expectation for improved outcomes are being demanded of both.

A basic tenant, that we believe will lead to the successful transformation of both systems, is that neither schools nor hospitals *by themselves* will be able to satisfactorily address the multidimensional needs of the community and of students working alone. The process of raising and educating healthy children who are able to succeed in our society requires new strategies for a community-wide commitment to addressing the needs of the whole child. School-based health services represent a service integration approach that recognizes the role that schools and health care systems can play in optimizing their resources in the quest to bring about the healthy development of children and families. This plan to integrate hospital services into the educational environment will go a long way in improving the lives of children in the counties we serve.

As a response to federal, state and local initiatives that address the needs for families to receive basic primary health care, Community Health Network (CHN) has successfully partnered with schools, churches, community associations, local businesses and funding sources to bring health education and health services to various communities while respecting their unique cultural situations. The School District in Indianapolis and surrounding counties are rife with adverse social indicators and all have used many initiatives to address these needs in their students,

families and community. The many needs and risk factors of its students led CHN to form partnerships with school systems. These partnerships led to the creation of the first school-based clinic 12 years ago. The partnerships chose locations for a full time school-based health clinic which provides health care and medical education for not only its students but for their families and the surrounding community. As we quickly discovered, the students and their families faced many obstacles to health, treatment, and academic achievement.

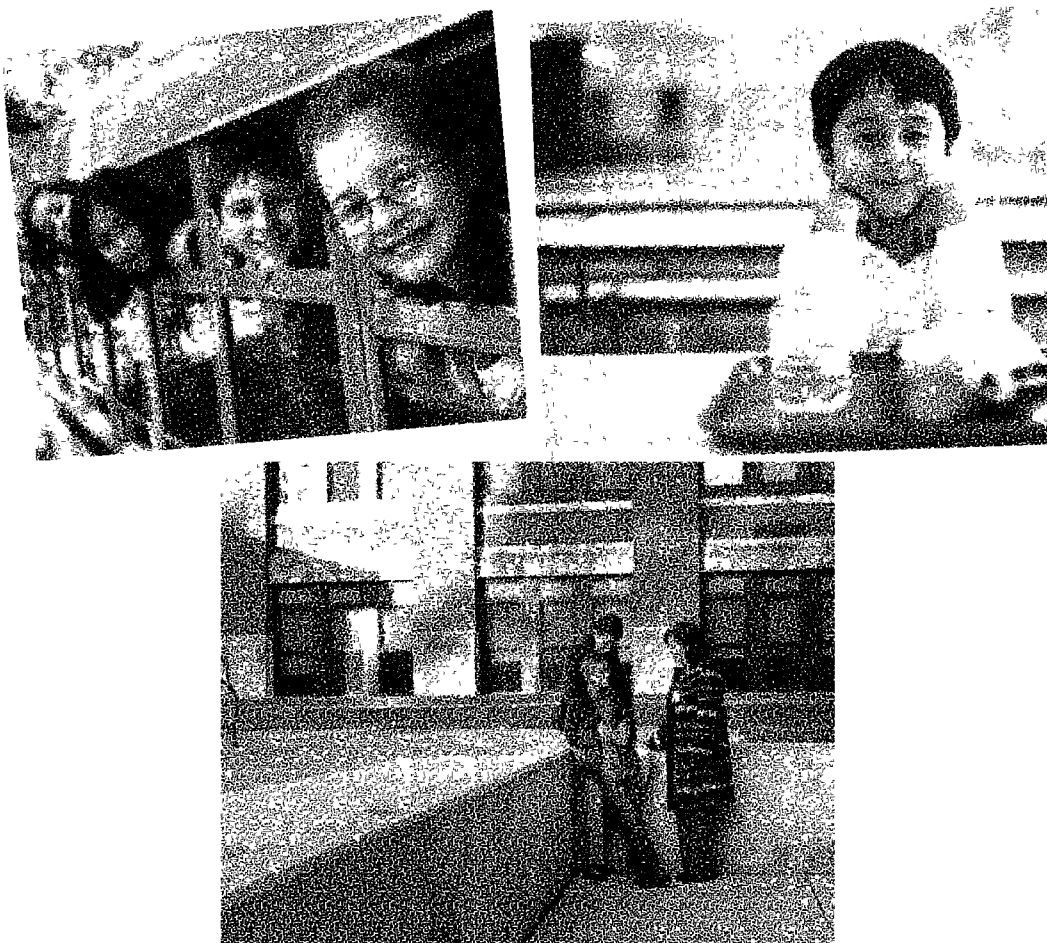
As the free and reduced lunch program statistics suggest, the numbers of at risk youth in our original clinic went from twenty to fifty percent. A thirty percent increase in the number of the students that fall into this category alone may represent unstable home situations due to economic challenges, however many more families than fall into this category may have limited access to supportive services necessary to manage their lives. Many in the community need support and connections with economic, legal, and social service as well as cultural, health and educational services.

By partnering and collaborating in adapting physicians, school nurses, counselors, athletic trainers and allied health professional, we believe we can begin to affect positive changes in many of these risk factors, and augment the benefits of educational efforts by the school. For example, examining downstream effects from the efforts we deployed at MSD Warren Hawthorne School Based clinic, not only did students demonstrate better health outcomes, fewer emergency room visits, and fewer missed school days, but they also performed better than other schools on the standardized ISTEP exams.

School-based wellness clinics

Helping kids be healthy so they can succeed in school is the mission of the school-based wellness clinics operated by Community Health Network. The clinics make a wide range of services convenient and affordable for school children and their families, and they are located right inside the school buildings.

The clinics provide such wellness services as immunizations, and also see children with minor illnesses or injuries. Sometimes another family member—sibling or parent—will also receive health care services at the clinics. The clinics help families connect with other health services as well. For example, parents without insurance are offered help in enrolling their kids in the Hoosier Healthwise program that insures children. School officials believe that the easy availability of health care services is one of the factors behind their students' success. For example, the students at clinic host site Hawthorne Elementary have made significant academic achievement throughout the clinics 11 year tenure at the school. Hawthorne third-graders recently had Warren Township's best ISTEP scores and the school received national recognition as a "Title I" School.



Behavioral Care School-Based program

Gallahue Mental Health Services, Community's outpatient program, collaborates with local schools to deliver treatment in a non-traditional mental health setting. The school-based program, started in 1997, enables families to access services in a school's supportive environment. Our program offers a unique and innovative approach to the delivery of mental health therapy through strength-based, family-focused, outpatient care.

This natural environment allows students, teachers and families to function together successfully in both the classroom and the community. Gallahue's school-based staff offers the added benefit of improving the relationship between staff and students as well as providing convenient access for students and their families who otherwise might not seek treatment. Home-based visits are offered as an added benefit to reach both the student and family.

Ultimately, our goal is to assist children and their families with learning, improving interpersonal and relationships skills; as well as becoming productive citizens in their community.

School crisis response

The network's behavioral care staff participates with several mental health organizations in Marion County on a school crisis response team. This team is composed of trained volunteers from various participating agencies, and services are provided at no cost to the schools served upon their request.

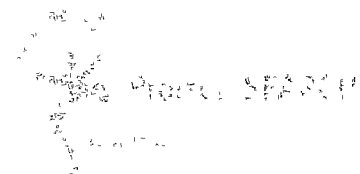
Volunteers provide crisis debriefing, education and consultation to school-age children and adolescents, teachers and school administrators. Services are provided at the school or another pre-arranged site such as a church or community center.

8. Workforce Development

Project SEARCH / Indiana

Project SEARCH/Indiana is a collaborative effort of the following:

- State of Indiana, Family & Social Services Administration/Office of Vocational Rehabilitation, funder
- Community Health Network, training site and employer
- Easter Seals Crossroads, job coaching and job accommodations provider
- Indianapolis Public Schools, educational provider
- Indiana University/Indiana Institute on Disability and Community, technical assistance provider



Why

Founded in Cincinnati, Ohio, Project SEARCH provides employment and education opportunities for individuals with significant disabilities. The program is dedicated to workforce development that benefits the individual, community and workplace. Along with in-depth student training, Project SEARCH educates employers about the potential of this underutilized workforce while meeting their human resource needs.

The ultimate goal of the above-mentioned Indiana collaborative partnership is to replicate this nationally recognized employment program for young people with disabilities throughout the state. Known as Project SEARCH/Indiana, this exciting prototype program launched in February 2008 at Community Hospital East in Indianapolis.

How

Project SEARCH/Indiana is a high school transition program targeted for students whose main goal is competitive employment. It is a worksite-based, school-to-work program for students with developmental and/or physical disabilities in their last year of public school eligibility.

The initial Project SEARCH/Indiana program takes place in a health care setting where total immersion in the workplace facilitates the learning process through continuous feedback and development of new marketable job skills.

Students are given support through on-the-job coaching and worksite accommodations with the ultimate goal of independence, in order to insure a successful transition to work as well as job retention and career advancement. A typical school day includes classroom instruction in employability and independent living skills; participation at one or more worksite rotations; lunch with peers; and feedback from the instructors.

Healthcare Career Mentoring and Job Shadowing Program

Program Description

The Healthcare Career Mentoring and Job Shadowing Program enables participating senior year students from Warren Township's Walker Career Center at Warren Central High School to enhance their opportunity to secure employment within the health care industry in addition to assisting in preparation for postsecondary educational endeavors.

Beginning in the first semester of the program participant's senior year, students partake in a weekly one-hour program orientation conducted at each respective district's Career Center. Weekly topics include, but are not limited to, Healthcare Career Industries and Disciplines, Career Technical Education's (CTE) 16 Career Clusters and 79 Career Pathways, Family, Career and Community Leaders of America, Inc.'s (FCCLA) Career Family Tree, Community Health Network's Nursing Appearance Standards, Professionalism, Healthcare Career Occupations and Salary Ranges, and Types of Healthcare Providers. Students will also be afforded the opportunity to become certified in Cardiopulmonary Resuscitation (CPR) as recognized by the American Heart Association.

During the second semester program participants will participate in a two-week orientation designed to provide an intense orientation prior to job shadowing placement. Topics include, but are not limited to, Introduction to Community Health Network, Exceptional Patient & Family Experience, Network Compliance Policies (HIPPA), and Safety. Additional curriculum-based instructions will be conducted in the areas of Professionalism, Career Options, Overview of Healthcare Career Industry and Disciplines, Medical Terminology, Family/Social Health, and Health Lifestyle.

Students that successfully complete the second semester two-week orientation will participant in a six-week job shadowing across various front-office and back-office medical disciplines within the

Community Health Network organization. Student job shadowing placement opportunities exist primarily in clinical out-patient health services and non-clinical healthcare fields.

Students completing both semesters of the program will take the Indiana State Department of Health's CNA examination. Student's who successfully pass the CNA examination and who graduate from each of the respective Career Centers with a high school diploma or GED in addition to being listed in good standing as a CNA on the Indiana State Nurse Aide Registry will be afforded a prioritized opportunity for CNA employment within the Community Health Network organization. Also, program graduates will receive prioritized opportunity for CNA employment with Bethany Village Nursing Home. Program graduates who prefer to continue with their postsecondary educational opportunities rather than initial employment will remain in the program tracking database regarding educational progress.

Goal & Objectives

The goal of the Healthcare Career Mentoring and Job Shadowing Program is to afford Career Center senior year healthcare students the opportunity to engage in hands-on and curriculum-based training that will significantly improve their skills needed for employment within the healthcare Industry.

The main objectives include:

1. Ensure that 75 percent of graduating program participants will be attending an accredited postsecondary institution and/or be employed by a healthcare provider no later than six months after graduating from high school and passing the nurse aide competency evaluation test.
2. Provide appropriate and varied learning experiences for program participants in accordance to each respective Career Center's educational goals and objectives.
3. Enable student participants increased access to professional networking and employment opportunities through job shadowing and career mentoring externships.

9. Other
N/A

Part V Facility Information *(continued)*

	Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for tax year 2011)		
1 During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8	<input checked="" type="checkbox"/>	
If "Yes," indicate what the Needs Assessment 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 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"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j <input checked="" type="checkbox"/> Other (describe in Part VI)		
2 Indicate the tax year the hospital facility last conducted a Needs Assessment <u>2011</u>		
3 In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	<input checked="" type="checkbox"/>	
4 Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	<input checked="" type="checkbox"/>	
5 Did the hospital facility make its Needs Assessment widely available to the public?	<input checked="" type="checkbox"/>	
If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):		
a <input checked="" type="checkbox"/> Hospital facility's website		
b <input checked="" type="checkbox"/> Available upon request from the hospital facility		
c <input checked="" type="checkbox"/> Other (describe in Part VI)		
6 If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):		
a <input checked="" type="checkbox"/> Adoption of an implementation strategy to address the health needs of the hospital facility's community		
b <input checked="" type="checkbox"/> Execution of the implementation strategy		
c <input checked="" type="checkbox"/> Participation in the development of a community-wide community benefit plan		
d <input checked="" type="checkbox"/> Participation in the execution of a community-wide community benefit plan		
e <input checked="" type="checkbox"/> Inclusion of a community benefit section in operational plans		
f <input checked="" type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the Needs Assessment		
g <input checked="" type="checkbox"/> Prioritization of health needs in its community		
h <input checked="" type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community		
i <input checked="" type="checkbox"/> Other (describe in Part VI)		
7 Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs		<input checked="" type="checkbox"/>
Financial Assistance Policy		
Did the hospital facility have in place during the tax year a written financial assistance policy that:		
8 Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	<input checked="" type="checkbox"/>	
9 Used federal poverty guidelines (FPG) to determine eligibility for providing free care?	<input checked="" type="checkbox"/>	
If "Yes," indicate the FPG family income limit for eligibility for free care <u>200</u> %		
If "No," explain in Part VI the criteria the hospital facility used.		

Community Health Needs Assessment

1. Since 1996, Community Health Network facilities have participated in the local and surrounding counties' Community Health Needs Assessments. These assessments have been the springboard to understanding and implementing strategies and programs that have targeted populations in need with specific outcomes driving the strategy for change. A very important lesson was learned in the first assessment:

When residents were asked what a healthy community looked like to them, they responded with clean and safe streets, NOT the absence of disease.

That began our journey into the social determinants of health and has brought us through many transformations of the Community Benefit Plan and the way in which we assess the needs of the community. Since that time, other assessment tools have been made available to the community by such agencies as United Way that assist us in assessing the community needs (i.e., Social Assets and Vulnerabilities Indicators) for our Community Benefit Plan.

In 2006, we contracted with an outside vendor to provide a targeted community assessment in the urban area directly around our eastside facility. This community assessment was used as a catalyst for the "Eastside Redevelopment Initiative," which has driven a successful group of projects and activities. Much like the assessment 10 years earlier, this assessment broke through some "myths and realities" of the neighborhood, such as perceptions and realities of crime and income in the community. As important as the data, these assessments have given us a snapshot of the community. The ongoing input of our community groups—through feedback mechanisms developed by and for our CBP—is just as important and can ultimately drive our actions and planning. We begin where our communities are.

In 2009, another significant assessment was provided to the Fishers community. The network marketing department collaborated with the Fishers community, bringing interested organizations together to provide an assessment of the Fishers area.

Other assessment strategies

Beginning in 2009, we began using an advanced mapping tool, Health Landscape, so that we can truly delve into areas of need. Once we receive information from our needs assessment, we can plot geographic data in our service areas in order to actually "see" on a map where our highest-need areas are located. This also allows us to identify service areas of other organizations so that we can work collaboratively on behalf of the community.

Beginning in 2010, we started to develop interest in the Healthy Communities Institute and brought local and state leaders together to review their product and process for implementation. Although the fees were minimal compared to other products, the groups could not agree on one standard product to assist in the development of the community health needs assessments for the five to seven counties

we serve. Consequently, we signed a contract with Healthy Communities Institute and will have completed our process for community health needs assessments by the end of 2012.

With all of the assessments we have conducted to date, we have never fulfilled all of the findings within these documents. The documents that are generated often are visions of the future rather than specific action steps for the current reality, in fact, as noted before - health is not often seen on quality of life plans generated by a community – rather the interpretation may be personal safety and clean streets as an indicator of a healthy community.

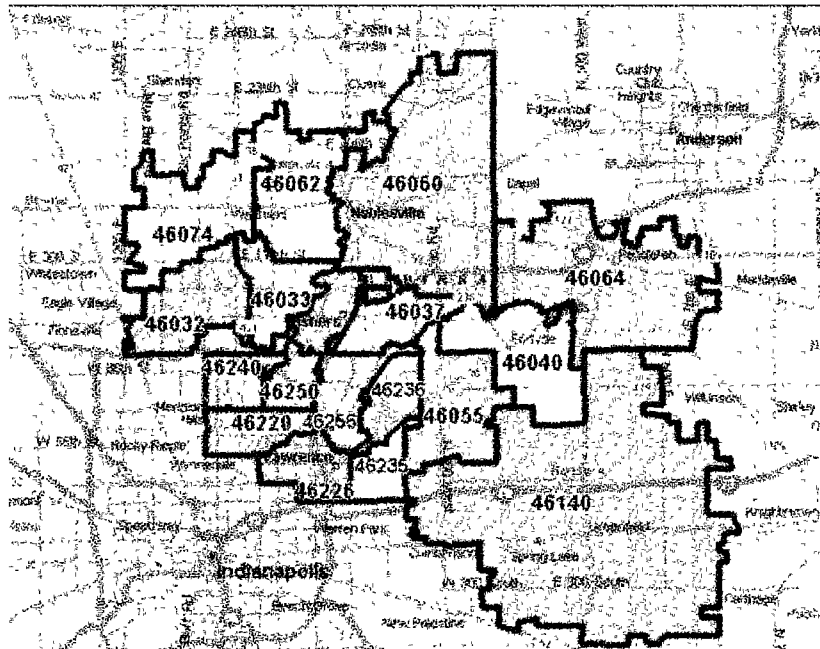
Summary of Assessments:

- 1996: Building Healthier Neighborhoods, Marion County,
- 1996: Partnership for a Healthier Johnson County
- 2001-ongoing: Minority Health Coalition of Marion County
- 2001-ongoing: Kids Count in Indiana, The Indiana Youth Institute
- 2002: Quality of Life in Marion County, A Community Snapshot
- 2005-ongoing: The SAVI Community Information System
- 2008: Community Needs Assessment—Windsor Village, Marion County, Indiana
- 2009: Fishers Community Assessment
- 2010: Jane Pauley Community Health Center FQHC Application requirements
- 2011: SEVA: Indian Immigration Health Needs Assessment
 - Town Hall Meeting Series
 - Near Eastside Community Organization: IEQHA & Better Healthcare Indiana
 - Follow up with Quality Life Addendum on Health
 - Preliminary Healthy Communities Institute Data

We will continue to generate data and information to guide our communities through health needs assessments with the hope of finding issues addressing them and measuring the positive and negative outcomes of our initiatives. We are encouraged by the product that we will be making available in the future through the Health Communities Institute and hope to be able to allow an eighth grade student to access our information for a school project on health.

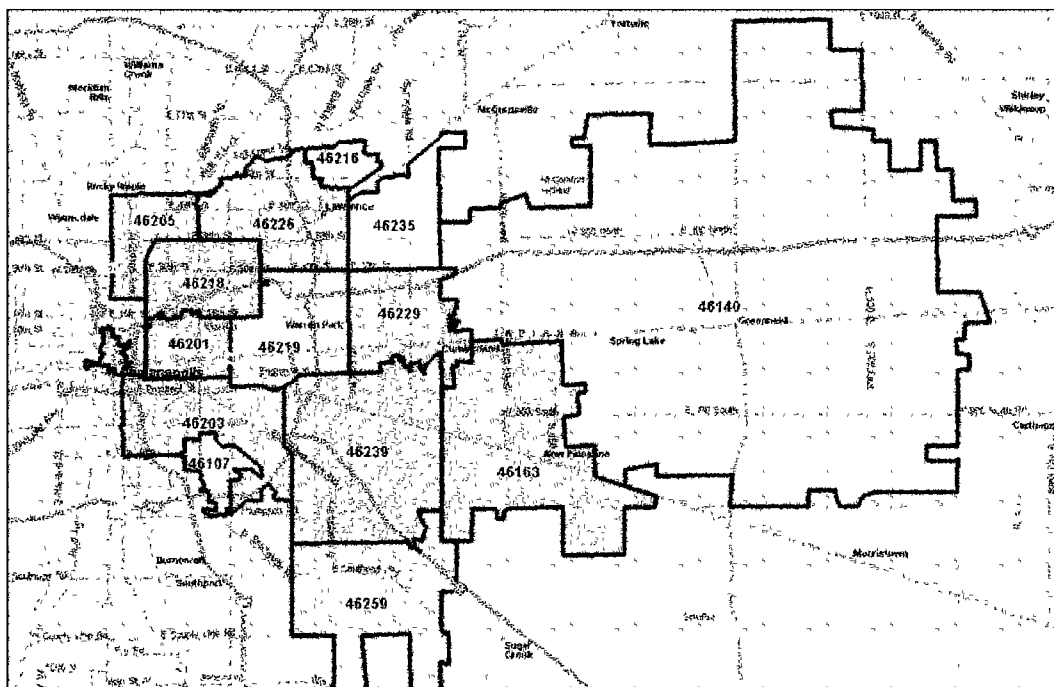
a. Each hospital facility has a defined services area. What follows is a map of the individual service areas of each market with associated zip codes.

North Market



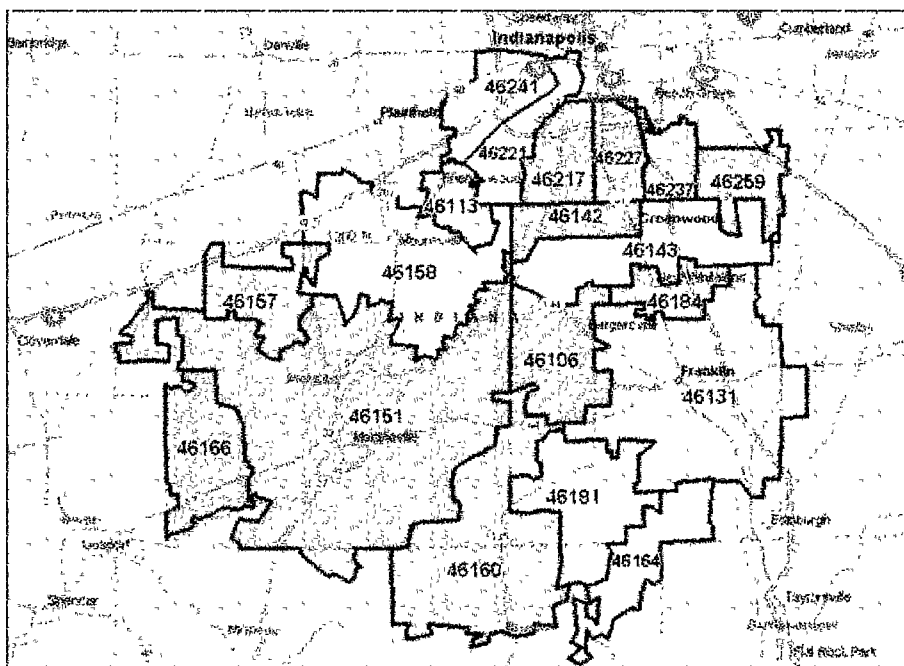
Community Hospital North			
Market Area			
ZIP	City	County	Overlapping ZipCodes
46032	Carmel	Hamilton	
46033	Carmel	Hamilton	
46037	Fishers	Hamilton	
46038	Fishers	Hamilton	
46040	Fortville	Hancock	
46055	Mc Cordsville	Hancock	
46060	Noblesville	Hamilton	
46062	Noblesville	Hamilton	
46064	Pendleton	Madison	Overlaps with Anderson Market Area
46140	Greenfield	Hancock	Overlaps with East Market Area
46216	Lawrence	Marion	Overlaps with East Market Area
46220	Broadripple 2	Marion	
46226	Lawrence	Marion	Overlaps with East Market Area
46235	S Oaklandon	Marion	Overlaps with East Market Area
46236	Oaklandon	Marion	
46240	Nora	Marion	
46250	Castleton	Marion	
46256	Castleton	Marion	
46074	Westfield	Hamilton	
Definition of Market Area			
Unique zip code geography for Community Hospital North			
There is no overlap between zip codes except for the following			
46064	Pendleton	North and Anderson overlap	
46140	Greenfield	North and East overlap	
46216	Lawrence	North and East overlap	
46226	Lawrence	North and East overlap	
46235	S Oaklandon	North and East overlap	

East Market



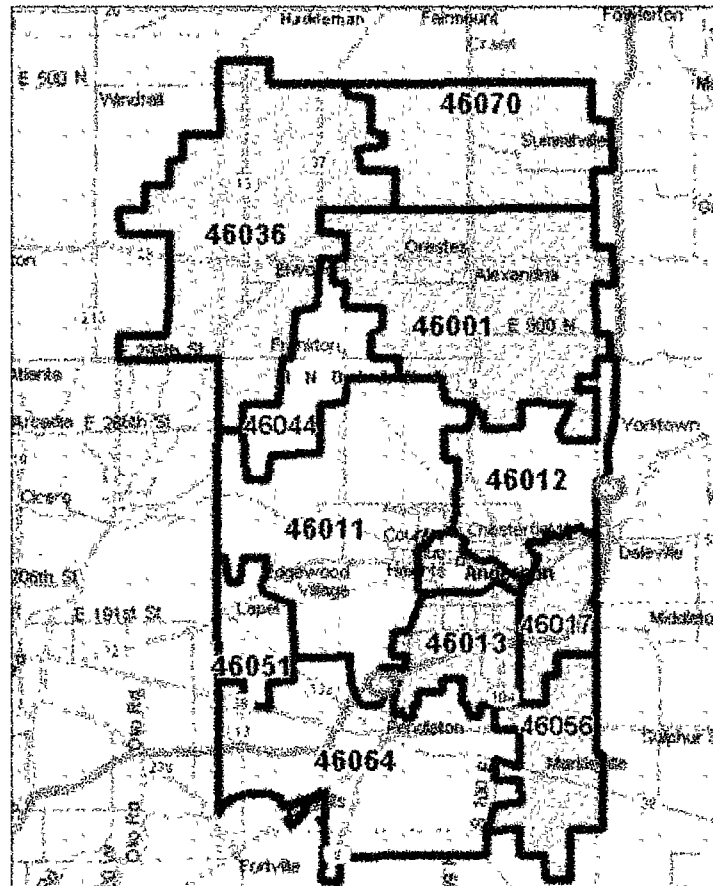
Community Hospital East			
Market Area			
ZIP	City	County	Overlapping ZipCodes
46107	Beech Grove	Marion	
46140	Greenfield	Hancock	Overlaps with North Market Area
46163	New Palestine	Hancock	
46201	Linwood	Marion	
46203	Garfield	Marion	
46204	Downtown	marion	
46205	Broadripple 2	Marion	
46216	Lawrence	Marion	Overlaps with North Market Area
46218	Brightwood	Marion	
46219	Eastgate	Marion	
46226	Lawrence	Marion	Overlaps with North Market Area
46229	Cumberland	Marion	
46235	S Oaklondon	Marion	Overlaps with North Market Area
46239	Wanamaker	Marion	
46259	Acton	Marion	
Definition of Market Area			
Unique zip code geography for Community Hospital East			
There is no overlap between zip codes except for the following			
46140	Greenfield		North and East overlap
46216	Lawrence		North and East overlap
46226	Lawrence		North and East overlap
46235	S Oaklondon		North and East overlap

South Market



Community Hospital South			
Market Area			
ZIP	City	County	Overlapping ZipCodes
46106	Bargersville	Johnson	
46113	Camby	Morgan	
46131	Franklin	Johnson	
46142	Greenwood	Johnson	
46143	Greenwood	Johnson	
46151	Martinsville	Morgan	
46157	Monrovia	Morgan	
46158	Mooresville	Morgan	
46160	Morgantown	Brown	
46164	Nineveh	Johnson	
46166	Paragon	Morgan	
46181	Trafalgar	Johnson	
46184	Whiteland	Johnson	
46217	Southport 2	Marion	
46221	W Indianapolis	Marion	
46227	Southport	Marion	
46237	Southport 3	Marion	
46241	South Indpls	Marion	
46259	Acton	Marion	
Definition of Market Area			
Unique zip code geography for Community Hospital South			
There is no overlap between zip codes			

Anderson Market



Madison County Market Area			
ZIP	City	County	Overlapping ZipCodes
46001	Alexandria	Madison	
46011	Anderson	Madison	
46012	Anderson	Madison	
46013	Anderson	Madison	
46016	Anderson	Madison	
46017	Anderson	Madison	
46036	Elwood	Madison	
46044	Frankton	Madison	
46048	Ingalls	Madison	
46051	Lapel	Madison	
46056	Markleville	Madison	
46064	Pendleton	Madison	Overlaps with North Market Area
46070	Summitville	Madison	
Definition of Market Area			
Unique zip code geography for Community Hospital Anderson			
There is no overlap between ZipCodes except for the following			
46064	Pendleton	North and Anderson overlap	

b. Demographics of the community: Each hospital facility has a defined services area. What follows is the demographics of the individual service areas of each market.

North

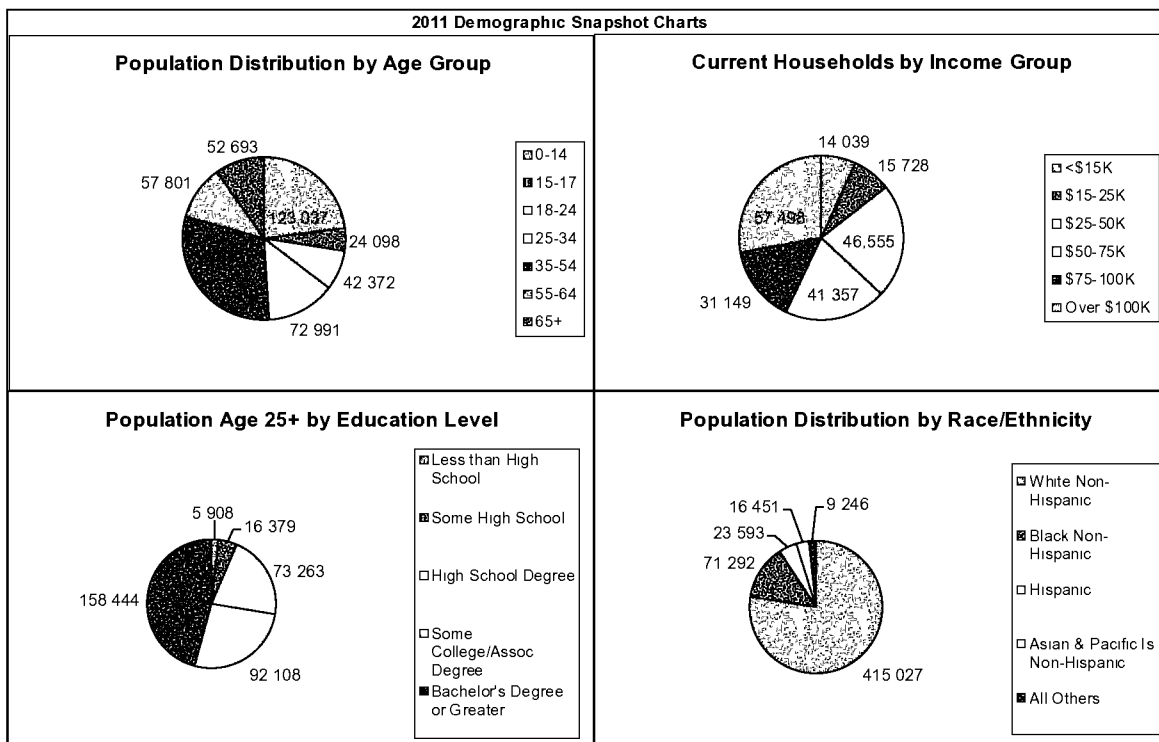
Demographics Expert 2.7
2011 Demographic Snapshot
Area North Market
Level of Geography ZIP Code

DEMOGRAPHIC CHARACTERISTICS								
	Selected					2011	2010	% Change
	Area	USA						
2000 Total Population	402 103	281 421 906	Total Male Population			263 608	289 124	9.7%
2011 Total Population	535 609	310 650 750	Total Female Population			272 001	297 890	9.5%
2016 Total Population	587 014	323 031 618	Females, Child Bearing Age (15-44)			110 924	114 225	3.0%
% Change 2011 - 2016	9.6%	4.0%						
Average Household Income	\$87 021	\$67 529						

POPULATION DISTRIBUTION						HOUSEHOLD INCOME DISTRIBUTION		
Age Distribution						Income Distribution		
Age Group	2011	% of Total	2016	% of Total	USA 2011	2011 Household Income	HH Count	% of Total
0-14	123 037	23.0%	133 031	22.7%	20.2%	<\$15K	14 039	6.8%
15-17	24 098	4.5%	27 248	4.6%	4.2%	\$15-25K	15 728	7.6%
18-24	42 372	7.9%	50 208	8.6%	9.7%	\$25-50K	46 555	22.6%
25-34	72 991	13.6%	70 763	12.1%	13.3%	\$50-75K	41 357	20.0%
35-54	162 617	30.4%	166 584	28.4%	27.6%	\$75-100K	31 149	15.1%
55-64	57 801	10.8%	71 894	12.2%	11.7%	Over \$100K	57 498	27.9%
65+	52 693	9.8%	67 286	11.5%	13.3%			
Total	535,609	100.0%	587,014	100.0%	100.0%	Total	206,326	100.0%

EDUCATION LEVEL				RACE/ETHNICITY			
Education Level Distribution				Race/Ethnicity Distribution			
2011 Adult Education Level	Pop Age 25+	% of Total	USA	Race/Ethnicity	2011 Pop	% of Total	USA
Less than High School	5 908	1.7%	6.3%	White Non-Hispanic	415 027	77.5%	64.2%
Some High School	16 379	4.7%	8.8%	Black Non-Hispanic	71 292	13.3%	12.1%
High School Degree	73 263	21.2%	28.9%	Hispanic	23 593	4.4%	16.1%
Some College/Assoc Degree	92 108	26.6%	28.3%	Asian & Pacific Is Non-Hispanic	16 451	3.1%	4.6%
Bachelor's Degree or Greater	158 444	45.8%	27.7%	All Others	9 246	1.7%	3.0%
Total	346,102	100.0%	100.0%	Total	535,609	100.0%	100.0%

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East

Demographics Expert 2.7
2011 Demographic Snapshot
Area: East Market
Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA		2011	2016	% Change
2000 Total Population	355,130	281,421,906	Total Male Population	182,916	186,995	2.2%
2011 Total Population	377,049	310,650,750	Total Female Population	194,133	197,238	1.6%
2016 Total Population	384,233	323,031,618	Females, Child Bearing Age (15-44)	78,265	75,944	-3.0%
% Change 2011 - 2016	1.9%	4.0%				
Average Household Income	\$51,733	\$67,529				

POPULATION DISTRIBUTION

Age Group	Age Distribution				
	2011	% of Total	2016	% of Total	USA 2011
0-14	86,366	22.9%	90,861	23.6%	20.2%
15-17	15,804	4.2%	15,334	4.0%	4.2%
18-24	33,645	8.9%	33,386	8.7%	9.7%
25-34	56,283	14.9%	50,608	13.2%	13.3%
35-54	100,750	26.7%	99,928	26.0%	27.6%
55-64	40,197	10.7%	44,667	11.6%	11.7%
65+	44,004	11.7%	49,449	12.9%	13.3%
Total	377,049	100.0%	384,233	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

2011 Household Income	Income Distribution		
	HH Count	% of Total	USA
<\$15K	23,450	15.6%	12.9%
\$15-25K	20,862	13.9%	10.8%
\$25-50K	47,169	31.4%	26.6%
\$50-75K	28,833	19.2%	19.5%
\$75-100K	14,521	9.7%	11.9%
Over \$100K	15,154	10.1%	18.3%
Total	149,989	100.0%	100.0%

EDUCATION LEVEL

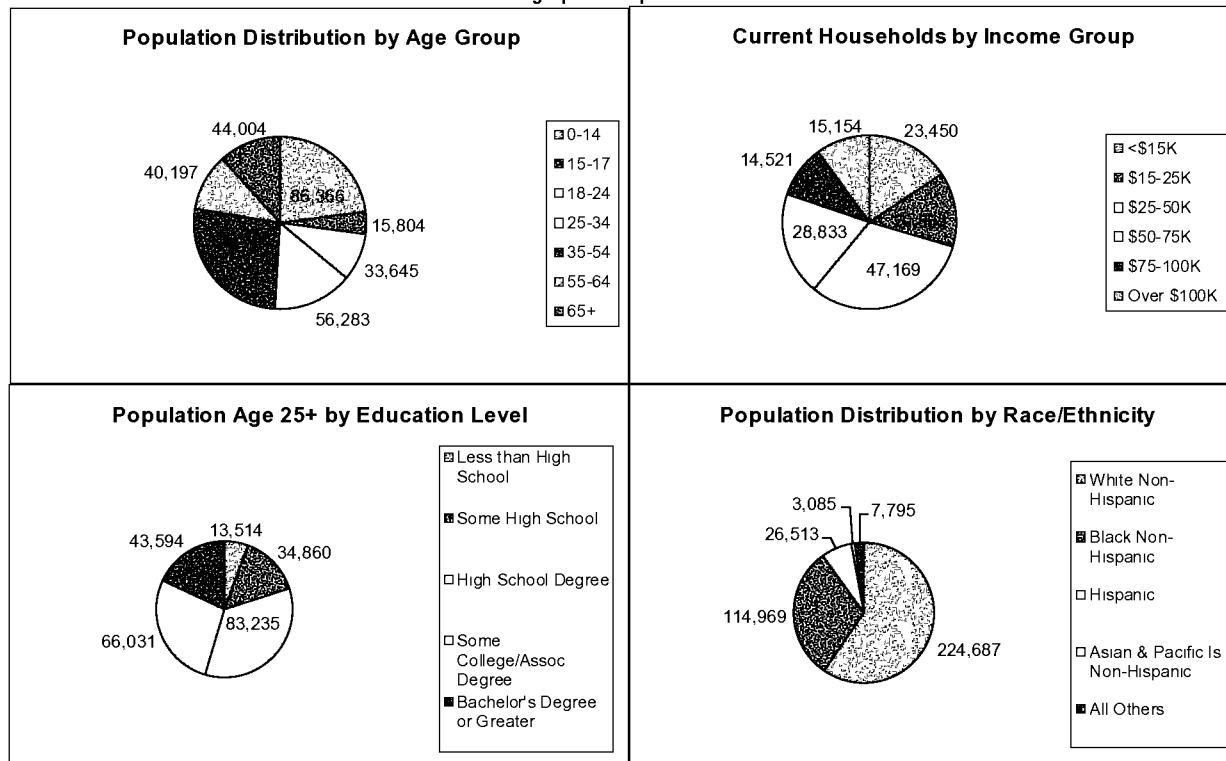
2011 Adult Education Level	Education Level Distribution		
	Pop Age 25+	% of Total	USA
Less than High School	13,514	5.6%	6.3%
Some High School	34,860	14.5%	8.8%
High School Degree	83,235	34.5%	28.9%
Some College/Assoc Degree	66,031	27.4%	28.3%
Bachelor's Degree or Greater	43,594	18.1%	27.7%
Total	241,234	100.0%	100.0%

RACE/ETHNICITY

Race/Ethnicity	Race/Ethnicity Distribution		
	2011 Pop	% of Total	USA
White Non-Hispanic	224,687	59.6%	64.2%
Black Non-Hispanic	114,969	30.5%	12.1%
Hispanic	26,513	7.0%	16.1%
Asian & Pacific Is Non-Hispanic	3,085	0.8%	4.6%
All Others	7,795	2.1%	3.0%
Total	377,049	100.0%	100.0%

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2011 Demographic Snapshot Charts



South

Demographics Expert 2.7
2011 Demographic Snapshot
Area: South Market
Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA		2011	2010	% Change
2000 Total Population	347,411	281,421,906	Total Male Population	196,663	205,335	4.4%
2011 Total Population	400,053	310,650,750	Total Female Population	203,390	212,267	4.4%
2016 Total Population	417,602	323,031,618	Females, Child Bearing Age (15-44)	80,841	80,410	-0.5%
% Change 2011 - 2016	4.4%	4.0%				
Average Household Income	\$63,839	\$67,529				

POPULATION DISTRIBUTION

Age Group	Age Distribution			USA 2011		
	2011	% of Total	2010	% of Total	2011	% of Total
0-14	86,272	21.6%	90,684	21.7%	20.2%	
15-17	17,088	4.3%	17,563	4.2%	4.2%	
18-24	35,476	8.9%	37,339	8.9%	9.7%	
25-34	55,173	13.8%	52,102	12.5%	13.3%	
35-54	112,275	28.1%	110,403	26.4%	27.6%	
55-64	46,165	11.5%	52,834	12.7%	11.7%	
65+	47,604	11.9%	56,677	13.6%	13.3%	
Total	400,053	100.0%	417,602	100.0%	100.0%	

HOUSEHOLD INCOME DISTRIBUTION

2011 Household Income	Income Distribution			USA		
	HH Count	% of Total	% of Total	2011	% of Total	% of Total
<\$15K	13,906	9.1%	12.9%			
\$15-25K	15,818	10.3%	10.8%			
\$25-50K	42,228	27.5%	26.6%			
\$50-75K	35,712	23.3%	19.5%			
\$75-100K	21,706	14.2%	11.9%			
Over \$100K	23,931	15.6%	18.3%			
Total	153,301	100.0%	100.0%			

EDUCATION LEVEL

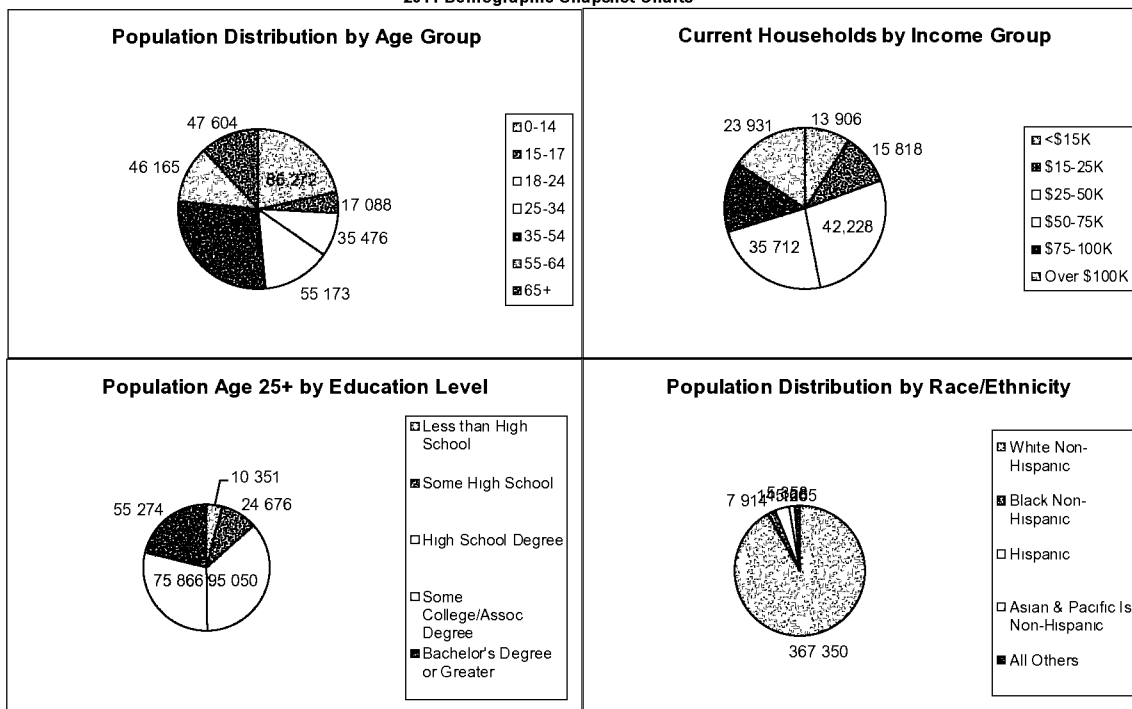
2011 Adult Education Level	Education Level Distribution			USA		
	Pop Age 25+	% of Total	% of Total	2011	% of Total	% of Total
Less than High School	10,351	4.0%	6.3%			
Some High School	24,676	9.4%	8.8%			
High School Degree	95,050	36.4%	28.9%			
Some College/Assoc Degree	75,866	29.0%	28.3%			
Bachelor's Degree or Greater	55,274	21.2%	27.7%			
Total	261,217	100.0%	100.0%			

RACE/ETHNICITY

Race/Ethnicity	Race/Ethnicity Distribution			USA		
	2011 Pop	% of Total	% of Total	2011	% of Total	% of Total
White Non-Hispanic	367,350	91.8%	64.2%			
Black Non-Hispanic	7,914	2.0%	12.1%			
Hispanic	14,166	3.5%	16.1%			
Asian & Pacific Is Non-Hispanic	5,358	1.3%	4.6%			
All Others	5,265	1.3%	3.0%			
Total	400,053	100.0%	100.0%			

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2011 Demographic Snapshot Charts



Anderson

Demographics Expert 27
2011 Demographic Snapshot
Area: Madison County Market
Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA		2011	2016	% Change
2000 Total Population	133,945	281,421,906	Total Male Population	66,468	65,959	-0.8%
2011 Total Population	132,845	310,650,750	Total Female Population	66,377	65,708	-1.0%
2016 Total Population	131,667	323,031,618	Females, Child Bearing Age (15-44)	24,170	23,237	-3.9%
% Change 2011 - 2016	-0.9%	4.0%				
Average Household Income	\$53,643	\$67,529				

POPULATION DISTRIBUTION

Age Group	Age Distribution			USA 2011		
	2011	% of Total	2016	% of Total	% of Total	
0-14	24,605	18.5%	24,302	18.5%	20.2%	
15-17	5,279	4.0%	4,935	3.7%	4.2%	
18-24	12,112	9.1%	12,703	9.6%	9.7%	
25-34	16,698	12.6%	15,737	12.0%	13.3%	
35-54	35,673	26.9%	33,427	25.4%	27.6%	
55-64	16,511	12.4%	16,686	12.7%	11.7%	
65+	21,967	16.5%	23,877	18.1%	13.3%	
Total	132,845	100.0%	131,667	100.0%	100.0%	

HOUSEHOLD INCOME DISTRIBUTION

2011 Household Income	Income Distribution			USA		
	HH Count	% of Total	% of Total			
<\$15K	7,085	13.4%	12.9%			
\$15-25K	7,278	13.7%	10.8%			
\$25-50K	16,709	31.5%	26.6%			
\$50-75K	10,522	19.8%	19.5%			
\$75-100K	5,782	10.9%	11.9%			
Over \$100K	5,658	10.7%	18.3%			
Total	53,034	100.0%	100.0%			

EDUCATION LEVEL

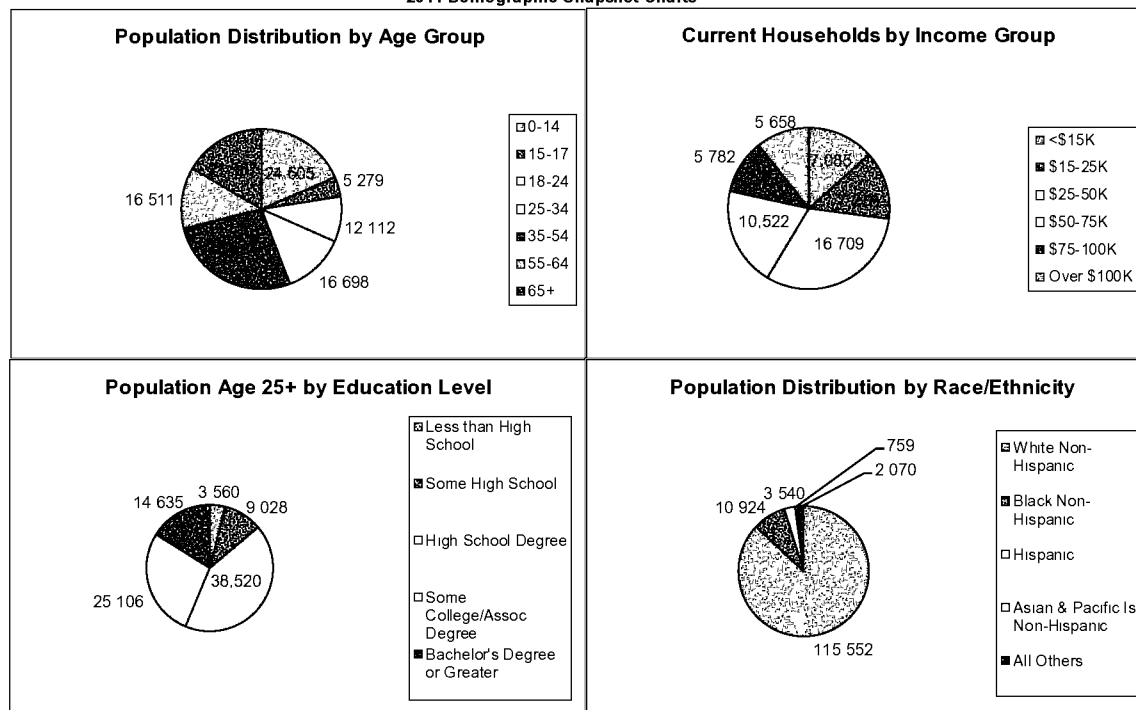
2011 Adult Education Level	Education Level Distribution			USA		
	Pop Age 25+	% of Total	% of Total			
Less than High School	3,560	3.9%	6.3%			
Some High School	9,028	9.9%	8.8%			
High School Degree	38,520	42.4%	28.9%			
Some College/Assoc Degree	25,106	27.6%	28.3%			
Bachelor's Degree or Greater	14,635	16.1%	27.7%			
Total	90,849	100.0%	100.0%			

RACE/ETHNICITY

Race/Ethnicity	Race/Ethnicity Distribution			USA		
	2011 Pop	% of Total	% of Total			
White Non-Hispanic	115,552	87.0%	64.2%			
Black Non-Hispanic	10,924	8.2%	12.1%			
Hispanic	3,540	2.7%	16.1%			
Asian & Pacific Is Non-Hispanic	759	0.6%	4.6%			
All Others	2,070	1.6%	3.0%			
Total	132,845	100.0%	100.0%			

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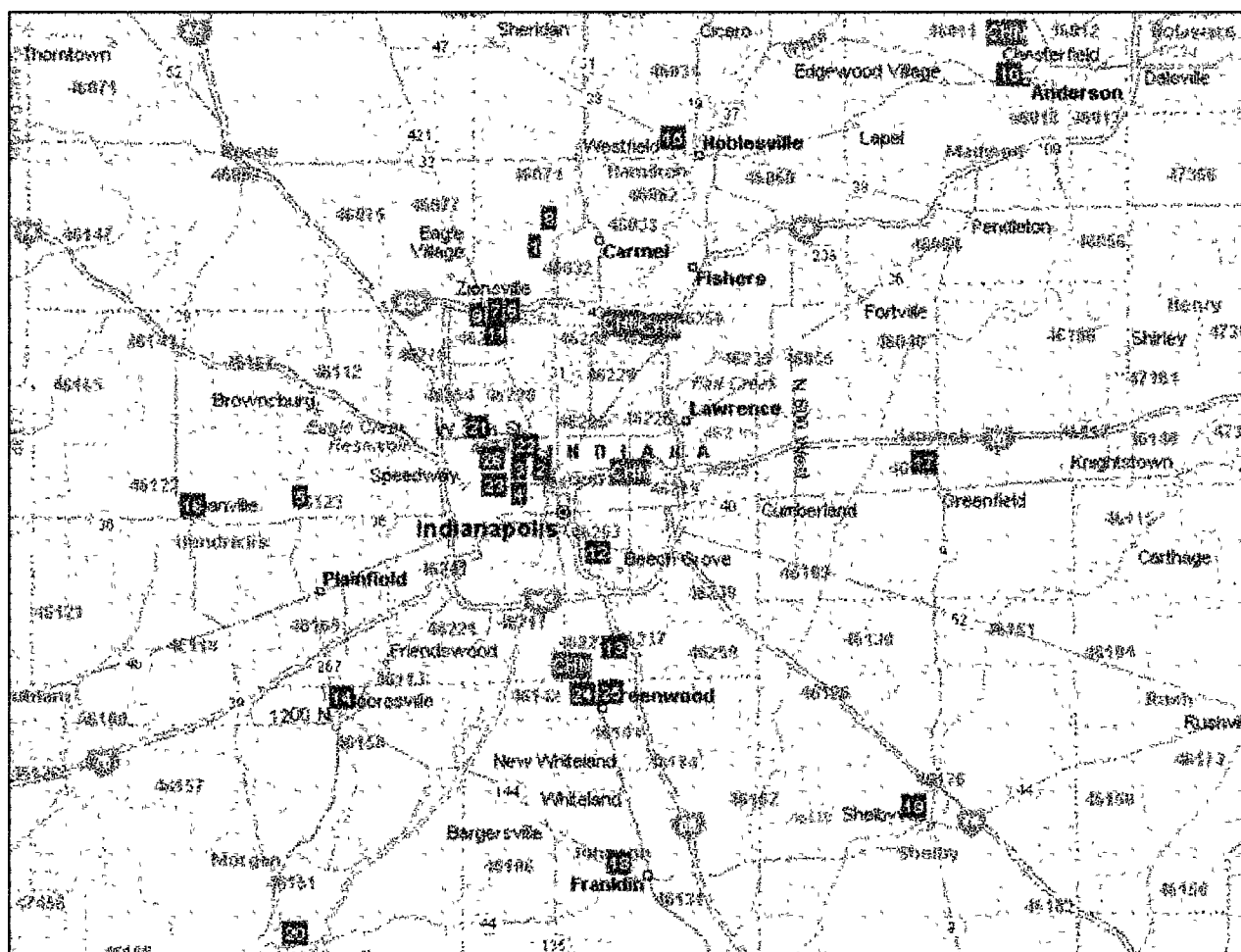
2011 Demographic Snapshot Charts



c. Existing health care facilities and resources within the community that are available to respond to the health needs of the community

Community Health Network Hospital Facilities and Other Hospital Competition

Community Health Network Hospital Facilities		St. Vincent Hospital Facilities		Suburban Hospital Facilities	
CHN	Community Hospital Anderson	6	St Vincent Children's Hospital	15	Riverside Hospital
CHN	Community Hospital East	7	St Vincent - 86th Street	16	Henderson Community
CHN	Community Hospital North	8	St Vincent Carmel	17	Marquette Memorial
CHN	Community Hospital South	9	St Vincent Women's	18	Johnson Memorial
CHN	The Indiana Heart Hospital	10	St Vincent St John's	19	Mayo
		11	St Vincent Seton Specialty Hospital (LTC)	20	Marquette Family
Clarian Health Partners Hospital Facilities		St. Francis Hospital Facilities		Other Hospital Facilities	
1	Clarian North Medical Center	12	St Francis Beech Grove	21	Providence
2	Indiana University Medical Center	13	St Francis Indianapolis	22	Wagner
3	Methodist	14	St Francis Mooresville	23	Proctor Hospital in Indianapolis
4	Riley Hospital for Children			24	Proctor Hospital of South
5	Clarian West Medical Center			25	Valley Vista Health System
				26	Seton Specialty Hospital Indianapolis (LTC)

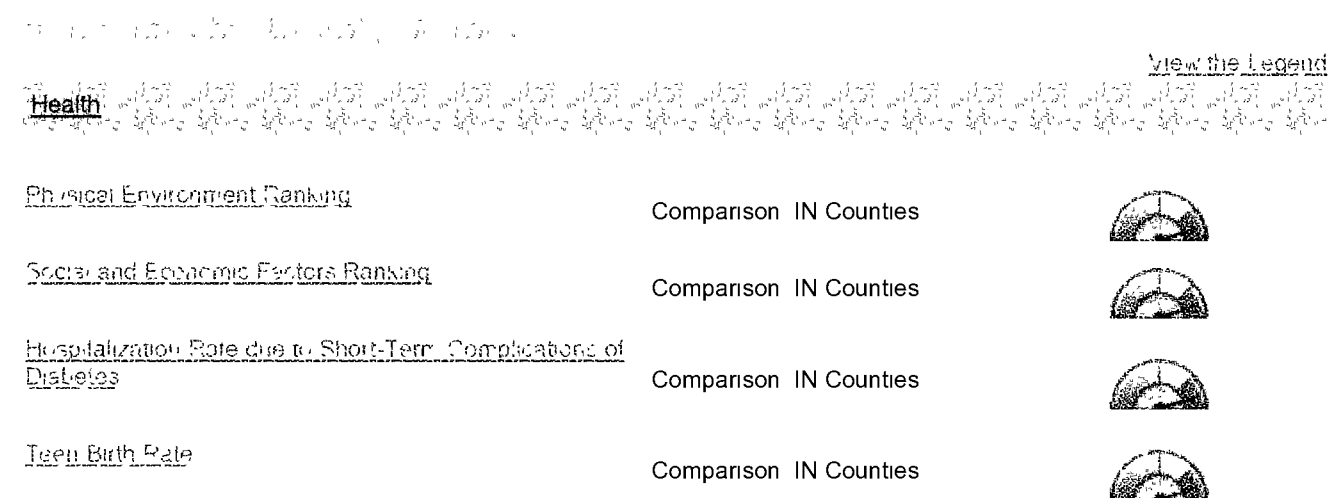




















d. How data was obtained

Community Health Network began to contract with Healthy Communities Institute in 2011. Healthy Communities Institute (HCI) was awarded “Best Community App” by the Health Data Initiative at its third annual Forum, The Health Datapalooza. HCI, a pioneer and leader in community health improvement technologies, was presented the award on June 5 by Assistant Secretary for Health for the U.S. Department of Health and Human Services (HHS), Howard Koh, M.D., M.P.H. The Healthy Communities Network® tracks over 100 health and quality of life indicators, offers guidance on over 1,300 community-level “promising practice” interventions, and includes features that help community members work with any stakeholders – such as government and other non-government groups – to effect change. The system also collects the locally unique knowledge of a region, blending it into the system to provide a common, understandable and constantly updated view for all stakeholders. The Network is divided into four distinct areas; Community Dashboard, Promising Practices, Collaboration Centers and Evaluation and Tracking. Online sources of data include the National Cancer Institute, Environmental Protection Agency, US Census Bureau, US Department of Education, and other national, state, and regional sources. Information on the site is updated as frequently as the source data is updated. News is updated each weekday, and the promising practices database continually expands.

e. The health needs of the community

By accessing the Community Health Network website and clicking on the Tab “About us” and scrolling down to “Caring for the Community” anyone in the network and the public can view the health needs of their community. As demonstrated below with the top red indicators for Marion County, the information is a “click away” and easily tracks the most demanding indicators that need to be addressed.



<u>Chlamydia Incidence Rate</u>	Comparison IN Counties	
<u>Gonorrhea Incidence Rate</u>	Comparison IN Counties	
<u>Hospitalization Rate due to Adult Asthma</u>	Comparison IN Counties	
<u>Hospitalization Rate due to Asthma</u>	Comparison IN Counties	
<u>Age-Adjusted Death Rate due to Lung Cancer</u> ^{NEW}	Comparison U S Counties	
<u>Mortality Ranking</u>	Comparison IN Counties	
<u>Hospitalization Rate due to Diabetes</u>	Comparison IN Counties	
<u>Hospitalization Rate due to Long-Term Complications of Diabetes</u>	Comparison IN Counties	
<u>Babies with Low Birth Weight</u>	Comparison IN Counties	
<u>Mothers who Received Early Prenatal Care</u>	Comparison IN Counties	
<u>Hospitalization Rate due to Urinary Tract Infections</u>	Comparison IN Counties	
<u>Lung and Bronchus Cancer Incidence Rate</u> ^{NEW}	Comparison U S Counties	
<u>Health Behaviors Ranking</u>	Comparison IN Counties	
<u>Morbidity Ranking</u>	Comparison IN Counties	
<u>Babies with Very Low Birth Weight</u>	Comparison IN Counties	
<u>Inadequate Social Support</u>	Comparison U S Counties	
<u>Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases</u>	Comparison U S Counties	
<u>Adults who Smoke</u>	Comparison U S Counties	

Economy

Foreclosure Rate

Comparison U S Counties



Homeownership

Comparison U S Counties



Households with Public Assistance

Comparison U S Counties



Homeowner Vacancy Rate

Comparison U S Counties



Renters Spending 30% or More of Household Income on Rent

Comparison U S Counties



Students Eligible for the Free Lunch Program ^{NEW}

Comparison U S Counties



Education

4th Grade Students Proficient in Reading

Comparison IN Counties



8th Grade Students Proficient in Math

Comparison IN Counties



High School Graduation

Comparison IN Counties



Student-to-Teacher Ratio

Comparison U S Counties



8th Grade Students Proficient in Reading

Comparison IN Counties



4th Grade Students Proficient in Math

Comparison IN Counties



Annual Particle Pollution

Comparison Air Quality Index



Annual Ozone Air Quality

Comparison Air Quality Index



Grocery Store Density ^{NEW}

Comparison U S Counties



Liquor Store Density

Comparison U S Counties



SNAP Certified Stores **NEW**

Comparison U S Counties



Houses Built Prior to 1950

Comparison U S Counties



Farmer's Market Density **NEW**

Comparison U S Value



Daily Ozone Air Quality

Comparison Air Quality Index



Fast Food Restaurant Density

Comparison U S Counties



Households without a Car and > 1 Mile from a Grocery Store

Comparison U S Counties



Low-Income and > 1 Mile from a Grocery Store

Comparison U S Counties



Recreation and Fitness Facilities **NEW**

Comparison U S Value



Recognized Carcinogens Released into Air

Comparison Prior Value



PST Releases

Comparison Prior Value



Government & Politics

Voter Turnout

Comparison IN Counties



Public Safety

Age-Adjusted Death Rate due to Motor Vehicle Collisions

Comparison U S Counties



Social Environment

Single-Parent Households

Comparison U S Counties



People 65+ Living Alone

Comparison U S Counties



Child Abuse Rate

Comparison IN Counties



Transportation

Households without a Vehicle

Comparison U S Counties



I. Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups

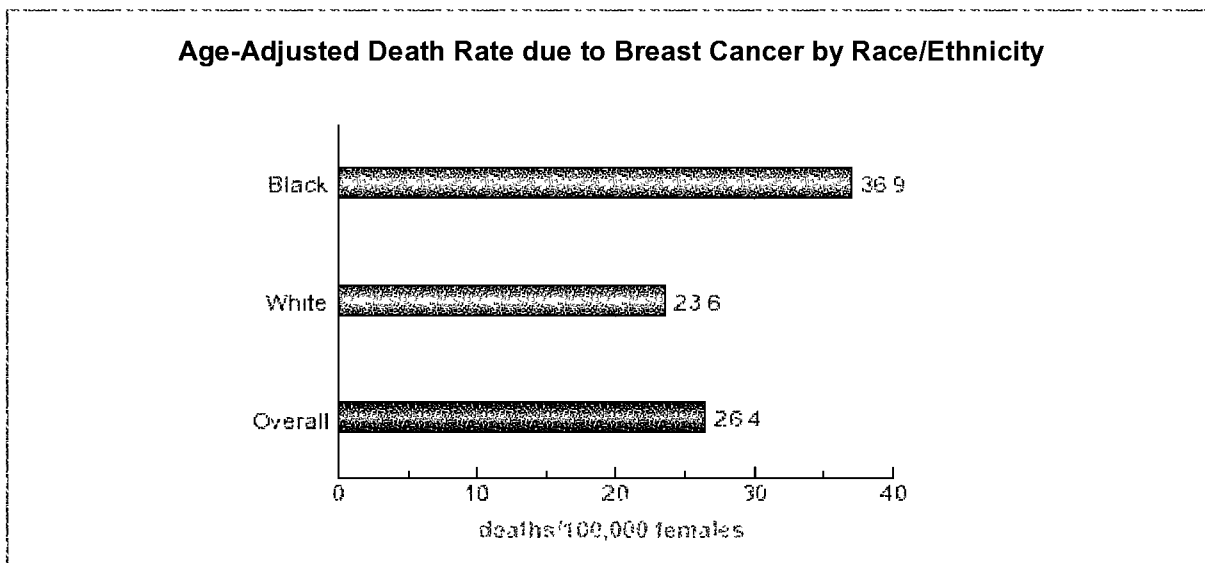
As demonstrated above and below, access to information on health disparities can be created with the HCI web based community health indicators. Please note that all data is meant as demonstration only and does not include the exhaustive amount of data and information that we use to determine the community needs of our service areas. All data can be displayed in several views and comparisons. The data also includes best practices from around the country and comparison to Healthy People 2020 so community members can view the current status. The often quoted phrase “a picture paints a thousand words” is illustrated by the display of information that has been designed to allow middle school students to use for projects and papers as well as public health experts.

Health Community Health Indicators

Health

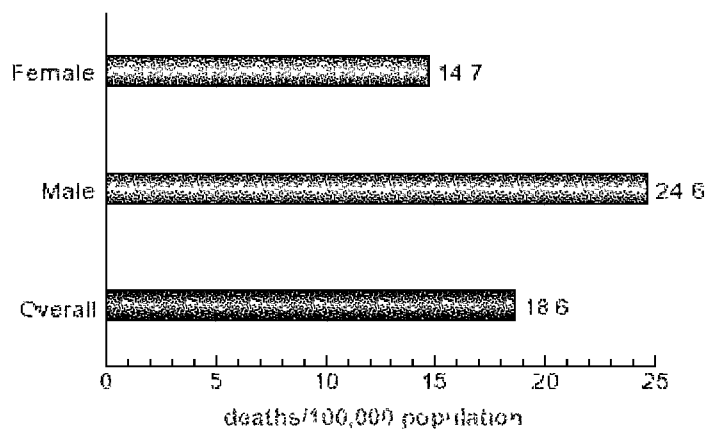
Cancer

Age-Adjusted Death Rate due to Breast Cancer **NEW**

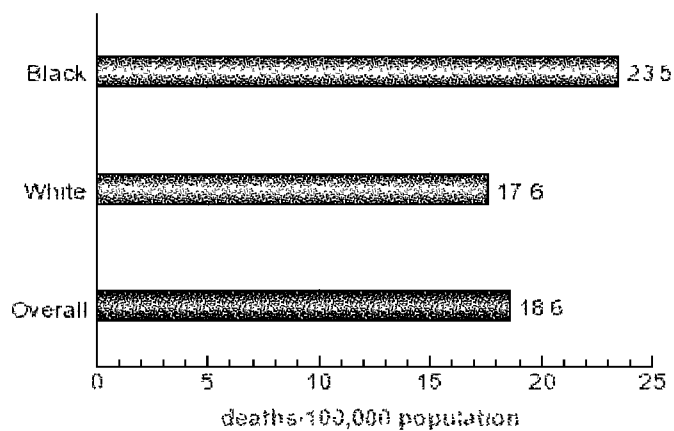


Age-Adjusted Death Rate due to Colorectal Cancer **NEW**

Age-Adjusted Death Rate due to Colorectal Cancer by Gender

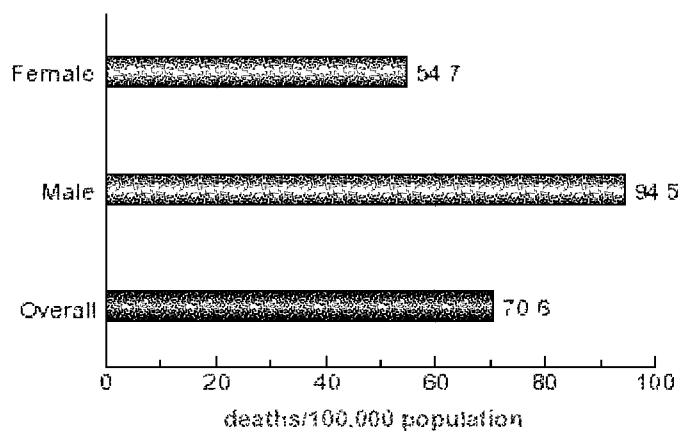


Age-Adjusted Death Rate due to Colorectal Cancer by Race/Ethnicity

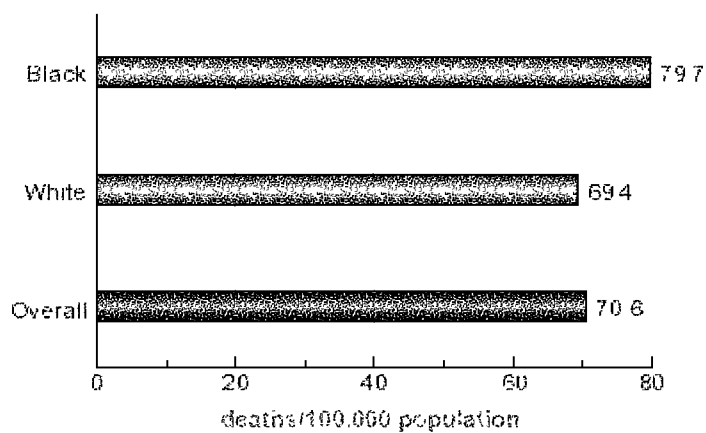


Age-Adjusted Death Rate due to Lung Cancer **NEW**

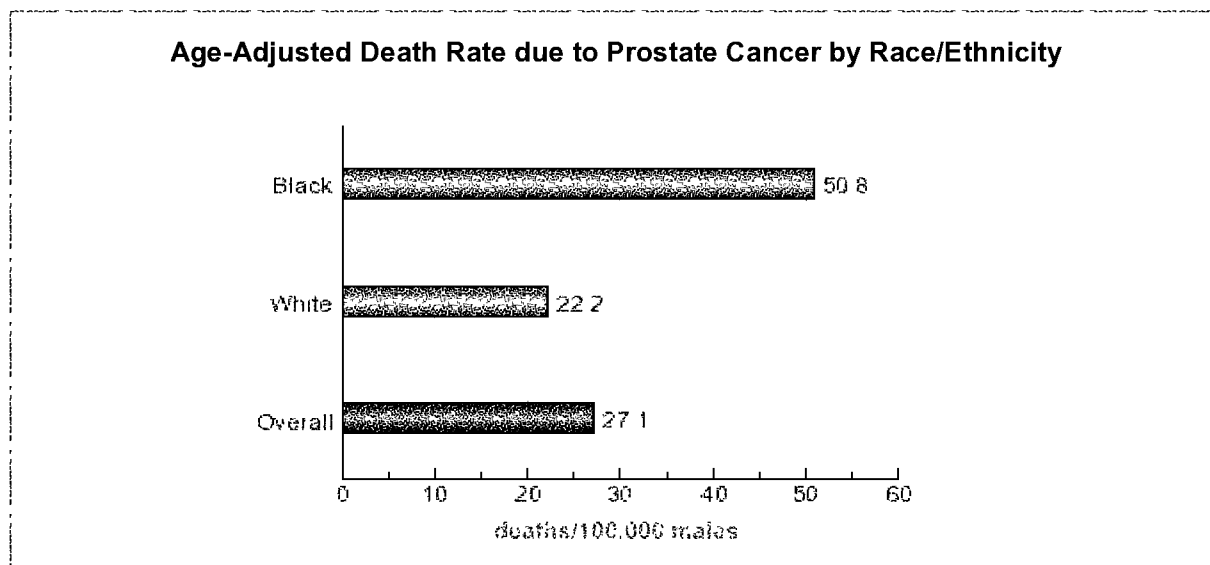
Age-Adjusted Death Rate due to Lung Cancer by Gender



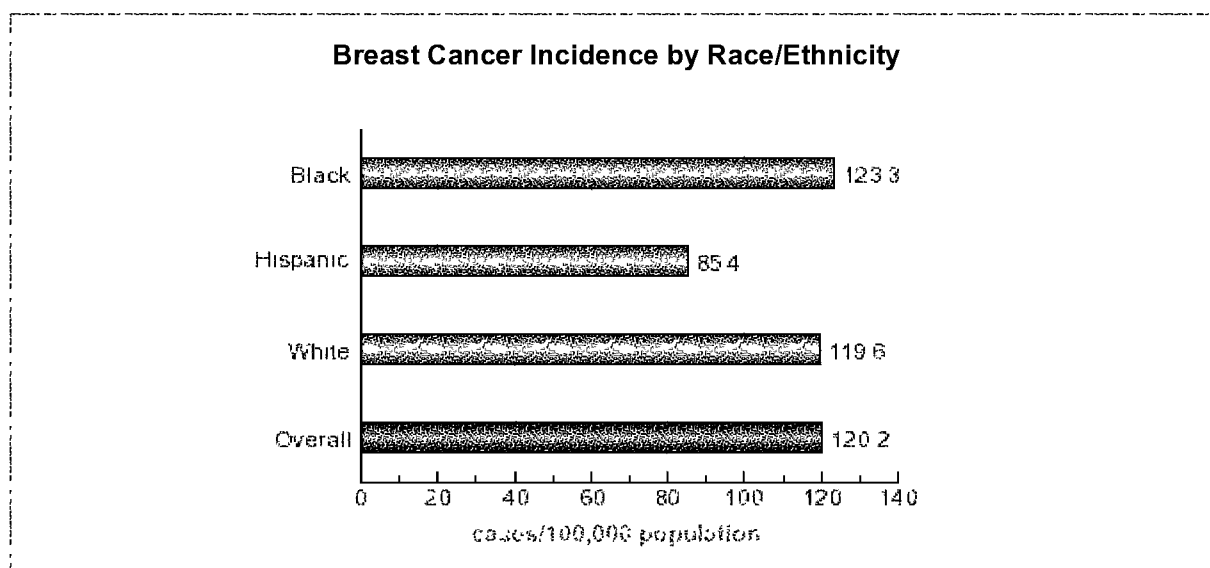
Age-Adjusted Death Rate due to Lung Cancer by Race/Ethnicity



Age-Adjusted Death Rate due to Prostate Cancer **NEW**

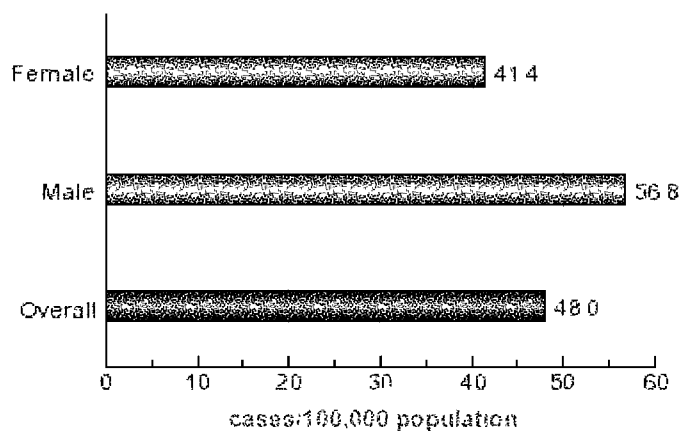


Breast Cancer Incidence Rate **NEW**

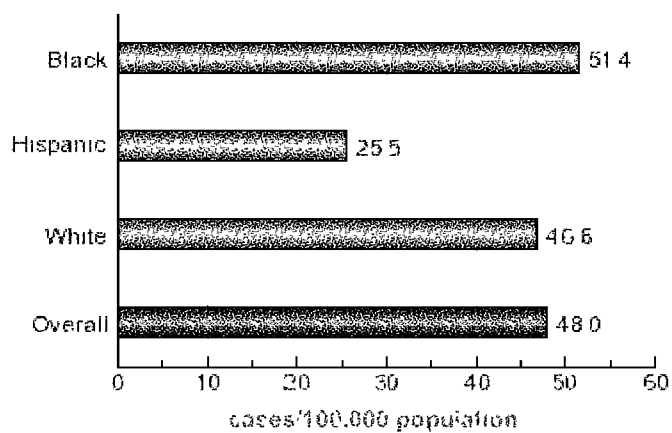


Colorectal Cancer Incidence Rate **NEW**

Colorectal Cancer Incidence Rate by Gender

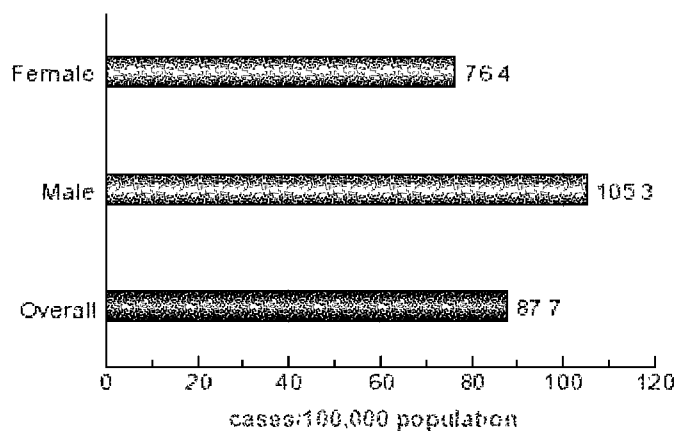


Colorectal Cancer Incidence by Race/Ethnicity

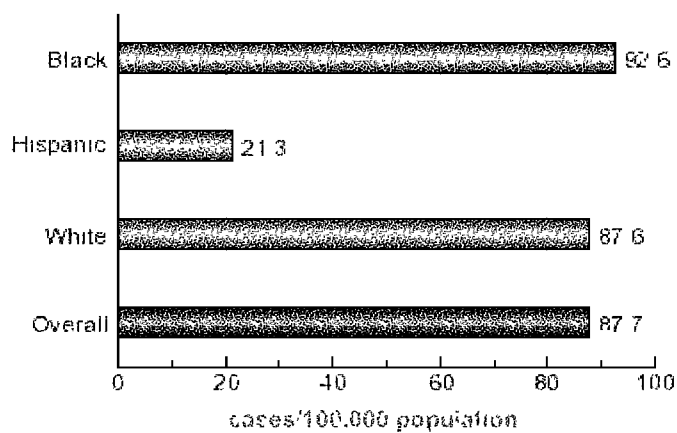


Lung and Bronchus Cancer Incidence Rate ^{NEW}

Lung and Bronchus Cancer Incidence Rate by Gender

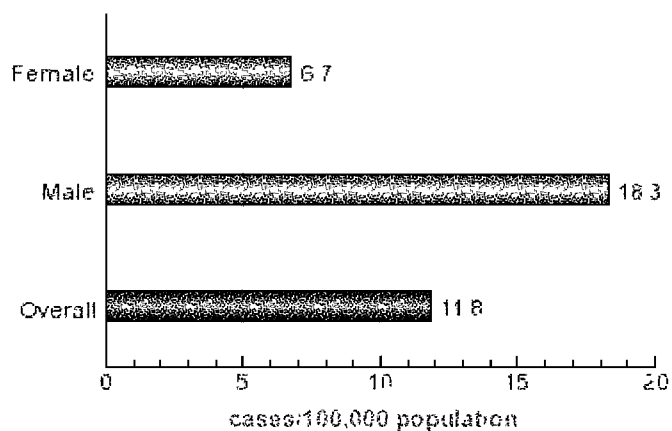


Lung and Bronchus Cancer Incidence Rate by Race/Ethnicity

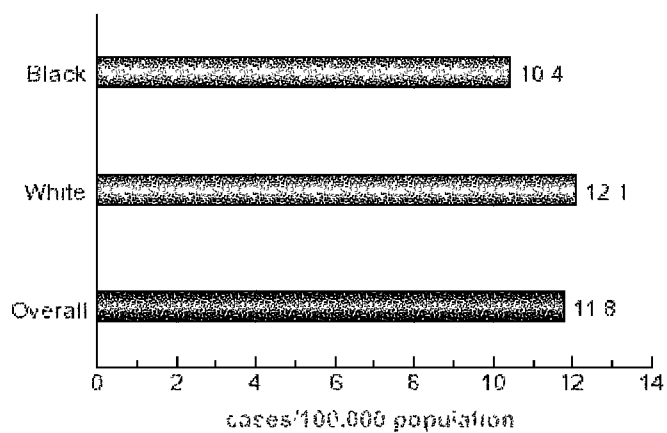


Oral Cavity and Pharynx Cancer Incidence Rate **NEW**

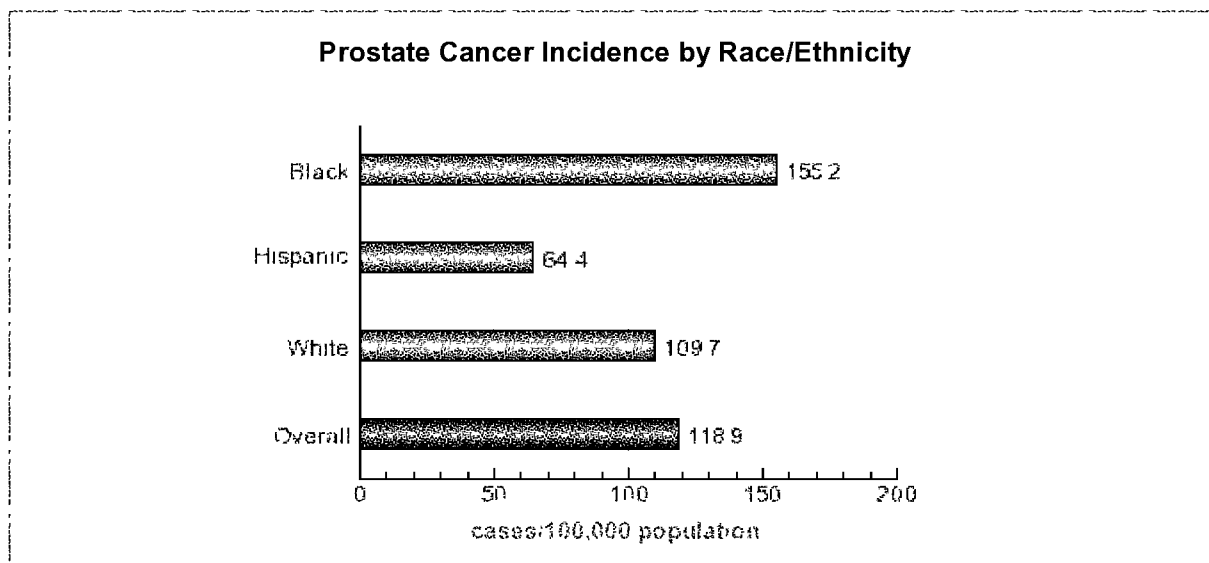
Oral Cavity and Pharynx Cancer Incidence Rate by Gender



Oral Cavity and Pharynx Cancer Incidence Rate by Race/Ethnicity

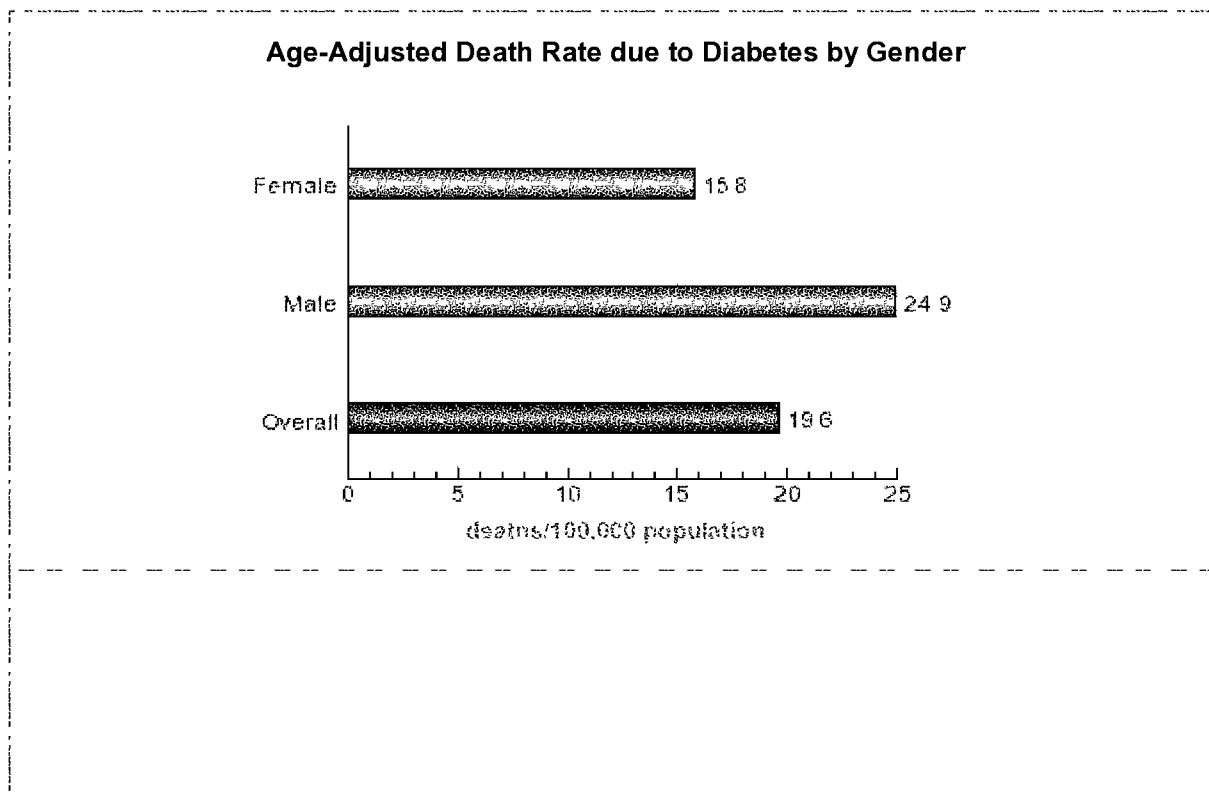


Prostate Cancer Incidence Rate **NEW**

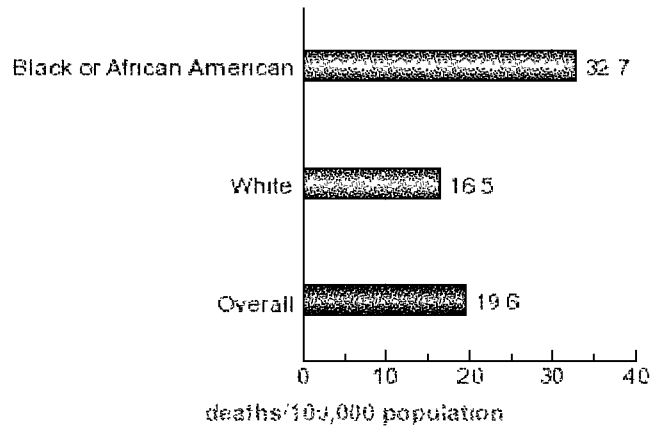


Diabetes

Age-Adjusted Death Rate due to Diabetes

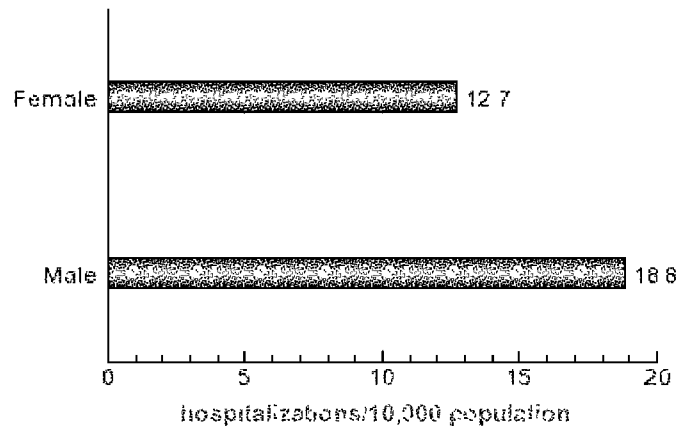


Age-Adjusted Death Rate due to Diabetes by Race/Ethnicity

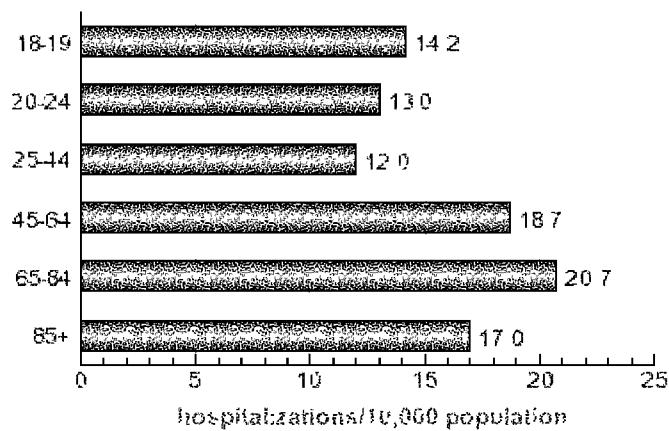


Hospitalization Rate due to Diabetes

Hospitalization Rate due to Diabetes by Gender

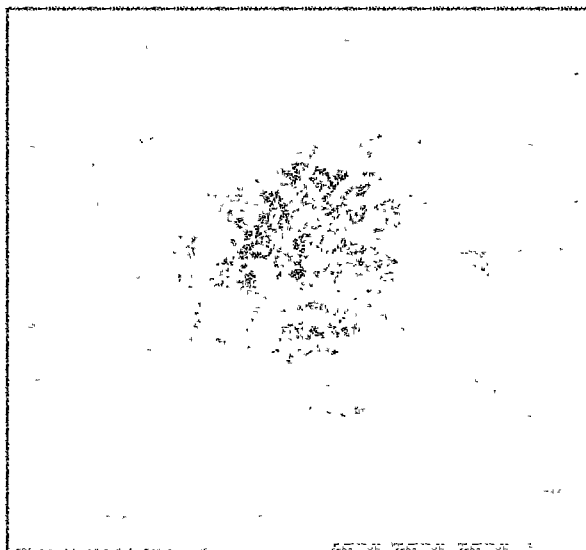


Hospitalization Rate due to Diabetes by Age

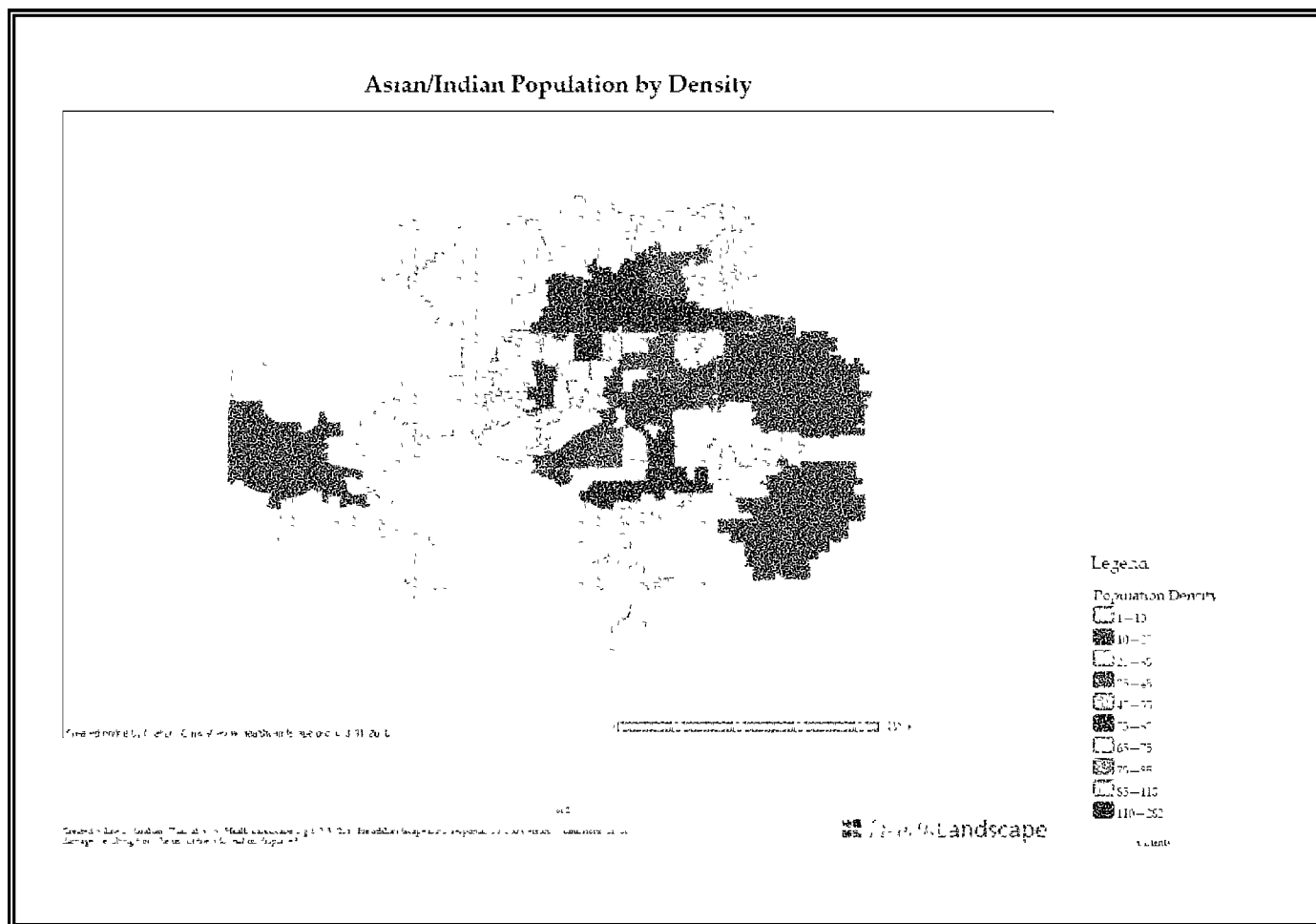


In 2011, Community Health Network began a supportive role with Seva Health & Services, Inc. Seva was in the process of establishing a free medical clinic in Central Indiana that will serve those who are uninsured or underinsured and are within 200 percent of the poverty level and in addition face health care challenges confronting many immigrant communities, which include language barriers, transportation challenges and unfamiliarity with the local health care systems. Seva will focus its services on the South Asian population who meet the eligibility criteria, as well as their uninsured family members who are on a temporary visit to the United States. Community Health Network assisted with identifying where these populations currently reside in the larger Indianapolis metropolitan area and shared this information with their board of directors for strategy and implementation support.

Asian/Indian Population in Central Indiana



Central Indiana Asian Indian Population used for SEVA planning outreach clinic for immigrant population.



g. The process for identifying and prioritizing community health needs and services to meet the community health needs.

The process for identifying and prioritizing community health needs and services to this point has been driven by what information and interests exist in the community. In the next year, we plan to use more data-driven decision processes and the best practice guidelines that can be obtained so easily through web-based information. We will sponsor focus groups to see what information we collect, how it is displayed and how it can be used to drive choice for the partners and collaborations that we are already involved in and those we will establish.

h. The process for consulting with persons representing the community's interests

In 2011, the network started conducting Town Hall Meetings as a process for consulting with persons representing the communities interests. There are several other forums for gaining the community and their experts opinion and feedback on the communities interests including neighborhood meetings, coalitions formed to assist in generating public health interests like Partnership for a Healthier Johnson County and Pioneering Healthy Communities

Community Health Network Town Hall Series: Changes in Health Care

Overview:

Community Health Network is partnering with local universities, health insurers, health providers, public health organizations, neighborhood groups, businesses and community leaders for a town hall series, *Changes in Health Care*, in an effort to engage the Indianapolis community in dialogue about the changing health care landscape. The first town hall is scheduled for Tuesday, March 8, 2011, at 6:30 p.m. The event, open to the public and by registration, will be held at Ivy Tech Community College, Lawrence Campus, 9301 East 59th Street, Indianapolis, IN, 46216. Parking is available in the east parking lot, auditorium entrance.

Town Hall Moderator and Event Coverage:

Inside Indiana Business host, Gerry Dick, will be the event moderator and media partner for the town hall series, ensuring coverage across a multi-media platform that extends the reach of each town hall. **Inside Indiana Business** will provide pre-event promotion and coverage, along with television packages that include taped interviews with panelists following each town hall. In addition, other local news media will be invited to cover the town halls. Those who want to attend the event can register at eCommunity.com.

Panelists and Topics:

Community is partnering with Binford Redevelopment and Growth (BRAG) neighborhood organization and Ivy Tech Community College for the March 8 town hall. Panelists for this event include: Bryan Mills, president and CEO, Community Health Network; Jane Lommel, president, BRAG; Dr. Kathleen Lee, vice chancellor of academic affairs, Ivy Tech; Dr. Concetta Raimondi, superintendent, MSD Lawrence Township; Rob Hillman, president and general manager, Anthem Blue Cross and Blue Shield in Indiana (or Dr. David Lee), vice president, provider engagement and contracting, Anthem Blue Cross and Blue Shield in Indiana; and Dr. Virginia Caine, director, Marion County Health Department.

Topics include: health care changes from the provider perspective; how new federal health regulations will impact community health; the future of health care careers; health care changes from an employer perspective; how federal health changes will impact the insurance industry; and what these changes mean for consumers.

Event Format:

Each panelist should be prepared to speak on his or her agenda topic for 3 to 5 minutes. Once each panelist has completed a brief presentation, the moderator will open up the forum for questions from the audience. Barbara Lewis-West, business of health reporter for Inside Indiana Business, will have a microphone to assist

the audience with their questions. The town hall is expected to last a full hour, but may go as long as 90 minutes, depending on the volume of participation from the audience.

i. Information gaps that limit the hospital facility's ability to assess the community's health needs

In the past year it has become apparent that there are many gaps in the data required to access and address the community health needs. Specifically, the data is too broad and lacks the ability to drive "actionable" activities. County level data does not illustrate the unique features, assets and liabilities of neighborhoods. We are currently drilling the data to zip code and census tract level to give more detail and hope to illustrate some of the more subtle states of health in the neighborhoods and cultures of the community.

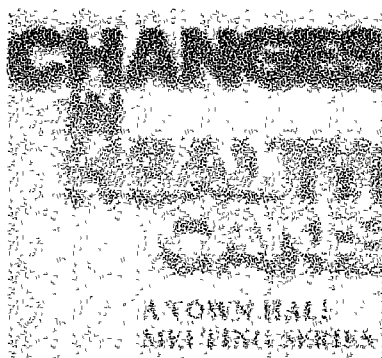
j. Other (describe in Part VI)

Please see response on page 30 for a description and history of other community health needs assessment strategies.

2. Indicate the tax year the hospital facility last conducted a Needs Assessment: 2011

3. In the Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted.

As stated earlier in the document, the network took part in a series of town hall meetings. We then took the town hall input and developed a larger strategy for the community surrounding the site of the second town hall at Martin University.



Community Health Network to host town hall on health care at Martin University;

May 24 event to feature panelists from education, health care and insurance sectors

Community Health Network is partnering with Martin University to host a town hall on *Changes in Health Care*. The event, open to the public, is the second town hall initiated by Community, in an effort to continue dialogue with the Indianapolis community about current and changing health care regulations impacting everyone. The town hall will be held Tuesday, May 24, at 7 p.m. at Martin University's Gathertorium, located at 2171 Avondale Place, Indianapolis. Free health screenings will be offered prior to the event, from 6 to 7 p.m.

The town hall will be moderated by Amos Brown, radio personality and host of *Afternoons with Amos* on WTLC. Inside Indiana Business will provide pre and post event coverage. Panelists for the town hall include: Bryan Mills, president and CEO, Community Health Network; Dr. Nicole Barnett, dean of the College of Business and Social Sciences, Martin University; Dan Krajnovich, CEO (Indiana/Kentucky) United Healthcare; and Dr. Virginia Caine, director, Marion County Public Health Department.

"We believe our first town hall this year was a success and we answered questions from many in the community," said Bryan Mills, president and CEO of Community Health Network. "Our goal is to continue this dialogue to help educate people on upcoming health care regulations. We have a broad mix of panelists with great knowledge of their industries. Their perspectives can provide some valuable information for the public at large," Mills said.

Topics of discussion will cover health care changes from the provider perspective, how new federal health regulations will impact community health; the future of health care careers; how federal health changes will impact the insurance industry; and what all these changes mean for the consumer.

The event is open to the public, but those planning to attend are encouraged to register online at townhall.ecommunity.com.

Community Health Network launched the *Changes in Health Care* town hall series March 8, with a town hall at the Ivy Tech Community College, Lawrence Campus. The network is planning additional meetings.



Follow Up To Town Hall Meeting:

The Indiana Employers Quality Health Alliance contracted with Better Healthcare for Indiana, a non-profit committed to grassroots-based health and healthcare transformation, to manage the follow up project. While Community Health Network convened a summit of high level community and health leaders, this approach focused at the neighborhood level, based on the reality that loosely coupled networks of residents and institutions are the key drivers of transformational change in complex adaptive systems like health and health care. The critical success factors for this approach are trust; using metrics to facilitate learning; learning by starting with small, simple projects; and accountability to each other. This approach rejects the traditional “command and control” strategic planning model, which uses metrics as a measuring rod to make sure that people lower in the hierarchy follow the plan.

A Project Leadership Team was formed, including, healthcare, public health, housing, business, community development, and ultimately leaders from the selected neighborhoods. A request for information (RFI) was sent to neighborhoods thought to be ready to participate and lead in this project. After review of the responses to the RFI, two neighborhoods were selected by the Leadership Team:

- Near Eastside Neighborhood (NESCO) is a collection of 20 tightly connected neighborhoods just east of downtown Indianapolis with a racially diverse population of 40,000, an average income of \$37,500, and a strong sense of history and dedication to community development. Recent accomplishments include a) completion of a 2007 Quality of Life Plan focused on family strengthening, education public safety, affordable housing, business development, livability, and leadership and neighborhood connections; b) construction of a new People’s Health Clinic; c) and investment of \$154 million through the Super Bowl Legacy Project that includes state-

of-the-art fitness center managed by IUPUI. NESCO was selected primarily because of its high level of readiness to tackle the health issue and because of the omission of health as a focus area in its QOL Plan.

Following planning meetings with leaders of several small, contained neighborhoods and of the larger neighborhood consortia, a half-day summit entitled “Neighborhood Health Gathering” was held on September 10, 2011, at the Martin University Gathertorium. Thirty people participated, including about 10 residents from each of the two larger neighborhoods. Regardless of neighborhood, participants reached consensus that “diabesity”—obesity and diabetes—was the chronic illness on which to focus and prevention should focus on five areas: nutrition education and access to health food; fitness activity, socialization of seniors; provider communications and relations; and drug and alcohol education. A variety of cutting edge facilitation techniques were used, including People Bingo, Life Stage Story Sharing, Neighbor-to-Neighbor interviews, Café Conversations, and Gallery Walk.

Information packets, including neighborhood statistical profiles, and story and context-setting remarks were used to kick off the dialogue. While the gathering did not produce the concrete action plans we had hoped for, it did result in elevating the focus on health and promoting the idea that health improvement needs to be an ongoing neighborhood-wide and lifestyle adjustment activity, not just a periodic one-on-one interaction with a physician or clinic, and some preliminary plan elements. Participants left the gathering on an upbeat note, but without a clearly defined pathway for action. That was left for the Leadership Team.

Following the gathering, the process seemed to stall. NESCO leaders were understandably preoccupied with Super Bowl activities. Then came the holidays. However, in January and February, the hard work of relationship-building, education, summit planning, and holding the summit began to pay off:

- A People’s Health Center “Thank You” breakfast with NESCO residents resulted in a commitment to an on-going working partnership focused on neighborhood-based prevention initiatives. The People’s Health Center Advisory Board will serve as the driver for this effort.
- The Chase Eastside Fitness Center opened, along with a Legacy Loop 5 K Run, a Legacy Health Bowl with NFL player participation. At long last, Super Bowl Week came to a successful end, and NESCO staff time was freed up to focus on health planning.
- The NESCO Board decided to incorporate a “health” component in its QOL Plan. Taking NESCO’s lead, the newly-unveiled Mid-North QOL Plan included health and wellness as one of its seven focus areas—the first such neighborhood QOL Plan to do so was Indianapolis.

Deliverables

Deliverable/Milestone	Completion Date	Status (was this deliverable completed as planned?)
Complete data analysis and local leader interviews to profile and select target neighborhoods	June	Yes
Begin Summit Planning Team meetings	June	Yes
Complete design alternative care delivery models	Deleted	No, not feasible to do this at this time.
Finalize Summit packet and agenda	August	Yes
Convene Summit	September	Yes
Complete communication of Summit outcomes	October	Yes
Facilitate Action Plan Team to flesh out details of key components of Action Plan	February	Yes. However, the action plan goals build the capacity to act; health improvement plans will follow
Complete Draft Action Plan and Budget	February	No, while the action plan was completed, the teams were not ready to develop a budget
Secure funding commitments	Postponed	No, not feasible to do at this time
Send out Press advisory to announce launch of Project	Postponed	No, premature; must wait until concrete health improvements are achieved
Complete Project and submit final report to NBCH	February	Yes

Project Successes

- Health is now viewed to be a priority in each neighborhood, whereas before it was viewed more as a private matter for individuals.
- Health will be added as a discrete component in the Quality of Life Plans for NESCO and Mid North neighborhoods.
- Enhanced, on-going dialogue between residents and each of their respective healthcare provider organizations has been institutionalized, whereas before the platforms for dialogue were not working well before.

- The “strategic doing” model for the summit agenda and facilitation worked well.

Project Challenges

- Giving up the illusion that a top-down, command and control approach to health planning can work is always difficult for strategic planning types. We found that the neighborhood organizing and strategic doing approach actually works, even though the time horizon for producing results is longer than the timeline for this Project.
- The Super Bowl priority in NESCO and the Community Health/Fitness Center financing process helped push the health planning effort off the front burner for many of the key players. We had not realized the magnitude of the constraint on NESCO staff resources. This seems to have resolved itself by now.
- Many healthcare institution leaders live in the old command and control world, and – with all the uncertainty and anxiety over health reform -- it is difficult for them to see why they should invest their time and dollars in complex, multi-sector collaboration that does not add to their bottom line. This challenge can be overcome by organizing and mobilizing neighborhood residents so they can speak with a unified, focused voice, built upon trust with each other and with their partner providers.
- The project might have moved further, and more quickly, if we had initially engaged some of the higher level leaders who were convened by other grantees. However, we remain convinced that the sort of neighborhood and citizen engagement that our approach took is absolutely essential to bring about the real and sustainable changes that will impact ordinary citizen over the long term.
- Neighborhood engagement and support is complex and difficult. It is hard to identify leadership at the levels closest to the people, even though their engagement is essential to long term success. This issue is made more difficult due to inherent apathy, cynicism and paranoia. The only answer to these is building trust through gradual, persistent, fundamental education and empowerment.
- A component of the problems we experienced is the failure of many previous efforts that were promised and promoted to improve life in the neighborhoods, but never actually occurred. The same is possible following our initiative, although we have made every effort to build the structures necessary to complete and implement the resulting plans.
- Early engagement of potential ongoing funding organizations would have improved the likelihood of acceptance, trust, and collaboration.

Best Practices

- The “Strategic Doing” approach for guiding forums and workshops to achieve trust and collaboration was developed by Ed Morrison at Purdue’s Center for Regional Development. It is used primarily in the field of economic development. However, we believe that it works well in health and health care and can be replicated.
- Use of the neighborhood as the basic unit for health transformation still makes sense to us. The fact that none of the six Quality of Life Plans developed in Indianapolis neighborhoods focused on health surprised us. We learned that the main reasons for this

were: a) health is viewed as a private matter and for many people is confused with healthcare; b) attaining health is viewed by many mainly as an individual choice, not connected to neighborhood-wide choices related to the build environment, food system, or school policies; most people perceive they have access to healthcare, even though data shows that access remains a big problem for dental, mental health, preventive, and chronic disease support services. We believe more effort should be focused at the neighborhood level, in contrast to the broader community level but more desirably in concert with it, at least in large cities.

- The life-stage storytelling and thinking exercise at the summit worked well. This encourages participants to think in terms of narrowly-defined populations as the target for improvement.

Implementation

- NESCO's track record in implementing its QOL plans is excellent. We are confident that the partnership with People's Health Center will produce viable projects and results within the next year.
- The Marion County Public Health Department (MCPHD), the Indiana Employers Health Alliance, and Better Healthcare for Indiana are committed to neighborhood-based health efforts. All three organizations have indicated they will continue to provide in-kind resource support for NESCO.

Overall Assessment

- Despite all of the Project challenges cited above, we believe this effort demonstrated the necessity of engaging more local and citizen involvement and the reality of the potential for this kind of approach to make real improvement in actual citizens' lives.
- Future grant initiatives from both government and foundations should put more emphasis and resources into building sustainable structures to strengthen relationships and partnerships between citizen groups and providers. The importance of supporting neutral conveners and community organizers, such as BHI, needs to be appreciated.
- Metrics are essential for health improvement. However, many grantors focus too heavily on the use of macro-level outcome indicators that can only be achieved through multi-sector efforts and multiple projects over many years. Alternatively, grantors should put more resources into citizen engagement, neutral convener infrastructure, and coalition-building.

4. Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI

The entire Community Health Network was involved in the community health needs assessments, which includes service areas that cover nine counties. With each assessment involving a specific neighborhood or community, the health facilities delivering services in

that geography were included. For example, the Partnership for health Johnson County includes Community Health Network, St Francis Hospital and Johnson Memorial Hospital as well as other community agencies such as the United Way. In Anderson, partnerships with St. Johns and Community Hospital Anderson and the FQHC work together to gather important community information.

In 2011, Community Health Network embarked on an initiative to standardize and optimize resources for Community Health Needs Assessments by bringing all hospitals and health organizations together several times to explore the possibilities of uniting to deliver one format for all CHNA necessary to comply with the IRS 990 Schedule H Requirements. Among the participants are key personnel from Indianapolis Public Health Department, United Way, IU Health, St Vincent Health, St Francis, IUPUI and IU Kelley School of Business. The meetings are still being conducted to explore and will hopefully terminate with agreement to unite.

Driven by the Federal mandate for hospitals and public health departments to conduct collaborative community assessments, Community Health Network participated with Better Healthcare for Indiana which convened three meetings where a variety of stakeholders expressed interest in making it easier and less costly for communities to access and communicate indicators of disease, health risk factors (environmental, personal, socioeconomic), consumption, cost, disparities, quality, and access.

The option of creating a data warehouse has been rejected as too costly and difficult to fund at this time. Another idea to conduct a multi-community pilot testing a primary data telephone survey has been rejected due to premature timing (i.e. the transition away from land lines makes sampling problematic), as well as cost. Yet, there remains a strong interest in undertaking a more pragmatic, low-cost project that inventories the existing secondary data bases, links them through a single website, and trains local community coalitions on how to use these tools. Among the existing databases, most prominently mentioned are SAVI, IndyIndicators, CDC's BRFA survey, Indiana Health Information Exchange and other HIE's.

5. Did the hospital facility make its Needs Assessment widely available to the public? If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):

Community Health Network made its CHNA available to the public through the network's website, upon request and through public forums, community groups and meetings.

6. If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):

- a. Adoption of an implementation strategy to address the health needs of the hospital facility's community*
- b. Execution of the implementation strategy*
- c. Participation in the development of a community-wide community benefit plan*
- d. Participation in the execution of a community-wide community benefit plan*
- e. Inclusion of a community benefit section in operational plans*
- f. Adoption of a budget for provision of services that address the needs identified in the Needs Assessment*
- g. Prioritization of health needs in its community*
- h. Prioritization of services that the hospital facility will undertake to meet health needs in its community*
- i. Other (describe in Part VI)*

The following information describes in detail the Community Benefit Plan adopted by the network in 2009:

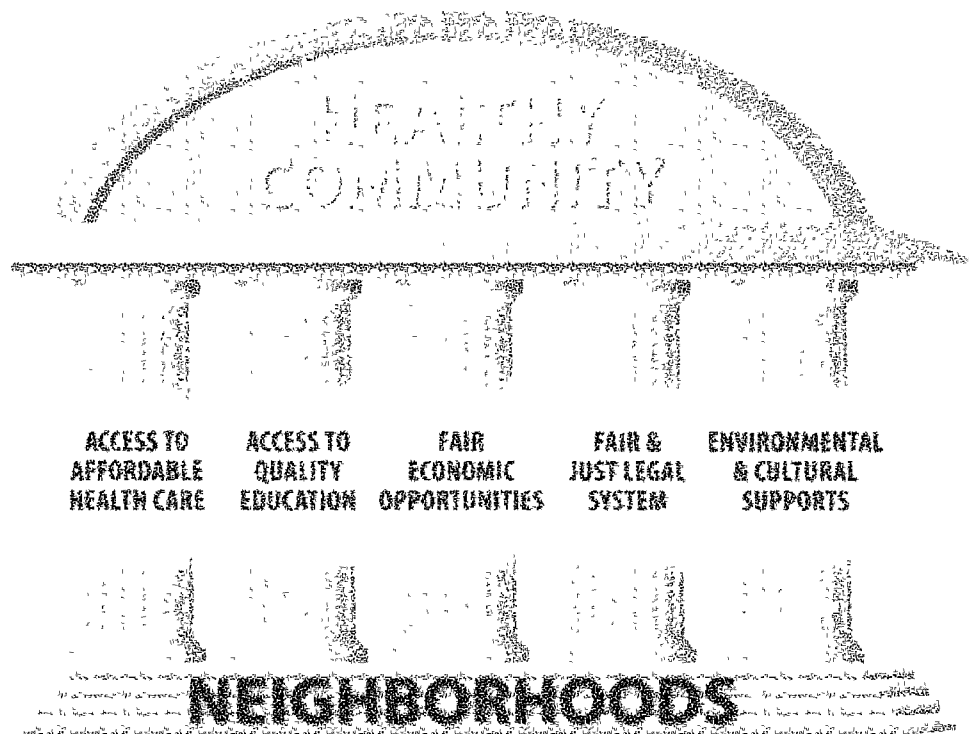
Building a sustainable infrastructure

The Community Benefit Plan (CBP) for our network provides hospital board members, administration, employees and our community with a framework to provide input, anticipate action and evaluate plans to build the health and the lives of the residents in our service areas. The creation of our CBP comes from the community we serve, with input and guidance from our board, the network CEO, hospital CEO, vice president of community benefit and several committees. The CBP utilizes data identifying areas of need and community members ready to transform their lives and those of their neighbors.

b. Execution of the implementation strategy

Network Community Benefit philosophy

Community Health Network recognizes five key areas needed to succeed in creating and sustaining a healthy community. Recognized pictorially as the pillars supporting a healthy community, they are: access to affordable health care; access to quality education; fair economic opportunities; a fair, equitable and just legal system; and availability of environmental and cultural support. Weakness in any one of these areas leads to weakness in all of them. Our past successes show that when we recognize all aspects of health, individuals and organizations step forward to be part of the success, to be part of the plan, and they are more than willing to bring their resources to bear on the identified strategy for a healthier community.



In the 1950s, it was the desire to improve the health of the community that led citizens on Community's east side to raise funds and build a hospital to serve the community. These residents wanted health care services designed in their best interest. They wanted easy access to medical resources. They wanted health care providers who would be respectful of a broad

spectrum of individuals. And they wanted a hospital that would honor its promise to keep the health of the community as its primary reason for existence. Today, the original Community Hospital has grown into one of the largest not-for-profit health systems in the state. What has not changed is our purpose, our compassion, and the passion of our commitment to community. It is a commitment that extends into neighborhoods, schools, businesses and churches of the communities we serve. Just as our founding community members, we are committed to illuminating and supporting those core strengths necessary to a thriving population of healthy individuals within strong sustainable communities. Over the course of the last few months, our leadership team, members of the network board and several physician leaders have developed a strategic plan and vision for our network. This plan will serve as our roadmap from 2010 through 2020. Through this process, we established a new mission statement, which starts with a commitment to the community:

Mission

“Deeply committed to the communities we serve, we enhance health and well-being.”

Values

Our values can be encapsulated as follows:

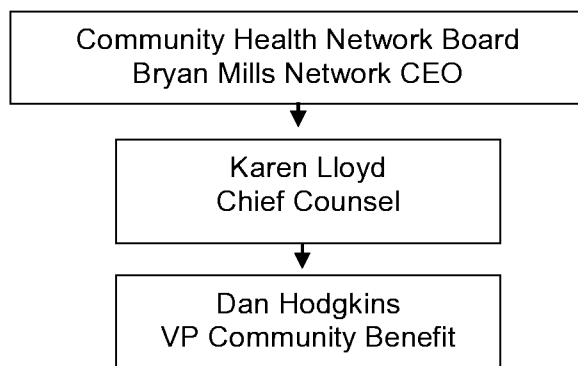
Patients First, Relationships, Integrity, Innovation, Dedication, Excellence

Vision

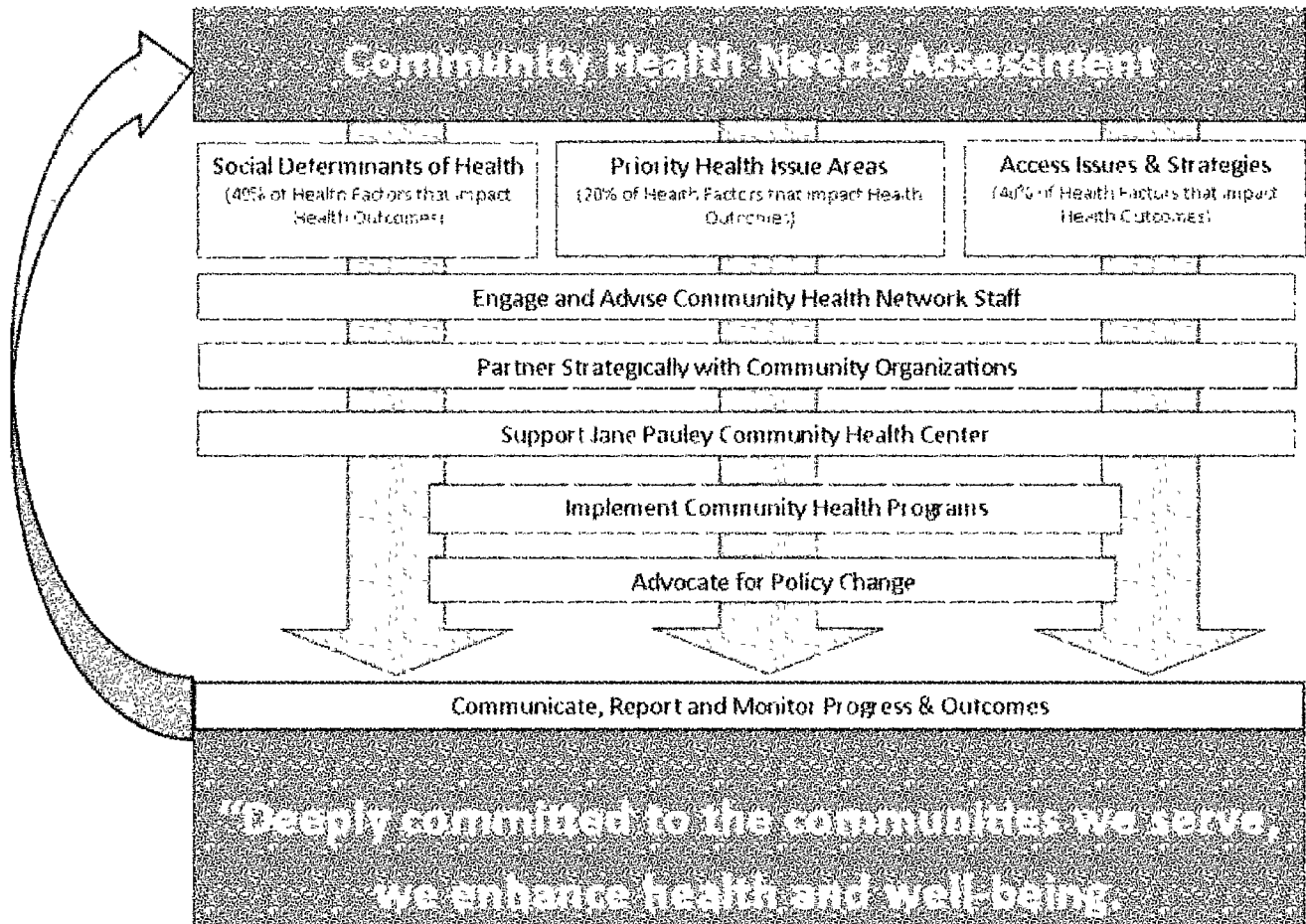
To be an integrated health care delivery system – centered on patients and inspired by physicians and other clinicians, recognized and accountable for:

Advancing the health status of our communities through outreach, wellness and prevention.

The board of our network plays an integral role in the community benefit plan and is involved in setting strategy and communicating the plan within the organization and the community at large. In 2010, with the IRS 990 Schedule H, the board participated and encouraged the network to be a leader in the country, so we were among the first to file under the new IRS guidelines. The VP of Community Benefit is housed along with the other compliance positions and reports directly to the Chief Counsel.



The Internal Community Benefit Prioritization Process



7. Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs.

The network does not have the resources to meet all of the needs identified in our community health needs assessments. Consequently, we have established the culture of collaborating to optimize community resources. All of our community work is performed with the buy-in from the communities we plan to work with and with the added value of the organizations they respect and trust.

Part VI / 7 State filing of a community benefit report

The organization files a community benefit report in the state of Indiana.



**Community Health
Network, Inc. and
Affiliates**

**Consolidated Financial Statements
December 31, 2011 and 2010**

Community Health Network, Inc. and Affiliates
Index
December 31, 2011 and 2010

	Page(s)
Report of Independent Auditors	1
Consolidated Financial Statements	
Consolidated Balance Sheets	2
Consolidated Statements of Operations and Changes in Net Assets	3-4
Consolidated Statements of Cash Flows	5
Notes to Consolidated Financial Statements	6-38
Additional Consolidating Schedules	
Report of Independent Auditors on Accompanying Consolidating Information	40
Consolidating Balance Sheets	41-42
Consolidating Statements of Operations and Changes in Net Assets	43-44



Report of Independent Auditors

To the Board of Directors of
Community Health Network, Inc.

In our opinion, the accompanying consolidated balance sheets and the related consolidated statements of operations and changes in net assets and cash flows present fairly, in all material respects, the financial position of Community Health Network, Inc. and Affiliates (the "Network") at December 31, 2011 and 2010, and the results of their operations and their cash flows for the years then ended, in conformity with accounting principles generally accepted in the United States of America. These financial statements are the responsibility of the Network's management. Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits of these statements in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

As discussed in Note 1 to the consolidated financial statements, the Network changed its presentation of revenues and provision for doubtful accounts as a result of the adoption of the amendments to the FASB Accounting Standards Codification resulting from Accounting Standards Update No. 2011-07, Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Healthcare Entities.

PricewaterhouseCoopers LLP

April 18, 2012

Community Health Network, Inc. and Affiliates
Consolidated Balance Sheets (in 000's)
Years Ended December 31, 2011 and 2010

	2011	2010
Assets		
Current assets		
Cash and cash equivalents	\$ 154,305	\$ 144,127
Restricted cash	2,851	2,400
Patient accounts receivable, less allowance for doubtful accounts and contractual adjustments of \$441,756 and \$407,575 in 2011 and 2010	185,422	175,904
Estimated third-party payor settlements	11,404	6,406
Assets limited as to use—held by trustee	13,176	9,530
Inventories	21,521	19,325
Other accounts receivable	19,061	18,300
Other current assets	20,841	10,684
Total current assets	438,581	386,676
Assets limited as to use		
Funds held by trustee, net of current portion	13,642	13,865
Board-designated funds	401,236	404,248
Reinsurance trust assets	12,801	11,616
Property, plant and equipment, net	682,163	650,149
Investments in unconsolidated affiliates	20,279	19,394
Intangible assets, net of accumulated amortization - software	12,255	-
Intangible assets, net of accumulated amortization - deferred financing costs	7,045	7,415
Due from (to) unconsolidated affiliates and related parties, net	801	1,387
Prepaid pension and postretirement assets	959	1,943
Other assets	7,516	7,693
Total assets	\$ 1,597,278	\$ 1,504,386
Liabilities and net assets		
Current liabilities		
Short-term borrowings	\$ 43,146	\$ 18,646
Current portion of long-term debt	17,141	16,679
Accounts payable	81,598	70,973
Accrued salaries and wages	61,262	40,569
Accrued interest	2,505	2,710
Pension underfunded liability - current	18,047	-
Estimated third-party payor settlements	3,537	2,867
Incurred but not reported liabilities	25,828	25,335
Other current liabilities	12,856	20,153
Total current liabilities	265,920	197,932
Accrued postretirement benefit cost	4,537	4,277
Accrued pension	52,471	83,193
Long-term debt, net of current portion	413,932	424,687
Pension underfunded liability- long-term	114,255	30,779
Other liabilities	9,740	6,973
Total liabilities	860,855	747,841
Net assets		
Unrestricted net assets		
Network unrestricted net assets	715,695	736,022
Noncontrolling interest	11,738	11,294
Total unrestricted net assets	727,433	747,316
Temporarily restricted net assets	4,673	4,987
Permanently restricted net assets	4,317	4,242
Total net assets	736,423	756,545
Total liabilities and net assets	\$ 1,597,278	\$ 1,504,386

The accompanying notes are an integral part of these financial statements.

Community Health Network, Inc. and Affiliates
Consolidated Statements of Operations and Changes in Net Assets (in 000's)
Years Ended December 31, 2011 and 2010

	2011	2010
Revenues and gains		
Net patient service revenue	\$ 1,332,963	\$ 1,213,135
Provisions for bad debts	72,765	\$ 63,585
Net patient service revenue less provision for bad debts	<u>1,260,198</u>	<u>1,149,550</u>
Service fee revenue	21,519	23,967
Other revenue	53,429	75,130
Other revenue - Electronic Health Record Incentive payments	12,635	-
Equity in earnings of unconsolidated affiliates	10,958	9,868
Total unrestricted revenues and gains	<u>1,358,739</u>	<u>1,258,515</u>
Operating expenses		
Salaries and benefits	725,372	662,252
Supplies and other expenses	478,771	466,815
Depreciation and amortization	64,511	70,248
Provision for bad debts	1,209	1,684
Interest and financing costs	13,202	12,554
Total operating expenses	<u>1,283,065</u>	<u>1,213,553</u>
Income from operations	<u>75,674</u>	<u>44,962</u>
Realized and unrealized (losses) gains on investments, net	(16,386)	51,668
Excess of net assets acquired in Westview Acquisition	34,636	-
Other, net	<u>(10)</u>	<u>690</u>
Excess of revenues over expenses and noncontrolling interests before income taxes	93,914	97,320
(Benefit) provision for income taxes	<u>(2,958)</u>	<u>4,991</u>
Excess of revenues over expenses	<u>96,872</u>	<u>92,329</u>
Excess of revenues attributable to noncontrolling interest	<u>(14,932)</u>	<u>(13,052)</u>
Excess of revenues over expenses attributable to the Network	<u>\$ 81,940</u>	<u>\$ 79,277</u>

The accompanying notes are an integral part of these financial statements

Community Health Network, Inc. and Affiliates
Consolidated Statements of Operations and Changes in Net Assets (in 000's)
Years Ended December 31, 2011 and 2010

	2011	2010
Change in unrestricted net assets		
Excess of revenues over expenses attributable to the Network	\$ 81,940	\$ 79,277
Under (over) funding of pension assets, net	(102,507)	57,268
Change in noncontrolling interest	444	(860)
Other changes, net	240	363
(Decrease) increase in total unrestricted net assets	(19,883)	136,048
Change in temporarily restricted net assets		
Restricted contributions received	1,383	865
Net assets released from restrictions	(1,522)	(1,529)
Investment (loss) income	(175)	298
Decrease in temporarily restricted net assets	(314)	(366)
Change in permanently restricted net assets		
Restricted contributions received	77	155
Other	(2)	(11)
Increase in permanently restricted net assets	75	144
(Decrease) increase in total net assets	(20,122)	135,826
Total net assets, beginning of year	756,545	620,719
Total net assets, end of year	\$ 736,423	\$ 756,545

The accompanying notes are an integral part of these financial statements.

Community Health Network, Inc. and Affiliates
Consolidated Statements of Cash Flows (in 000's)
December 31, 2011 and 2010

	2011	2010
Cash flows from operating activities		
(Decrease) increase in net assets	\$ (20,122)	\$ 135,826
Adjustments to reconcile increase in net assets to net cash provided by operating activities		
Depreciation and amortization	64,511	70,248
Provision for bad debts	73,974	65,269
Deferred tax benefit	(7,772)	(26)
Increase in net assets from the Westview acquisition	(42,136)	-
Equity in earnings of unconsolidated affiliates	(10,958)	(9,868)
Net changes in unrealized (gains) losses on investments	46,814	(36,231)
Other non cash charges, net	1,760	6,674
Change in (over)/underfunded pension/postretirement liabilities/assets	102,507	(57,268)
Distributions received from unconsolidated affiliates	10,556	9,956
Change in prepaid pension cost	(30,722)	(4,893)
Investment income received	9,862	5,857
Other adjustments	(601)	886
Changes in operating assets and liabilities		
Patient accounts receivable	(75,233)	(79,181)
Other assets	(4,205)	(1,612)
Accounts payable	3,146	5,688
Estimated third-party payor settlements	(4,729)	149
Other liabilities	13,428	19,813
Net cash provided by operating activities	<u>130,080</u>	<u>131,287</u>
Cash flows from investing activities		
Acquisitions of property, plant and equipment	(57,955)	(50,894)
Acquisitions of property, plant and equipment-CHS Expansion	-	(40,753)
Acquisitions of intangible asset - software	(12,255)	-
Proceeds from sale (purchase of) property, plant and equipment	(431)	418
(Purchases)/sales of investments, net	(51,245)	1,727
Investments in unconsolidated affiliates	-	(152)
Cash acquired in the acquisition of Westview and its affiliates	5,354	-
Distributions received from unconsolidated affiliates	-	160
Due to unconsolidated affiliates and related parties, net	1,301	981
Net cash used in investing activities	<u>(115,231)</u>	<u>(88,513)</u>
Cash flows from financing activities		
Proceeds from issuance of debt	24,500	5,146
Repayments of debt	(17,535)	(14,552)
Changes in restricted contributions and investment income	(1,636)	(674)
Cash flows provided by (used in) financing activities	<u>5,329</u>	<u>(10,080)</u>
Net increase in cash and cash equivalents	<u>20,178</u>	<u>32,694</u>
Cash and cash equivalents, beginning of year	<u>144,127</u>	<u>111,433</u>
Cash and cash equivalents, end of year	<u>\$ 164,305</u>	<u>\$ 144,127</u>
Supplemental disclosures of cash flow information		
Cash paid during the year for		
Interest	\$ 13,450	\$ 13,608
Income taxes	\$ 4,722	\$ 5,332
Non cash disclosures of cash flow information		
Acquisition of property, plant and equipment included in accounts payable at December 31	\$ 4,838	\$ 5,941

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

1. Organization and Summary of Significant Accounting Policies

Organization

Community Health Network, Inc, an Indiana non-profit corporation and its non-profit and for-profit affiliates (collectively the "Network") comprise a full-service integrated health delivery system in central Indiana. The Network operates five acute care hospitals as well as a specialty hospital, nine immediate care centers, a primary and specialty care physician organization, forty ambulatory care centers, ten freestanding surgery centers, seven outpatient imaging centers, two ambulatory endoscopy centers, four nursing homes and an assisted living facility.

Effective December 31, 2011, Community Health Network, Inc. merged into Community Hospitals of Indiana, Inc. Community Hospitals of Indiana, Inc. was the surviving corporation. Upon completion of the merger, Community Hospitals of Indiana, Inc. was renamed Community Health Network, Inc. ("CHNw"). CHNw is a non-profit corporation which operates two acute care hospital facilities on the northeast and eastern sides of Indianapolis.

Effective August 1, 2011, the Network affiliated with Indianapolis Osteopathic Hospital, Inc. d/b/a Westview Hospital and its affiliates (collectively "Westview"). The intent of the affiliation is to provide expanded services to residents in central Indiana. The affiliation was accounted for as an acquisition and thus the net assets and operations of Westview are included in the Network's consolidated financial statements beginning August 1, 2011. See Note 14.

Effective June 1, 2011, the Network entered into a clinical collaboration agreement with Johnson Memorial Hospital ("Johnson"). The intent of the collaboration is to provide higher quality and more affordable primary and secondary care to Johnson County residents. The collaboration agreement does not change any management, ownership or governance structures of Johnson

Basis of Presentation and Consolidation

The accompanying consolidated financial statements were prepared in accordance with generally accepted accounting principles in the United States of America ("U.S. GAAP" or "GAAP") and include the assets, liabilities, revenues and expenses of all wholly owned subsidiaries, majority owned subsidiaries and when applicable, entities for which the Network has a controlling interest.

The consolidated financial statements include the following wholly owned entities:

- Community Hospital South, Inc. ("CHS"), a non-profit corporation which operates an acute care hospital facility on the south side of Indianapolis; CHNw and CHS are collectively referred to as ("Community Hospitals Indiana");
- Community Hospitals of Anderson and Madison County, Inc. ("CHA"), a non-profit corporation which provides acute health care services to residents of Anderson, Indiana and surrounding communities;
- Indianapolis Osteopathic Hospital, Inc. d/b/a Westview Hospital, a non-profit corporation which provides acute health care services to residents on the west side of Indianapolis. Health Institute of Indiana, Inc. ("Healthplex") is a non-profit wholly owned fitness center of Westview. Westview Hospital Foundation, Inc. ("Foundation") is a non-profit corporation organized to support the activities of Westview;
- Community Physicians of Indiana, Inc. ("CPI") d/b/a Community Physicians Network, a non-profit corporation which employs the Network's primary care and specialty physicians;
- Community Health Network Foundation, Inc. ("Foundation"), a non-profit corporation established to raise and expend funds for the benefit of CHNw and other related organizations;

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

- Visionary Enterprises, Inc. ("VEI"), a taxable, for-profit subsidiary corporation which consists primarily of ambulatory surgery center development in Indiana and Michigan, and management and other consulting services;
- Community Home Health Services, Inc. ("CHHS"), a non-profit corporation whose operations consist primarily of providing home health care and hospice services to patients in thirteen central Indiana counties, CHHS consolidates its wholly owned subsidiary, Community at Home, LLC, a non-profit Indiana corporation which provides sales of home health care products;
- Indiana ProHealth Network, Inc., a provider association consisting of physicians and hospital members in central Indiana and the primary vehicle by which the Network contracts for risk with payors. Effective December 31, 2011, Indiana ProHealth Network, Inc. was merged with VEI-ProHealth, Inc. which was converted to Indiana Pro Health Network, LLC ("ProHealth"). ProHealth is a subsidiary of VEI;
- Indiana Heart Hospital, LLC ("IHH") d/b/a Community Heart and Vascular, a non-profit corporation which operates a specialty hospital specializing in cardiac care as well as provides cardiac services to CHNw;
- CHN Assurance Company, Ltd. ("Captive") is a company incorporated under the law of the Cayman Islands and wholly owned subsidiary of CHNw. The Captive reinsures policies for the Network including: primary hospital professional liability, doctor's professional liability and general liability. The Captive's professional liability policy is on a claims made basis and includes prior acts coverage for various entities owned by the Network, while the general liability policy is on an occurrence basis. On an annual basis, the Captive's ceding insurer requires the Captive to maintain an outstanding letter of credit to address any potential exposure between premiums paid and expected losses. Due to favorable claims experience and adequate funding, the fronting company no longer requires a letter of credit for the policy years beginning March 1, 2011 and 2012, respectively.
- The Network also consolidates its interest in the following entities:
 - South Campus Surgery Center, LLC ("SCSC")
 - North Campus Surgery Center, LLC ("NCSC")
 - East Campus Surgery Center, LLC ("ECSC")
 - Hamilton Surgery Center, LLC ("Noblesville")
 - Surgicare LLC ("Surgicare"),
 - Community LTC, Inc. ("LTC")
 - Effective December 31, 2010, Community Business Innovations, Inc. ("CBI") was merged into CHNw and is no longer a separate legal entity.

Significant intercompany accounts and transactions have been eliminated.

On January 26, 2012, CHNw signed a letter of intent to affiliate with Howard Regional Health System, Inc. ("Howard"). Howard is a county owned health system which operates an acute care hospital in Kokomo, Indiana.

Use of Estimates in the Preparation of Financial Statements

The preparation of the consolidated financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Significant estimates and assumptions are used for, but not limited to (a) allowance for contractual

Community Health Network, Inc. and Affiliates

Notes to Consolidated Financial Statements

December 31, 2011 and 2010

revenue adjustments, (b) allowance for doubtful accounts; (c) depreciation lives of long-lived assets and (d) reserves for professional, workers' compensation and comprehensive general insurance liabilities risk. Future events and their effects cannot be predicated with certainty; accordingly the accounting estimates require the exercise of judgment. The accounting estimates used in the preparation of the consolidated financial statements will change as new events occur, as more experience is acquired, as additional information is obtained and as our operating environment changes. The Network evaluates and updates its assumptions and estimates on an ongoing basis and may employ outside experts to assist in its evaluation, as considered necessary. Actual results could differ from those estimates.

Reclassifications

Certain reclassifications have been made to the 2010 financial statements to conform to the 2011 presentation.

Cash and Cash Equivalents

For purposes of reporting cash flows, cash and cash equivalents include cash on hand, amounts due from banks and funds invested temporarily in money market accounts that are purchased with original maturities of three months or less.

The Network has entered into overnight sweep transaction agreements to purchase and resell direct obligations of, or obligations that are insured as to principal and interest by, U.S. Government agencies. At December 31, 2011 and 2010, cash and cash equivalents include \$22,465 and \$47,175, respectively, of overnight sweep transaction agreements.

Restricted Cash

As of December 31, 2011 and 2010, CHNw has restricted cash of \$2,851 and \$2,400, respectively, related to collateral calls on its 1995 Series debt as well as collateral related to CHNw's guarantee of Westview's long-term debt. The monies are held in a separate cash account and can only be used to fund the collateral call requirements issued by the bank. As the fair value of the debt outstanding increases, the monies are released by the bank into CHI's operating cash account.

Allowance for Doubtful Accounts

The Network's accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, the Network analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts, provision for bad debts and provision for charity. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third party coverage, the Network analyzes contractually due amounts and provides an allowance for doubtful accounts, provision for bad debts and charity for expected uncollectible deductibles and co-insurances. For receivables associated with self-pay patients, the Network records a provision for bad debts and charity 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 all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts. For CHNw, CHS, VEI and IHH accounts that are sent to collection companies the accounts remain as accounts receivable on the balance sheet. These accounts are not written off unless returned from the collection company. As such the allowance for doubtful accounts is significant for this component of the accounts receivable.

The Network's allowance for doubtful accounts increased by 9.56% in fiscal year 2011 from fiscal year 2010. This increase is the result of accounts that were transferred to the collection company during fiscal year 2011. For CHNw, CHS, VEI and IHH accounts transferred to collections during fiscal year 2011 represented 10.86% of the total gross accounts receivable. In fiscal year 2011

Community Health Network, Inc. and Affiliates

Notes to Consolidated Financial Statements

December 31, 2011 and 2010

Westview was consolidated onto the Network financial statements which attributed to \$2,985 of the overall increase from fiscal year 2010. The Network has not changed its charity care or uninsured discount policies during fiscal years 2011 or 2010.

Inventories

Inventories consist primarily of medical and surgical supplies and pharmaceuticals. All inventories are valued at the lower-of-cost or market. Cost is determined by the Network using a weighted average cost method, which approximates cost under the first-in, first-out method.

Assets Limited as to Use

Assets limited as to use consist of cash and cash equivalents, U S Government obligations, corporate bonds, and marketable equity securities, and are stated at fair value. The fair values of these investments are based on quoted market prices. The investments are classified as trading securities. The trading securities classification is based on the Network's investment strategy and investment philosophies which permits investment managers to execute purchases and sales of investments without prior approval of Network management. All unrestricted unrealized holding gains and losses are recorded in investment income in the period in which they occur.

Reinsurance trust assets are maintained by the Captive. All realized and unrealized gains or losses are recorded in income. For reinsurance trust assets, fair value is determined as described in Note 3. Realized gains and losses on sales of investments are determined using the specific identification cost method and are included in excess of revenues over expenses.

Property, Plant and Equipment

Property, plant and equipment are recorded at cost or, if donated, at the fair value at date of donation. Assets under capital lease obligations are recorded at the present value of the aggregate future minimum lease payments at the beginning of the lease term. For financial statement purposes, the Network primarily uses the straight-line method of computing depreciation over the shorter of the estimated useful lives of the respective assets or the life of the lease term, excluding any lease renewals, unless the lease renewals are reasonably assured.

Costs of maintenance and repairs are charged to expense when incurred; costs of renewals and betterments are capitalized. Upon sale or retirement of property, plant and equipment, the cost and related accumulated depreciation are eliminated from the respective accounts, and the resulting gain or loss is included in the consolidated statements of operations and changes in net assets.

Long-lived assets are evaluated for possible impairment whenever circumstances indicate that the carrying amount of the asset, or related group of assets, may not be recoverable from future estimated cash flows. Fair value estimates are derived from independent appraisals, established market values of comparable assets or internal calculations of future estimated cash flows.

Change in Estimates for Long-lived Assets

The Network periodically performs assessments of the estimated useful lives of its long-lived assets. In evaluating the useful lives, the Network considers how long the long-lived assets will remain functionally efficient and effective, given changes in the physical and economic environments, the levels of technology and competitive factors. If the assessment indicates that the long-lived assets will continue to be used for a longer period than previously anticipated, the Network will revise the estimated useful lives resulting in a change in estimate. Changes in estimates are accounted for on a prospective basis by depreciating the assets current carrying values over their revised remaining useful lives.

Community Health Network, Inc. and Affiliates

Notes to Consolidated Financial Statements

December 31, 2011 and 2010

Investments in Unconsolidated Affiliates

Investments in affiliates not controlled by the Network are reported under the equity method of accounting. Under the equity method, the investments are initially recorded at cost, increased or decreased by the investor's share of the profits or losses of the investee and reduced by cash distributions received. Distributions received from investees that represent a return on investment are classified as operating cash flows on the consolidated statement of cash flows. Those distributions that represent a return of investment are classified as investing cash flows.

Intangible Assets

Bond discounts and other costs associated with the issuance of long-term debt, principally underwriters' fees, are carried at cost, net of accumulated amortization. These amounts are amortized to interest expense using the effective interest method over the life of the bonds. Software costs are recorded at cost. The software costs are amortized over the estimated useful lives of the software. The estimated useful lives range from 7-10 years.

Self-Insured Risk

A substantial portion of the Network's professional and general liability risks except for Westview are insured through a self-insured retention program written by the Network's consolidated wholly-owned offshore captive insurance subsidiary, the Captive, as previously described.

Reserves for professional and general liability risks, including incurred but not reported claims, were \$12,707 and \$11,723 at December 31, 2011 and 2010, respectively. These amounts are recorded and included in the Captive's incurred but not reported liabilities in the accompanying consolidating balance sheets.

Westview's professional and general liability risks are insured through a self-insurance retention program written by Suburban Health Organization Segregated Portfolio Company, LLC ("SHO Captive"), a captive insurance company. Westview is a member of the SHO Captive through a 20% ownership interest. Westview accounts for its interest in the SHO Captive through the equity method of accounting. The premiums paid to the SHO Captive are reflected in Westview's operating expenses in the accompanying consolidating statement of operations.

Provisions for the self-insured risks are based upon actuarially determined estimates. Loss and loss expense reserves represent the estimated ultimate net cost of all reported and unreported losses incurred through the respective consolidated balance sheet dates. The reserves for unpaid losses and loss expenses are estimated using individual case-basis valuations and actuarial analyses. Those estimates are subject to the effects of trends in loss severity and frequency. The estimates are continually reviewed and adjustments are recorded as experience develops or new information becomes known. The changes to the estimated reserve amounts are included in current operating results.

The Network is self-insured for employee medical benefit risks through ProHealth except for Westview which is self-insured. Reserves for medical claims liabilities and estimated incurred but not reported claims were \$12,686 and \$14,576 at December 31, 2011 and 2010, respectively. These amounts are recorded and included in ProHealth's incurred but not reported liabilities in the accompanying consolidating balance sheets for the Network excluding Westview. Westview recorded the amounts in accrued salaries and wages. Incurred but not reported claims reserves represent estimates for claims that are incurred but not reported. These estimates are determined using individual case-basis data and are continually reviewed and adjusted as new experienced information becomes known. The changes in estimated reserve amounts are included in current operating results.

Although considerable variability is inherent in reserve estimates, management believes the reserves for losses and loss expenses are adequate; however, there can be no assurance that the ultimate liability will not exceed management's estimates.

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Network has been limited by donors to a specific time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Network in perpetuity.

Net Patient Service Revenue

The Network recognizes patient service revenue associated with services provided to patients who have third-party payor 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 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 and charity related to uninsured patients in the period the services are provided. Patient service revenue, net of contractual allowances, discounts and charity allowances recognized in the period from these major payor sources, is as follows:

(In Thousands)	<u>Third Party Payors</u>	<u>Self-pay</u>	<u>Total All Payors</u>
Patient service revenue (net of contractual allowances and discounts)	\$ 1,276,969	\$ 55,994	\$ 1,332,963

Charity Care

The Network maintains records to identify and monitor the level of charity care it provides. The Network provides charity care to patients whose income level is below 200% of the Federal Poverty Level. Effective January 1, 2010, the Network early adopted Accounting Standards Update ("ASU") No. 2010-23, *Health care Entities (Topic 954): Measuring Charity Care for Disclosure*. As a result of ASU No. 2010-23, 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 includes the amount of costs forgone for services and supplies furnished under its charity care policy and was \$26,939 and \$25,693 for the years ended December 31, 2011 and 2010, respectively. Charity care cost was determined on the application of the associated cost-to-charge ratios.

Donor-restricted Gifts

Unconditional promises to give cash and other assets are reported at fair value at the date the promise is received. The gifts are reported as either temporarily or permanently restricted contributions if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statement of operations as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reflected as unrestricted contributions in the accompanying consolidated financial statements.

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

The following is a summary of pledge receivables as of December 31, 2011 and 2010.

	2011	2010
Pledge receivables in less than one year	\$ 1,135	\$ 788
Pledge receivables in one to five years	571	1,291
Pledge receivables in more than five years	38	55
	<u>1,744</u>	<u>2,134</u>
Less: allowance for doubtful accounts and discounts	286	342
	<u>\$ 1,458</u>	<u>\$ 1,792</u>

Electronic Health Record Incentive Payments

The America Recovery and Reinvestment Act of 2009 ("ARRA") established incentive payments under the Medicare and Medicaid programs for certain professionals and hospitals that meaningfully use certified electronic health record ("EHR") technology. Under the programs incentive payments will be paid out over a four year period to hospitals and physicians meeting designated EHR meaningful use criteria. The Centers for Medicare and Medicaid Services ("CMS") has chosen to take a phased approach to defining meaningful use (through three stages), using criteria that becomes more stringent over time.

The definition of the stages are as follows:

Stage 1- The hospital must electronically capture health information in a coded format. Additionally, the hospital must use EHR technology during the meaningful use period to meet 14 required objectives. The hospital must also elect five additional objectives to meet.

Stage 2- The hospital expands on Stage 1 to focus on continuous quality improvement at point of care. Additionally, the hospital must demonstrate greater use of computerized physician order entry and more exchange of information.

Stage 3- The hospital expands on the previous stages to focus on promoting improvements in quality, safety and efficiency with an emphasis on decision support, patient access to self-management tools, access to comprehensive patient data and improving population health.

In order to receive incentive payments, a hospital which is able to meet the meaningful use criteria must attest that during the EHR reporting period, the hospital:

- Used certified EHR technology and specify the technology used;
- Satisfied the required meaningful use objectives and associated measures for the applicable stage,
- Must specify the EHR reporting period and provide the result of each applicable measure for all patients admitted to the inpatient and emergency department of the hospital during the EHR reporting period for which a selected measure is applicable.

Community Health Network, Inc. and Affiliates

Notes to Consolidated Financial Statements

December 31, 2011 and 2010

The results of the measurements are required to be submitted to CMS. For Medicare and Medicaid, the meaningful use periods follow the Federal fiscal year of October 1 to September 30. Meaningful use is measured on a year by year basis. The EHR reporting period for the first payment year is any continuous 90 day period. Subsequent payments years are 365 days per year.

The incentive payments are computed as the product of a base amount times the number of discharges times a Medicare factor computed based on inpatient days and charity care charges times a transition factor as determined by CMS.

The Network recognizes the EHR incentives payments using a government grant recognition model. The Network determined the EHR incentive payments are similar to grants that are related to income and recognizes the incentive payments ratably over each meaningful use period. The Network recognizes the incentive payments when it is reasonably assurance that it will comply with the conditions attached to them and that the grants will be received.

The recognition of the income related to the EHR incentive payments is based on Network management's best estimates and the amounts are subject to change, with such changes impacting the operations in the period in which they occur. Any material changes would be disclosed by the Network as a change in accounting estimate. The Network recognized \$12,635 for the year ended December 31, 2011.

Acquisition Costs

The Network records acquisitions costs as incurred as operating expenses.

Tax Status

CHNw, CHS, CHA, CHHS, CPI, IHH and Westview are exempt from federal income taxes under Section 501(c) (3) of the Internal Revenue Code (the "Code"), and the Foundation is exempt from federal income taxes under Section 501a(c) (3) of the Code. IHH filed its Form 1023 application timely and is awaiting determination from the Internal Revenue Service. VEI is a for-profit taxable entity and is subject to federal and state income taxes. ProHealth, NCSC, SCSC, ECSC, Noblesville, Surgicare and MSI are generally not subject to federal or state income taxes as income earned flows through to its members.

Fair Value of Financial Instruments/Measurements

The carrying amounts of cash and cash equivalents, accounts receivable, accounts payable, and other current liabilities approximate fair value because of the relatively short maturities of these financial instruments. The fair value of long-term debt was determined using discounted future cash flows, with a discount rate equal to interest rates for similar types of borrowing arrangements.

The fair value of the Network's long-term debt instruments and related interest approximates \$429,457 and \$429,724 as compared to carrying values of \$431,073 and \$441,366 as of December 31, 2011 and 2010, respectively.

The Network measures fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The Network uses also a fair value hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The Network uses a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value as follows:

- Level 1- Observable inputs such as quoted prices in active markets;

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

- Level 2- Inputs, other than the quoted prices in active markets, that are observable either directly or indirectly; and
- Level 3- Unobservable inputs in which there is little or no market data, which require the reporting entity to develop its own assumptions

Assets and liabilities measured at fair value are based on one or more of three valuation techniques. The three valuation techniques are as follows:

- Market approach- Prices and other relevant information generated by market transactions involving identical or comparable assets or liabilities,
- Cost approach- Amount that would be required to replace the service capacity of an asset (i.e. replacement cost); and
- Income approach- Techniques to convert future amounts to a single present amount based on market expectations (including present value techniques, option-pricing models and lattice models.)

Subsequent Events

The Network evaluated subsequent events through April 18, 2012, the date the Network consolidated financial statements were issued. All material matters are disclosed in the footnotes to the consolidated financial statements.

New Accounting Pronouncements

Effective January 1, 2011, the Network adopted ASU 2010-24, *Health Care Entities (Topic 954): Presentation of Insurance Claims and Related Insurance Recoveries*, which clarifies that a health care entity should not net insurance recoveries against a related claim liability. The adoption did not have a material impact on the Network's financial condition, results of operations or cash flows.

Effective January 1, 2011, the Network adopted ASU 2011-07, *Health Care Entities (Topic 954): Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowances for Doubtful Accounts for Certain Health Care Entities*, which requires certain health care entities to change the presentation of their statement of operations by reclassifying the provision for bad debts associated with patient service revenue from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts). Additionally, those entities are required to provide enhanced disclosure about their policies for recognizing revenue and assessing bad debts. The early adoption of ASU 2011-07 is reflected in the Network's 2011 and 2010 consolidated financial statements and footnotes.

Effective January 1, 2011, the Network adopted ASU 2011-08, *Intangibles- Goodwill and Other (Topic 350): Testing Goodwill for Impairment* which permits an entity to first assess qualitative factors to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount as a basis for determining whether it is necessary to perform the two step goodwill impairment test. The early adoption of this standard did not have any impact on the Network's financial conditions, results or operations or cash flows.

2. Net Patient Service Revenue and Concentrations of Credit Risk

The Network has agreements with third-party payors that provide for payments to the Network at amounts different from its established rates. Payment arrangements with major third-party payors include:

- Medicare—Inpatient acute care services, outpatient services and home health services

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

rendered to Medicare program beneficiaries are paid at prospectively determined rates. These rates vary according to patient classification systems that are based on clinical, diagnostic, and other factors. The Network is reimbursed for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports by the Network and audits thereof by the Medicare fiscal intermediary. The Network's classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review by a peer review organization under contract with the Network. The Network's Medicare cost reports have been audited by the Medicare fiscal intermediary through December 31, 2010. The Network is awaiting final audit reports to be issued. Laws and regulations governing the Medicare program are complex and subject to interpretation. As a result, there is at least a possibility that recorded estimates could change by a material amount in the near term. Adjustments to revenue related to prior period cost reports increased net patient service revenue by approximately \$167 and \$5,013 for the years ended December 31, 2011 and 2010, respectively. Medicare patients account for approximately 41.1% and 39.1% of gross patient charges for years ended December 31, 2011 and 2010, respectively.

- **Medicaid**—Inpatient services rendered to Medicaid program beneficiaries are reimbursed based on prospectively determined rates per discharge and outpatient services are reimbursed based on a fee for service basis, based on predetermined fee schedules. Medicaid patients account for approximately 12.2% and 11.3% of gross patient charges for years ended December 31, 2011 and 2010, respectively.

The Network has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the Network under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined per diem rates.

Provisions have been made in the consolidated financial statements for estimated contractual adjustments, representing the difference between the established charges for services and estimated total payments to be received from third-party payors. Estimated settlements are accrued in the period the related services are rendered and adjusted in future periods as settlements are determined.

The Network has qualified as a Medicaid Disproportionate Share ("DSH") provider under Indiana Law (IC 12-15-16(1-3)) and, as such, is eligible to receive DSH payments for the most recently determined state fiscal year 2011. The amount of these additional DSH funds is dependent on regulatory approval by agencies of the federal and state governments, and is determined by the level, extent and cost of uncompensated care as well as other factors. For the years ended December 31, 2011 and 2010, DSH payments have been made by the State of Indiana and amounts received were recorded as revenue based on data acceptable to the State of Indiana less any amounts management believes may be subject to adjustment. DSH payments are recorded by the Network after eligibility is determined by the State of Indiana and the payments are determined to be earned. If payments are received prior to eligibility being determined, the payments are recorded as current deferred revenue and recorded in current other liabilities until eligibility is determined.

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

Net patient service revenue, as reflected in the accompanying consolidated statements of operations and changes in net assets, consist of the following for the years ended December 31, 2011 and 2010:

	2011	2010
Gross patient service revenue	\$ 3,335,995	\$ 2,912,132
Deductions from gross patient service revenue		
Medicare/Medicaid contractual adjustments	1,198,572	1,050,327
Other adjustments	725,689	579,029
Charity discounts for patient care	78,771	69,641
Net patient service revenue	\$ 1,332,963	\$ 1,213,135
Provision for bad debts	72,765	63,585
Net patient service revenue less provision for bad debts	\$ 1,260,198	\$ 1,149,550

The Network grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. A significant portion of the Network's revenue is concentrated by payor mix. The concentration of gross receivables by payor class for both patients and third-party payors at December 31, 2011 and 2010 is as follows:

	2011	2010
Medicare	26 %	27 %
Medicaid	12	13
Managed care and commercial insurance	44	42
Patients	18	18
	<u>100 %</u>	<u>100 %</u>

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.

3. Assets Limited as to Use

Funds Held by Trustee

The following is a summary of assets limited as to use, which are held by trustees, at December 31, 2011 and 2010:

	2011	2010
Cash and cash equivalents	\$ 26,818	\$ 23,395
Less amount classified as current assets to meet current obligations	13,176	9,530
Noncurrent asset	\$ 13,642	\$ 13,865

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

The Hospital Revenue Bond Agreements (Note 7) require that the initial bond proceeds be held by a bank trustee until such funds are expended for eligible assets. Certain other funds are also held by the bank trustee as additional security for the bondholders and the periodic deposits of principal and interest requirements. These amounts, including interest earned from temporary investments, are segregated in accounts maintained by a bank trustee. Use of the funds is restricted to debt service requirements. All funds are cash and cash equivalents which approximate fair value and are designated as Level 1 in accordance with ASC 820.

Board-designated Funds

The Network classifies its Board designated funds and reinsurance trust assets as trading securities. Those investments are marked to market each month.

The following is a summary of the investments limited as to use, which are board-designated funds, at December 31, 2011 and 2010:

	2011 Cost	2011 Market
Cash and cash equivalents	\$ 3,302	\$ 3,298
U.S. Treasury bonds	19,459	20,736
Corporate bonds	80,631	78,165
Equity securities	232,575	223,318
Hedge fund of funds	18,895	18,824
REITS/other	66,009	56,895
	<u>\$ 420,871</u>	<u>\$ 401,236</u>

	2010 Cost	2010 Market
Cash and cash equivalents	\$ 1,461	\$ 1,461
U.S. Treasury bonds	55,278	56,006
Corporate bonds	45,064	45,042
Equity securities	201,302	219,537
Hedge fund of funds	15,870	16,533
REITS/other	58,092	65,669
	<u>\$ 377,067</u>	<u>\$ 404,248</u>

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

2011 Description	Fair Value Measurements at Reporting Date Using			
	2011	Level 1	Level 2	Level 3
Fixed Income	\$ 82,316	\$ 53,565	\$ 28,751	\$ -
Equity—Domestic Large Cap	83,475	47,472	36,003	-
Equity—Domestic Small Cap	28,538	17,398	11,140	-
Equity—International	103,783	103,783	-	-
Hedge Fund of Funds	18,824	-	-	18,824
REITS/Other	84,300	84,300	-	-
Total	<u>\$ 401,236</u>	<u>\$ 306,518</u>	<u>\$ 75,894</u>	<u>\$ 18,824</u>

2010 Description	Fair Value Measurements at Reporting Date Using			
	2010	Level 1	Level 2	Level 3
Fixed Income	\$ 87,996	\$ 87,996	\$ -	\$ -
Equity—Domestic Large Cap	85,809	51,990	33,819	-
Equity—Domestic Small Cap	33,303	19,007	14,296	-
Equity—International	110,568	110,568	-	-
Hedge Fund of Funds	16,534	-	-	16,534
REITS/Other	70,038	70,038	-	-
Total	<u>\$ 404,248</u>	<u>\$ 339,599</u>	<u>\$ 48,115</u>	<u>\$ 16,534</u>

	Rollforward of Level 3 Investments
Balance as of January 1, 2010	\$ 15,494
Purchases	-
Investment gain-realized/unrealized	1,040
Balance as of December 31, 2010	<u>\$ 16,534</u>
 Balance as of January 1, 2011	 \$ 16,534
Purchases	3,025
Investment gain-realized/unrealized	(735)
Balance as of December 31, 2011	<u>\$ 18,824</u>

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

The fair values of the board designated funds are provided to the Network's investment manager and are determined as follows:

- a) The funds designated as level 1 inputs represent equity securities and investable mutual fund shares that are traded on major stock exchanges. Thus, the fair value is determined based on quoted prices in an active market.
- b) The funds designated as level 2 inputs represent publicly traded securities held in separate institutional investment accounts managed by a professional money manager. The individual securities are traded on major stock exchanges but the blended portfolio is not investable as a unit. The fair value is determined by reviewing the underlying valuation of each individual publically traded stock that comprises the holdings of the fund.
- c) The funds designated as level 3 inputs represents hedge funds. The fair values of the hedge funds are obtained from individual hedge fund managers and custodians. The hedge fund of fund manager employs best practices controls and due diligence to ensure the valuations are reflective of fair value. Additionally, the individual hedge funds are audited annually and an audit report issued.

Investment income for 2011 and 2010 related to Board-designated funds consists of the following:

	2011	2010
Interest and dividend income	\$ 20,139	\$ 10,391
Unrealized (loss) gain	(46,814)	36,231
Net realized gain on sales of investment securities	9,878	4,559
Total investment (loss) income	<u>\$ (16,797)</u>	<u>\$ 51,181</u>

The Network's investment expenses for the years ended December 31, 2011 and 2010 were \$630 and \$695, respectively.

Reinsurance Trust Assets

The assets in the trust consist of cash and cash equivalents and are maintained in a domestic trust account. These assets are restricted and may not be withdrawn or used without the consent of the trust administrator.

The following is a summary of the investments limited as to use, which are reinsurance trust assets, at December 31, 2011 and 2010:

	2011 Cost	2011 Market	2010 Cost	2010 Market
U.S. Treasury bonds	\$ -	\$ -	\$ -	\$ -
Corporate bonds	3,982	4,218	4,630	4,825
Federal Government Agency mortgage backed securities	4,123	4,356	4,621	4,821
Cash and cash equivalents held in trust	4,227	4,227	1,970	1,970
	<u>\$ 12,332</u>	<u>\$ 12,801</u>	<u>\$ 11,221</u>	<u>\$ 11,616</u>

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

<u>2011</u> Description	<u>Fair Value Measurements at Reporting Date Using</u>			
	2011	Level 1	Level 2	Level 3
Federal Government Agency and mortgage backed securities	\$ 4,356	\$ -	\$ 4,356	\$ -
Corporate bonds	4,218		4,218	
U.S. Treasury bonds	-	-	-	-
Money Market Funds	4,227	4,227	-	-
Total	<u>\$ 12,801</u>	<u>\$ 4,227</u>	<u>\$ 8,574</u>	<u>\$ -</u>

<u>2010</u> Description	<u>Fair Value Measurements at Reporting Date Using</u>			
	2010	Level 1	Level 2	Level 3
Federal Government Agency and mortgage backed securities	\$ 4,821	\$ -	\$ 4,821	\$ -
Corporate bonds	4,825	-	4,825	-
U.S. Treasury bonds	-	-	-	-
Money Market Funds	1,970	1,970	-	-
Total	<u>\$ 11,616</u>	<u>\$ 1,970</u>	<u>\$ 9,646</u>	<u>\$ -</u>

The fair values of the reinsurance trust assets are provided by the Captive's investment manager and are determined as follows:

- a) The fair value of fixed income securities including corporate debt are generally determined on the basis of valuations provided by a pricing service which will typically utilize industry accepted valuation models and observable market inputs to determine valuation; some valuations or model inputs provided/used by the pricing service may be, or be based upon, broker quotes
- b) The fair value of investments in money market funds is determined based on the net asset value per share provided by the administrators of the funds.

Investment income for 2011 and 2010 related to reinsurance trust assets consists of the following:

	2011	2010
Interest income	\$ 349	\$ 392
Net realized/unrealized gains on investment securities	69	96
Total investment income	<u>\$ 418</u>	<u>\$ 488</u>

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

4. Property, Plant and Equipment

Property, plant and equipment and accumulated depreciation consist of the following at December 31, 2011 and 2010.

	Estimated Useful Lives	2011	2010
Land and land improvements	0-20 years	\$ 30,119	\$ 27,593
Buildings and improvements	10-90 years	797,068	767,170
Equipment	3-20 years	572,740	536,207
Construction in progress		9,291	9,628
		<u>1,409,218</u>	<u>1,340,598</u>
Less: accumulated depreciation		<u>727,055</u>	<u>690,449</u>
		<u>\$ 682,163</u>	<u>\$ 650,149</u>

Depreciation expense was \$63,668 and \$69,599 for 2011 and 2010, respectively. Effective January 1, 2011, the Network revised the useful lives of its hospital and hospital related buildings and building improvements. The lives were increased, in some instances, an additional 40 years depending on the nature and type of the building improvement. The effect of these changes in estimates, compared to the original depreciation for the year ended December 31, 2011 was a reduction in depreciation expense of \$4,421.

Property, plant and equipment include \$1,175 and \$1,093 of net capitalized interest at December 31, 2011 and 2010, respectively.

5. Investments in Unconsolidated Affiliates

The Network has equity investments in various surgery centers, Mid America Clinical Laboratory ("MACL") and other entities. The following is a summary of the Network's investments in unconsolidated affiliates for the years ended December 31, 2011 and 2010:

	Surgery Centers	MACL	Other	Total
Balance, December 31, 2009	<u>\$ 15,097</u>	<u>\$ 3,993</u>	<u>\$ 400</u>	<u>\$ 19,490</u>
Capital contributions	152	-	-	152
Distributions	(5,598)	(1,364)	(3,154)	(10,116)
Change from equity method to consolidation		-	-	-
Equity in net income	<u>4,978</u>	<u>2,048</u>	<u>2,842</u>	<u>9,868</u>
Balance, December 31, 2010	<u>\$ 14,629</u>	<u>\$ 4,677</u>	<u>\$ 88</u>	<u>\$ 19,394</u>
Capital contributions	-	-	483	483
Distributions	(5,354)	(2,301)	(2,901)	(10,556)
Equity in net income	<u>5,763</u>	<u>2,295</u>	<u>2,900</u>	<u>10,958</u>
Balance, December 31, 2011	<u>\$ 15,038</u>	<u>\$ 4,671</u>	<u>\$ 570</u>	<u>\$ 20,279</u>

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

Summarized and aggregated financial statement information for the surgery centers, MACL and the other unconsolidated affiliates is as follows (in thousands):

	Surgery Centers	MACL	Other	Total
Total assets	\$ 24,101	\$ 34,514	\$ 18,414	\$ 77,029
Total liabilities	7,758	13,170	9,978	30,906
Net assets	16,343	21,344	8,436	46,123
Revenues	53,008	83,877	44,088	180,973
Operating income	14,884	10,450	12,147	37,481
Net income	14,295	10,434	11,880	36,609
Network's equity in net income of unconsolidated affiliates	4,162	2,295	4,501	10,958

6. Transactions with Unconsolidated Affiliates and Related Parties

The Network provides services to and makes purchases on behalf of various unconsolidated affiliated entities. The range of ownership in unconsolidated affiliates is 2% to 70% percent. Amounts due to unconsolidated affiliates and related parties consist of the following at December 31, 2011 and 2010:

	2011	2010
Notes payable—North Campus Office Associates (NCOA)	\$ 1,263	\$ 1,114
Receivables from physicians	(1,473)	(758)
Due (from)/to Spec Prime/MedPrime	593	225
Due (from)/to Indiana Surgery Centers	(886)	(2,118)
Other receivables/payables, net	(298)	150
Due (from)/to unconsolidated affiliates and related parties, net	<u>\$ (801)</u>	<u>\$ (1,387)</u>

7. Debt

Short-term Borrowings

Short-term borrowings represent outstanding borrowings under bank lines of credit. At December 31, 2011 and 2010 the following amounts were outstanding:

	Maximum Borrowings	Outstanding Balance	
		2011	2010
CHI	\$ 50,000	\$ 29,646	\$ 5,146
VEI	13,500	13,500	13,500
CHA	2,000	-	-
		<u>\$ 43,146</u>	<u>\$ 18,646</u>

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

The bank lines of credit are due on demand. Interest is payable monthly on VEI's line of credit. VEI's short-term debt is collateralized by mortgages on six properties and is also guaranteed by CHI. Interest is at a floating rate, and the weighted-average effective rate on short-term borrowings was 1.19% and 1.02% for the years ended December 31, 2011 and 2010, respectively. CHI's short-term debt is collateralized under the same terms as the Master Indentures described below. Interest is at a floating rate. The weighted-average effective rate on CHI's short term borrowings was 1.57% and .59% for the years ended December 31, 2011 and 2010, respectively.

Long-term debt

Long-term debt at December 31, 2011 and 2010 is summarized as follows:

	<u>Obligated Entity</u>	<u>2011</u>	<u>2010</u>
Indiana Finance Authority, Adjustable Rate Hospital Revenue Bonds, Series 2009 A; interest payable monthly (0.13% effective rate at December 31, 2011) due July 1, 2011 to July 1, 2039	CHI	\$ 39,180	\$ 40,000
Unamortized discount		<u>(136)</u>	<u>(140)</u>
		<u>39,044</u>	<u>39,860</u>
Indiana Finance Authority, Adjustable Rate Hospital Revenue Bonds, Series 2009 B, interest payable monthly (0.07% effective rate at December 31, 2011) due July 1, 2011 to July 1, 2039	CHI	58,760	60,000
Unamortized discount		<u>(203)</u>	<u>(211)</u>
		<u>58,557</u>	<u>59,789</u>

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

	Obligated Entity	2011	2010
Indiana Health Facility Financing Authority, Hospital Revenue Bonds, Series 2005A; interest payable semiannually	CHI		
4.50% serial bonds due May 1, 2008 to May 1, 2025		\$ 62,515	\$ 65,560
5.00% term bonds due May 1, 2035		78,970	78,970
Unamortized premium		3,634	3,790
		<u>145,119</u>	<u>148,320</u>
Indiana Health Facility Financing Authority, Adjustable Rate Hospital Revenue Bonds, Series 2005B; interest payable monthly (0.09% effective rate at December 31, 2011) due May 1, 2008 to May 1, 2035	CHI	17,000	17,400
Indiana Health Facility Financing Authority, Adjustable Rate Hospital Revenue Bonds, Series 2005C, interest payable monthly (0.20% effective rate at December 31, 2011) due May 1, 2008 to May 1, 2035	CHI	17,000	17,500
Indiana Health Facility Financing Authority, Adjustable Rate Hospital Revenue Bonds, Series 2000A and 2000B; interest payable monthly (0.13% effective rate at December 31, 2011) due July 1, 2002 to July 1, 2028	CHI	38,000	38,200
Indiana Health Facility Financing Authority, Adjustable Rate Hospital Revenue Bonds, Series 1997A and 1997B; interest payable monthly (0.10% effective rate at December 31, 2011) due July 1, 2020 to July 1, 2027	CHI	30,000	30,000
Indiana Health Facility Financing Authority, Hospital Revenue Refunding and Improvement Bonds, Series 1995, interest payable semiannually	CHI		
5.6% term bonds due May 15, 2014		5,985	6,030
5.7% term bonds due May 15, 2022		37,368	37,368
Unamortized discount		(262)	(287)
		<u>43,091</u>	<u>43,111</u>

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

	Obligated Entity	2011	2010
Indiana Health Facility Financing Authority, Hospital Revenue Bonds, Series 1993, interest payable semiannually 6.00% term bonds, due January 1, 2023	CHA	\$ 12,920	\$ 13,855
		<u>12,920</u>	<u>13,855</u>
Indiana Health Facility Financing Authority, Hospital Revenue Refunding and Improvement Bonds, Series 1992, interest payable semiannually: 6.40% term bonds due May 1, 2012 with mandatory redemption from May 1, 2006 to 2012 Unamortized discount	CHI	6,810	13,210
		<u>(7)</u>	<u>(16)</u>
		<u>6,803</u>	<u>13,194</u>
Indiana Health Facility Financing Authority, Hospital Revenue Bonds, Series 1992A; interest payable semiannually 6.85% term bonds due July 1, 2022	CHI	11,250	12,230
		<u>11,250</u>	<u>12,230</u>
Hospital Authority of Madison County, Inc., Hospital Revenue Bonds, Series 1988A; interest payable semiannual 8.00% term bonds, due January 1, 2014	CHA	2,600	3,340
		<u>2,600</u>	<u>3,340</u>
Fifth Third Bank, Term Loan; interest payable quarterly (1.25% effective rate at December 31, 2011), due December 31, 2011 to December 30, 2014	WV	6,430	-
		<u>6,430</u>	<u>-</u>
Other long-term debt		3,259	4,567
		<u>431,073</u>	<u>441,366</u>
Less. current portion of long-term debt		17,141	16,679
Long-term debt, net of current portion		<u>\$ 413,932</u>	<u>\$ 424,687</u>

Series 2009 A and 2009 B

On June 30, 2009, the Indiana Finance Authority ("IFA") issued Adjustable Rate Hospital Revenue Bonds, Series 2009 A and 2009 B, in the aggregate amount of \$100,000 for the purpose of making a loan to CHI. The proceeds of this loan from IFA are available to finance, refinance or reimburse the costs of constructing, acquiring, renovating or equipping certain health facility property used by CHI. As credit support for the 2009 A and 2009 B bonds, the Network has two outstanding letters of credit with banks for a maximum aggregate principal draw amount of \$97,940 plus accrued interest as of December 31, 2011. The letters of credit expire for the 2009 A and 2009 B Series on May 29, 2013 and June 30, 2013, respectively. The Series 2009 A and Series 2009 B bonds are subject to redemption prior to their stated maturity at the option of CHI on a thirty day notice in whole or in part, at a redemption price equal to 100% of the principal amount plus interest at the date of redemption.

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

Series 2005A, 2005B and 2000C

On May 1, 2005, the Indiana Health Financing Authority, (the "Authority") issued Hospital Revenue Bonds, Series 2005A and Adjustable Rate Hospital Revenue Bonds, Series 2005B and 2005C, in the aggregate amount of \$190,320 for the purpose of making a loan to CHI. The proceeds of this loan from the Authority are available to finance, refinance or reimburse the costs of constructing, acquiring, renovating or equipping certain health facility property used by CHI. As credit support for the 2005B and 2005C bonds, the Network has two outstanding letters of credit with banks for a maximum aggregate principal draw amount of \$34,000 plus accrued interest as of December 31, 2011. The letters of credit expire May 4, 2013. The Series 2005A bonds maturing on or after May 1, 2016 are subject to redemption prior to their respective stated maturities, by the Authority, upon the direction of CHI at a redemption price equal to 100% of the principal amount plus accrued interest thereon to the date fixed for redemption. The Series 2005B and Series 2005C bonds are subject to redemption prior to their stated maturity at the option of CHI on a thirty day notice in whole or in part, at a redemption price equal to 100% of the principal amount plus interest at the date of redemption.

Series 2000A and 2000B

On November 1, 2000, the Authority issued Adjustable Rate Hospital Revenue Bonds, Series 2000A and 2000B, in the aggregate amount of \$40,000 for the purpose of making a loan to the Network. The proceeds of this loan from the Authority were available to finance, refinance or reimburse the costs of constructing, acquiring, renovating or equipping certain health facility property used by CHI. As of December 31, 2011, the outstanding letter of credit with the bank associated with this debt is the principal amount of \$38,000 plus accrued interest. The letter of credit expires May 29, 2013. The Series 2000A and 2000B bonds are subject to redemption at the option of CHI on a thirty day notice at a redemption price equal to 100% of the principal amount plus interest at the date of redemption.

Series 1997A and 1997B

On August 1, 1997, the Authority issued its Adjustable Rate Hospital Revenue Bonds, Series 1997A and Series 1997B in the aggregate amount of \$30,000 for the purpose of making a loan to the Network. The proceeds of this loan from the Authority were used for the financing of certain health facility property. As of December 31, 2011, the outstanding letter of credit with the bank associated with this debt is the principal amount of \$30,000 plus accrued interest. The letter of credit expires May 1, 2013. The Series 1997A and 1997B bonds are subject to redemption at the option of CHI on a thirty day notice at a redemption price equal to 100% of the principal amount plus interest at the date of redemption.

Series 1995

On November 15, 1995, the Authority issued \$75,050 of Hospital Revenue Refunding and Improvement Bonds (Series 1995 Bonds). Concurrent with the issuance of the bonds, the Network and the Authority entered into a loan agreement (the "Agreement") in which the Network agreed to make loan payments to meet the terms of the hospital revenue bonds. The Agreement restricts the amount of indebtedness that the Network may incur and provides to the Authority an interest in the Network's gross revenues sufficient to meet principal and interest obligations. The Series 1995 Bonds are callable in accordance with the provisions of the Agreement commencing May 15, 2006 at prepayment prices ranging from 102 percent to 100 percent of the principal outstanding.

In May 2007, CHI made a tender offer to existing 1995 Series Bondholders for a 102 percent tender price. At the end of the offer, CHI called and redeemed the remaining \$2,067 in bonds outstanding at a price of 101 percent.

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

A bank purchased the tendered bonds for par value. Simultaneously, CHI and the bank entered into an interest rate swap agreement (the "1995 swap"), the purpose of which was to synthetically convert the tendered bonds from a fixed rate to a variable rate based on the Securities Industry and Financial Markets Association Municipal Swap Index ("SIFMA") plus .30 percent. In September 2010, the 1995 swap was renewed and the variable rate is based on SIFMA plus 1.25 percent. The 1995 swap matures between July and September 2013. The variable rate at December 31, 2011 was 1.35%. The swap is a fair value hedge recognized on the consolidated balance sheets at its fair value with changes, as a result of ineffectiveness since inception, being recorded in interest expense. The swap is in place throughout the term of the outstanding bonds, but may be terminated by CHI or the bank with 30 and 180 days notice, respectively. Neither the terms nor conditions of the original bonds were altered in any way. The fair value and net gain associated with the 1995 swap were immaterial.

Series 1993, 1992, 1992A, and 1988A

With respect to the Series 1993, 1992, 1992A, and 1988A Hospital Revenue Bonds, there are loan agreements between CHI, CHA and the conduit issuing authorities with similar terms as described for the Series 1995 Hospital Revenue Bonds except the bonds are callable as follows: January 1, 2007 for Series 1993, May 1, 2002 for Series 1992; July 1, 2002 for Series 1992A; and January 1, 2001 for Series 1988A.

In February 2004, CHI made a tender offer to existing 1992 and 1992A Series Bondholders for a 102 percent tender price. At the end of the offer, CHI called and redeemed the remaining \$7,250 in bonds outstanding at a price of 101 percent.

A bank purchased the tendered bonds for par value. Simultaneously, CHI and the bank entered into an interest rate swap agreement (the "1992 swap"), the purpose of which was to synthetically convert the tendered bonds from a fixed rate to a variable rate based on the Bond Market Association Municipal Swap Index plus .40 percent. In September 2010, the 1992 swap was renewed and the variable rate is based on SIFMA plus 1.25 percent. The 1992 swap matures between January 2012 and September 2013. The variable rate at December 31, 2011 was 1.35%. The swap is a fair value hedge recognized on the consolidated balance sheet at its fair value with changes as a result of ineffectiveness since inception being recorded in interest expense. The swap is in place throughout the term of the outstanding bonds, but may be terminated by CHI or the bank with 30 and 180 days notice, respectively. Neither the terms nor conditions of the original bonds were altered in any way. The fair value and net gain associated with the 1992 swap were immaterial.

Term Loan

On December 29, 2011, Westview refunded its Hospital Authority of Marion County Adjustable Rate Demand Hospital Revenue Bonds, Series 2004 with a term loan financed through Fifth Third Bank ("Term Loan"). The Term Loan bears interest at the 30 day LIBOR rate plus 125 basis points adjusted monthly. Principal and interest payments are due quarterly with a final balloon payment of approximately \$5,250 due December 30, 2014. The Term Loan is secured by a general security agreement pledging Westview's assets and the unconditional guarantee by CHNW.

In general, the various Network debt agreements restrict the amount of indebtedness that the Network may incur, the sale, lease or other disposition of operating assets, and the acceptable investments of the trust funds. In addition, these agreements require a debt service ratio at the end of any fiscal year of at least 1.10. The Network was in compliance with all debt covenants at December 31, 2011.

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

Scheduled principal repayments on long-term debt are as follows:

2012	\$ 17,141
2013	16,694
2014	17,120
2015	17,137
2016	17,901
Thereafter	342,054
	<hr/> 428,047
Plus: unamortized premium, net	3,026
	<hr/> \$ 431,073

For 2011 and 2010, interest cost incurred and capitalized in connection with the construction of capital assets aggregated \$173 and \$129, respectively

8. Employee Benefit Plans

Defined Benefit and Other Postretirement Benefit Plans

The Network has defined benefit retirement plans covering substantially all employees of CHI, CHA, CHHS, IHH, and CBI. Effective December 27, 2010, all Network employees excluding CHA employees, are employed by CHNw and leased to the Network's respective subsidiaries and/or affiliates rather than being employed by individual employers. Effective with the adoption of the single Network employer on December 27, 2010, CHNw also became the sponsor for all of the Network's defined benefit and defined contributions plans, excluding the CHA plan

The Network's funding policy is to contribute the equivalent of the minimum funding required by the Employee Retirement Income Security Act of 1974, as amended. The benefits for these plans are based primarily on years of service and the 60-consecutive-month period of employment producing the highest total income. The measurement date for the Network's plan is December 31 except for the Replacement Plan which is January 1.

The CHNw Retirement Plan is a defined benefit plan. The provisions of this plan relate to all employees of CHNw, CHA, CHHS, IHH and CPI. These employees are eligible to participate in the plan after one year of eligible service as defined by the plan document. Participants are 100% vested after five years of service. Effective May 27, 2006, CHA froze the accrual of benefits and participation in the CHNw Retirement Plan and established its own 403(b) plan. Effective March 8, 2010, the CHNw Retirement Plan was amended to limit the maximum benefit that may be accrued by individuals who choose to remain participants in the CHNw Retirement Plan after March 7, 2010. Additionally, participants in the CHNw Retirement Plan were offered a onetime choice between continued participation in the CHNw Retirement Plan, and, if applicable, CHNw's 403(b) plan, or participation in the Network's 401(k) plan as of March 8, 2010. All participants who remained in the CHNw Retirement Plan and CHNw 403(b) plan as of March 8, 2010 ceased participation in those plans effective as of December 25, 2011 and began participation in the Network's 401(k) plan effective as of December 26, 2011. In conjunction with the freeze of benefits in the CHNw Retirement Plan, the Network recognized income of \$5,669 for the year ended December 31, 2011. CHNw made contributions to the plan of \$29,686 and \$4,981 during 2011 and 2010, respectively.

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

The Replacement plan is a defined benefit plan. The Network began accounting for the Replacement plan in 2011 and the fair value of the plan assets was \$11,395 at January 1, 2011. The defined benefit provisions of the plan apply to all employees of the Network hired prior to January 1, 1984. The plan was originally established on that date to provide such employees those benefits otherwise available under the Federal Insurance Contributions Act during the period January 1, 1981 to December 31, 1983 when the Network withdrew coverage of its employees under the Act. Pursuant to the Social Security Amendment Act of 1983, the Network reentered the Social Security system on January 1, 1984. As a result funding of the plan was terminated during 1985. If authorized by the Network's Board of Directors, each Replacement plan participant may elect to contribute to the plan an amount each pay period, subject to the maximum established by the Board of Directors. Such authorization was not granted during 2011 and 2010.

The Network also has other postretirement benefit plans covering substantially all of its employees, providing retirees' health insurance benefits for the same premium as the Network pays for active employees. The Network funds the plan on a cash basis.

Effect on Operations

The components of net periodic pension expense for defined benefit retirement plans and the postretirement benefit plan for the year ended December 31 were as follows:

	Pension Benefits		Postretirement Benefits	
	2011	2010	2011	2010
Service cost	\$ 6,846	\$ 7,459	\$ 278	\$ 292
Interest cost	25,903	24,467	129	123
Expected return on plan assets	(27,491)	(41,614)	-	-
Amortization of prior service cost, net	(6,527)	16,513	(107)	(91)
Net pension (income) expense	<u>\$ (1,269)</u>	<u>\$ 6,825</u>	<u>\$ 300</u>	<u>\$ 324</u>

Obligations and Funded Status

The change in benefit obligations, plan assets and funded status for the Network's defined benefit retirement plans are as follows:

	Pension Benefits		Postretirement Benefits	
	2011	2010	2011	2010
Change in benefit obligation				
Benefit obligation, beginning of period	\$ 480,453	\$ 499,450	\$ 2,334	\$ 2,290
Service cost	6,846	7,459	278	292
Interest cost	25,903	24,467	129	123
Amendments	-	(3,259)	-	-
Actuarial gain (loss)	75,682	(4,687)	877	(398)
Curtailment	-	(39,275)	-	-
Participant contributions	-	-	35	30
Expenses paid - actual	(177)	-	-	-
Benefits paid - actual	(16,300)	(14,587)	(75)	(3)
Benefit obligation, end of period	<u>\$ 572,407</u>	<u>\$ 469,568</u>	<u>\$ 3,578</u>	<u>\$ 2,334</u>

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

	Pension Benefits		Postretirement Benefits	
	2011	2010	2011	2010
Change in plan assets				
Fair value of plan assets, beginning of year	\$ 368,725	\$ 325,322	\$ -	\$ -
Actual return on plan assets	7,667	41,614	-	-
Contributions	29,686	4,981	75	3
Expenses paid - actual	(177)	-	-	-
Benefit paid - actual	(16,300)	(14,587)	(75)	(3)
Fair value of plan assets, end of year	\$ 389,601	\$ 357,330	\$ -	\$ -

	Pension Benefits		Postretirement Benefits	
	2011	2010	2011	2010
Reconciliation of Funded status				
Accrued pension cost	\$ (50,504)	\$ (81,458)	\$ (4,537)	\$ (4,277)
Prepaid pension asset (liability)	(132,302)	(30,779)	959	1,943
Funded status	(182,806)	(112,237)	(3,578)	(2,334)
Unrecognized net actuarial loss (gain)	132,726	37,219	(1,094)	(2,095)
Unrecognized prior service credit (cost)	(424)	(6,440)	135	152
Accrued pension cost	\$ (50,504)	\$ (81,458)	\$ (4,537)	\$ (4,277)

Accumulated Benefit Obligation

Selected information from the plans with accumulated benefit obligation in excess of plan assets at December 31, were as follows:

	Pension Benefits		Postretirement Benefits	
	2011	2010	2011	2010
Projected benefit obligation	\$ 572,407	\$ 469,568	\$ -	\$ -
Accumulated benefit obligation	\$ 572,407	\$ 469,144	\$ 3,578	\$ 2,334
Fair value of plan assets	\$ 389,601	\$ 357,330	\$ -	\$ -

Actuarial Assumptions

Weighted average assumptions used to determine benefit obligations as of December 31.

	Pension Benefits		Postretirement Benefits	
	2011	2010	2011	2010
Discount rate	4.61%	5.48%	4.61%	5.60%
Rate of compensation increase	0.00-3.50%	3.50%	-	-

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

Weighted average assumptions used to determine net periodic benefit cost for the years ended December 31:

	Pension Benefits		Postretirement Benefits	
	2011	2010	2011	2010
Discount rate	5.48%	5.93%	5.60%	5.44%
Rate of compensation increase	3.50%	3.50%	-	-
Expected long-term rate of return on plan assets	7.40-8.40%	7.60%	-	-

The expected long term rate of return assumes targeted allocations are maintained and returns fall within standard deviation derived from simulation of ten year range of returns on each plan's assets. The rate is reevaluated based on actual returns in the current period. The rate was 7.40-8.40% and 7.6% for 2011 and 2010, respectively.

Assumed Health Care Costs

In establishing the net periodic postretirement benefit expense and year end benefit obligation, a 7.0% and 9.0% annual rate of increase in per capital cost of covered health benefits was assumed for 2011 and 2010, respectively. The rate was assumed to decrease gradually to 4.5% and 6.0% over a 15-year period and an 18-year period for 2011 and 2010, respectively. Changing the assumed health care cost trend rates by one percentage point in each year would cause an incremental increase in the accumulated postretirement benefit obligation of less than \$472 and \$279 in 2011 and 2010, respectively. In addition, changing the assumed health care cost trend rates by one percentage point in each year would cause an incremental increase in the service cost and interest cost components of the net periodic post retirement benefit cost of \$67 and \$44 in 2011 and 2010, respectively.

Plan Assets

The weighted-average allocation of the defined benefit plans at December 31, 2011 and 2010, by asset category are as follows:

	Retirement Plan			Replacement Plan		
	2011		2010	2011		2010
	Target	Actual	Actual	Target	Actual	Actual
	Allocation	Allocation	Allocation	Allocation	Allocation	Allocation
Equity securities	41%	40%	42%	54%	51%	56%
Fixed income securities	35%	37%	37%	20%	23%	22%
Real estate	6%	6%	5%	7%	7%	6%
Other	18%	17%	16%	19%	19%	16%
Total	100%	100%	100%	100%	100%	100%

The plans are administered under a single investment policy statement, which outlines objectives and guidelines for supervising investment strategy and evaluating the investment performance for all investment assets of CHNw. The policy seeks to preserve principal, emphasizing long-term growth without undue exposure to risk. Investment performance return targets are based on consumer price, corporate bond and stock indexes as well as volatility standards (beta) and positive risk-adjusted performance (alpha). The plan fiduciaries oversee the investment allocation process, which includes selecting investment managers, setting long-term strategic targets and monitoring asset allocations. Target allocation ranges are guidelines, not limitations, and plan fiduciaries may occasionally approve allocations above or below a target range.

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

2010 Description	Fair Value Measurements at Reporting Date Using			
	2010	Level 1	Level 2	Level 3
Fixed income	\$ 132,872	\$ 36,644	\$ 96,228	\$ -
Equity - Domestic Large Cap	53,150	30,428	22,722	-
Equity - Domestic Small Cap	20,629	10,404	10,225	-
Equity - International	74,263	74,263	-	-
Hedge Fund of Funds	16,574	-	-	16,574
REITS/other	59,842	59,842	-	-
Total	<u>\$ 357,330</u>	<u>\$ 211,581</u>	<u>\$ 129,175</u>	<u>\$ 16,574</u>

2011 Description	Fair Value Measurements at Reporting Date Using			
	2011	Level 1	Level 2	Level 3
Fixed income	\$ 143,370	\$ 7,566	\$ 137,532	\$ -
Equity - Domestic Large Cap	62,945	32,720	30,225	-
Equity - Domestic Small Cap	19,467	9,546	9,921	-
Equity - International	74,120	74,120	-	-
Hedge Fund of Funds	18,031	-	-	18,031
REITS/other	71,668	71,668	-	-
Total	<u>\$ 389,601</u>	<u>\$ 195,620</u>	<u>\$ 177,678</u>	<u>\$ 18,031</u>

**Rollforward of
Level 3 Investments**

Balance as of January 1, 2010	\$ 16,255
Purchases	(750)
Investment gain-realized/unrealized	1,069
Balance as of December 31, 2010	<u>\$ 16,574</u>

Balance as of January 1, 2011	\$ 16,574
Replacement plan	540
Purchases	1,600
Investment gain-realized/unrealized	(683)
Balance as of December 31, 2011	<u>\$ 18,031</u>

Cash Flows

The Network expects to make a contribution of \$24,519 to the CHNw Retirement Plan in fiscal 2012. The Network expects to make a contribution of approximately \$60 to the CHNw Postretirement Plan in fiscal 2012.

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

Estimated Future Benefit Payments

Plan benefit payments, which reflect expected future service, are expected to be paid as follows:

	Pension Benefits	Postretirement Benefits
2012	\$ 18,047	\$ 60
2013	\$ 19,953	\$ 99
2014	\$ 21,652	\$ 131
2015	\$ 23,255	\$ 168
2016	\$ 24,849	\$ 220
2017-2021	\$ 148,001	\$ 1,741

Other

The Network sponsors defined contribution plans covering certain employees. As mentioned above, CHNw became the employer of all employees throughout the Network except for CHA and Westview. Effective with the adoption of the single employer on December 27, 2010, CHNw became the sponsor of all the Network's defined benefit and defined contributions plans except for the CHA and Westview plans. Employer contributions are made to these plans based on a percentage of employee compensation. The cost of the Network's defined contribution plans was approximately \$23,099 and \$18,701 for 2011 and 2010, respectively.

One of the defined contribution plans relates to VEI's profit sharing 401(k) plan, in which employees are eligible to participate immediately upon hire and after attaining 21 years of age. Effective January 1, 2011, VEI's plan was amended to remove the requirement that an employee must be 21 years of age to participate in the plan. Participants may contribute from 1% to 50% of compensation, as defined. Each year, VEI's Board of Directors may elect to match a portion of participant contributions through a discretionary profit sharing contribution.

IHH has a 401(k) plan, in which employees are eligible to participate immediately upon hire and after attaining 21 years of age. Participants may contribute from 1% to 100% of compensation, as defined. IHH matches 50% of participant contributions up to 5% of the participants' compensation.

CPI has a defined contribution profit sharing plan in which employees who are designated as CPI physicians and are paid on the compensation model are eligible to participate after the completion of one year of service. This plan is an employer funded plan whereby the funding is charged to the participating physician's practice as an overhead expense. The year ending December 31, 2009 was the final year that employer contributions were made to the plan. CPI terminated the plan effective December 31, 2009. CPI is in the process of distributing the assets of the plan.

CHA has a defined contribution 403(b) plan. Employees are eligible to participate immediately upon employment. Participants may contribute up to 100% of compensation, as defined. CHA is permitted to match 100% of participant contributions up to 3% of the participant's compensation. CHA elected to cease matching participant contributions effective May 10, 2009.

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

The Network has a 401(k) plan. Employees of the Network hired after February 9, 2008 are eligible to participate immediately upon employment. Participants may contribute up to 100% of compensation, as defined. The Network matches 100% of participant contributions up to 6% of the participant's compensation. Each year, the Network may elect to provide a discretionary employer contribution to plan participants.

Westview has a 401(k) plan. Employees are eligible to participate in the plan after completing more than one year of service, working 1,000 hours during the year and after attaining 21 years of age. Participants may contribute up to 100% of compensation, as defined. Westview provides funding rates of 5% of each eligible employee's compensation not in excess of the taxable wage base and 10% over the taxable wage base.

9. Income Taxes

For 2011 and 2010, federal taxable income originating in the Network's for-profit entities was approximately \$9,300 and \$12,000, respectively. Income tax (benefit) expense of (\$2,958) and \$4,991 respectively, has been provided thereon. The primary difference between income tax expense and taxes computed at the federal statutory rate of 34 percent is state income taxes and the recognition of income tax benefit on net operating loss carryforwards ("NOLs"). The recognition of NOLs was the result of the merger of Indiana ProHealth, Inc. into a subsidiary of VEI effective December 31, 2011.

At December 31, 2011, VEI has unused federal income tax operating loss carry forwards of approximately \$14,500, which expire at various dates through 2025.

10. Operating Leases

The Network leases certain of its facilities and equipment under noncancelable operating lease agreements. The leases contain various renewal options and clauses for escalation based on increases in interest costs, as defined. Rental expense for these leased facilities and equipment aggregated \$37,429 and \$31,635 for 2011 and 2010, respectively.

Future minimum rental payments for each of the next five years at December 31, 2011 are as follows:

2012	\$ 34,555
2013	28,821
2014	23,780
2015	17,614
2016	14,770
Thereafter	42,699
	<u>\$ 162,239</u>

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

11. Functional Expenses

The Network provides services to residents within its geographic locations. Expenses related to providing these services are as follows:

	2011	2010
Nursing services	\$ 261,971	\$ 301,598
Other professional services	457,608	395,886
General services	53,262	103,545
Fiscal services	164,615	159,693
Administrative services	144,047	100,276
Employee health and welfare	162,711	84,188
Health service claims expense	(40,071)	(16,119)
Depreciation and amortization	64,511	70,248
Provision for bad debts	1,209	1,684
Interest	13,202	12,554
	<u>\$ 1,283,065</u>	<u>\$ 1,213,553</u>

12. Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Network has been limited by donors to a specific time period or purpose. Temporarily restricted net assets as of December 31, 2011 and 2010 are available for the following purposes:

	2011	2010
Medical education	\$ 1,530	\$ 1,737
Clinical/patient support	719	641
Capital improvements	2,424	2,609
	<u>\$ 4,673</u>	<u>\$ 4,987</u>

Permanently restricted net assets have been restricted by donors to be maintained by the Network in perpetuity. Permanently restricted net assets as of December 31, 2011 and 2010 are as follows, with a description of how the investment income is to be used:

	2011	2010
Medical education	\$ 2,413	\$ 2,375
Clinical/patient support	209	196
Capital improvements	1,695	1,671
	<u>\$ 4,317</u>	<u>\$ 4,242</u>

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

The Network is an income beneficiary of certain irrevocable trusts. The aggregated income (loss) from these trusts was (\$175) and \$298 for the years ended December 31, 2011 and 2010, respectively.

13. Commitments and Contingencies

Community Hospital of Anderson and Madison County

On August 9, 1996, Community entered into an affiliation agreement with CHA. The agreement provides that if Community merges, affiliates, or is acquired by another health care organization, Community must deposit \$31,900 into a foundation to fund health care programs and initiatives in Madison County, Indiana.

Pending Litigation and Medical Malpractice Insurance Coverage

Claims for employment matters, medical malpractice and breach of contract have been asserted against the Network by various claimants, and provision for such claims is made in the financial statements when management considers the likelihood of loss from the contingency to be probable and reasonably estimable. The claims are in various stages of processing and some will ultimately be brought to trial. There are known incidents occurring through December 31, 2011 that may result in the assertion of additional claims, and other claims may be asserted arising from services provided to patients in the past.

The Network is in compliance with the Indiana Medical Malpractice Act which limits the amount of recovery to \$1,250 for individual malpractice claims, \$250 of which would be paid by the Network and the balance being paid by the State of Indiana Patient Compensation Fund. Management believes the ultimate disposition of existing medical malpractice and other claims will not have a material effect on the consolidated financial position or results of operations of the Network.

Purchase Commitments

As of December 31, 2011, the Network had purchase commitments for various equipment and services of \$29,240.

14. Acquisition

On August 1, 2011, the Network affiliated with Westview. No consideration was exchanged related to the affiliation. The affiliation was accounted for as an acquisition and thus purchase accounting rules were applied in accordance with ASC 958, *Not for Profit Entities: Mergers and Acquisitions* ("ASC 958"). The Network recognized the fair value of Westview's assets and liabilities in its consolidated financial statements as of August 1, 2011 using various fair value techniques, including independent appraisals for property, plant and equipment. The excess of the fair value of the assets received over the liabilities acquired represents an inherent contribution received and is recorded as the excess of net assets acquired in the accompanying consolidated financial statements. Westview's profit and losses are reflected in the Network's accompanying consolidated statement of operations from August 1, 2011 through December 31, 2011.

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

The fair value of the assets and liabilities acquired as of August 1, 2011 is as follows:

Cash and cash equivalents	\$ 5,192
Patient accounts receivable, net	8,259
Other current assets	1,127
Property, plant and equipment	34,262
Other long term assets	6,869
Total assets	<u>55,709</u>
Current liabilities	7,439
Long term debt	6,134
Total liabilities	<u>13,573</u>
Excess in fair value of net assets acquired	<u>\$ 42,136</u>

Included in the excess in fair value of net assets acquired is a contribution of \$7,500 made by the Network to Westview shortly before the affiliation. This was not considered part of the consideration transferred to Westview in accordance with applicable business combination guidance.

15. Community Benefits (unaudited)

The Network defines community benefit as a planned, managed, organized, and measured approach to a health care organization's participation in meeting identified community health needs, particularly of the poor and other underserved groups, by improving health status and quality of life.

The Network segregates its community benefits into benefits for the poor and benefits for the community.

Benefits for the poor include traditional charity and unpaid cost of Medicaid and other indigent care programs. Traditional charity care includes free or discounted health and health-related services provided to persons who cannot afford to pay. Unpaid cost of Medicaid and other indigent care programs represents the uncompensated cost of services provided to persons covered by public programs for the poor.

Benefits for the community include unpaid cost of Medicare and other community benefits. Unpaid cost of Medicare represents the uncompensated cost of services provided to persons covered by the Medicare program. Other community benefit represents activities or services to improve community health.

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements
December 31, 2011 and 2010

The net cost to the Network of providing benefits for the poor and the community is as follows:

	2011	2010
Benefits for the poor		
Traditional charity care	\$ 26,939	\$ 25,693
Unpaid cost of Medicaid and other indigent care programs	57,850	57,948
	<u>84,789</u>	<u>\$ 83,641</u>
Benefits for the community		
Unpaid cost of Medicare	107,273	101,615
Other community benefits	26,463	22,229
	<u>133,736</u>	<u>123,844</u>
Total community benefits	<u>\$ 218,525</u>	<u>\$ 207,485</u>

The benefits provided are measured at total cost net of any offsetting revenues or subsidy payments received. Charity care cost, unpaid cost of Medicaid and other indigent care programs and unpaid cost of Medicare were determined based on the application of the associated cost-to-charge ratios. Other community benefits represent actual costs.

Costs forgone for services and supplies furnished under the Network's uninsured discount policy approximated \$6,956 and \$5,417 for the years ended December 31, 2011 and 2010, respectively. Uninsured discounts represent a standard discount on charges as it relates to patients who have no insurance coverage. Uninsured discount cost was determined based on the application of the associated cost-to-charge ratios to charges.

Total community benefits were 17.12% and 17.10% of total operating expenses in 2011 and 2010, respectively.

Additional Consolidating Information



**Report of Independent Auditors
on Accompanying Consolidating Information**

To the Board of Directors of
Community Health Network, Inc.

The report on our audits of the consolidated financial statements of Community Health Network and affiliates, (the "Network") at December 31, 2011 and 2010 and for the years then ended appears on page 1 of this document. These audits were conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole. The consolidating balance sheets at December 31, 2011 and 2010 and the consolidating statements of operations and changes in net assets for the years then ended are presented for the purposes of additional analysis of the consolidated financial statements rather than to present the financial position and results of operations and changes in net assets of individual organizations. Accordingly, we do not express an opinion on the financial position, results of operations and changes in net assets of the individual organizations. However, the consolidating information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and, in our opinion, is fairly stated, in all material respects, in relation to the consolidated financial statements taken as a whole.

As discussed in Note 1 to the consolidated financial statements, the Network changed its presentation of revenues and provision for doubtful accounts as a result of the adoption of the amendments to the FASB Accounting Standards Codification resulting from Accounting Standards Update No. 2011-07, Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Healthcare Entities.

PricewaterhouseCoopers LLP

April 18, 2012

Community Health Network
Consolidating Balance Sheets (in 000's)
December 31, 2011

	Consolidated	Eliminations	CHI	CP1	CHA	VEI	Foundation	CHHS	ProHealth	TIHH	Westview	CHN	CHNW
Assets													
Current assets													
Cash and cash equivalents	\$ 84,305	\$ -	\$ 77,504	\$ 2,596	\$ 17,390	\$ 55,768	\$ 881	\$ 621	\$ 1,803	\$ 2,423	\$ 3,080	\$ 330	\$ 189
Restricted cash	2,851	(4,877)	14,244	9,953	8,676	8,418	-	4,588	-	21,343	7,098	-	-
Patent accounts receivable, net	85,422	-	8,952	-	2,452	-	-	-	-	-	-	-	-
Estimated third-party payor settlements	11,404	-	5,544	-	2,287	-	-	-	-	-	5,345	-	-
Assets limited as to use-held by trustee	3,176	-	10,634	-	2,306	4,569	-	336	-	3,631	545	-	-
Inventories	21,521	(834)	7,699	1255	67	4,945	150	94	3,804	120	327	68	-
Other accounts receivable	8,996	-	8,800	2,251	200	9,082	3	179	55	645	63	18	-
Other current assets	20,905	-	-	-	-	-	-	-	-	-	-	-	-
Total current assets	438,581	(5,511)	235,658	16,035	44,267	87,583	2,054	5,788	5,762	28,062	16,558	536	189
Assets limited as to use													
Funds held by trustee, net of current portion	13,642	-	13,642	-	-	-	-	-	-	-	-	-	-
Board-designated funds	401,235	-	335,853	-	33,800	32,500	-	-	-	-	40	-	-
Reinsurance trust assets	12,801	-	-	-	-	-	-	-	-	-	-	12,801	-
Property, plant and equipment, net	682,833	-	5,116,447	12,160	44,709	37,721	3,937	2,395	202	36,628	34,137	-	-
Investments in unconsolidated affiliates	20,278	(232,293)	207,875	-	326	3,723	-	-	-	-	403	-	40,183
Intangible assets, net of accumulated amortization	19,300	-	18,902	-	211	-	-	-	-	-	36	51	-
Due from unconsolidated affiliates and related parties	(672)	-	99,094	(92,265)	(2,435)	(1,644)	(2,609)	(2,318)	8,266	(4,442)	-	-	(32,759)
Prepaid pension and postretirement assets	959	-	959	-	-	-	-	-	-	-	-	-	-
Other assets	8,999	(3,119)	4,428	1023	-	5,656	566	140	-	243	547	-	-
Total assets	\$ 1,597,278	\$ (240,945)	\$ 1,425,863	\$ (23,067)	\$ 20,320	\$ 133,018	\$ 36,281	\$ (3,815)	\$ 14,230	\$ 60,481	\$ 52,281	\$ 8,388	\$ 9,223
Liabilities and fund balance													
Current liabilities													
Short-term borrowings	\$ 43,146	\$ -	\$ 29,846	\$ -	\$ -	\$ 13,500	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Current portion of long-term debt	17,141	-	14,325	-	2,014	21	-	-	-	50	731	-	-
Accounts payable	81,598	(634)	58,085	3,958	2,101	6,635	29	522	164	7,291	2,176	43	1208
Accrued salaries and wages	61,262	-	33,145	5,077	7,077	4,333	164	1570	-	7,100	2,776	-	-
Accrued interest	2,505	-	1,861	-	492	33	-	-	-	-	19	-	-
Estimated third-party payor settlements	3,537	-	855	-	431	-	-	11	-	2,008	401	-	-
Incurred but not reported	25,028	(4,877)	4,919	-	263	160	-	-	2,686	-	-	2,707	-
Pension underfunded liability	18,047	-	18,047	-	-	-	-	-	-	-	-	-	-
Other current liabilities	2,556	(3,119)	2,388	1,081	2,530	1,883	68	250	21	910	238	516	6,277
Total current liabilities	265,920	(6,622)	153,202	10,116	14,908	26,335	261	2,353	2,891	17,382	6,341	13,268	7,485
Accrued postretirement benefit cost	4,537	-	4,537	-	-	-	-	-	-	-	-	-	-
Accrued pension costs	52,471	-	38,888	-	-	1719	-	10,323	-	1,741	-	-	-
Long-term debt, net of current portion	419,332	-	391,639	-	16,593	-	-	-	-	23	5,777	-	-
Pension underfunded liability- long-term	14,255	-	14,255	-	-	-	-	-	-	-	-	-	-
Other liabilities	9,740	-	2,705	1045	-	-	-	-	-	5,990	-	-	-
Net assets													
Unrestricted net assets													
Network unrestricted net assets	715,695	(223,207)	704,873	(34,228)	88,819	90,368	27,010	(8,491)	1,339	35,355	40,163	20	1738
Noncontrolling interest	11,738	(9,032)	6,264	-	-	14,568	-	-	-	-	-	-	-
Total unrestricted net assets	727,433	(232,239)	711,137	(34,228)	88,819	104,936	27,010	(8,491)	1,339	35,355	40,163	20	1738
Temporarily restricted net assets	4,873	-	-	-	-	-	4,673	-	-	-	-	-	-
Permanently restricted net assets	4317	-	-	-	-	-	4,317	-	-	-	-	-	-
Total net assets	736,423	(232,239)	711,137	(34,228)	88,819	114,954	36,000	(8,491)	1,339	35,355	40,163	20	1738
Total liabilities and net assets	\$ 1,597,278	\$ (240,945)	\$ 1,425,863	\$ (23,067)	\$ 20,320	\$ 133,018	\$ 36,281	\$ (3,815)	\$ 14,230	\$ 60,481	\$ 52,281	\$ 8,388	\$ 9,223

Community Health Network
Consolidating Balance Sheets (in 000's)
December 31, 2010

	Consolidated	Eliminations	CHI	CPI	CHA	VEI	Foundation	CHHS	ProHealth	THH	Westview	CHN	CHNW
Assets													
Current assets													
Cash and cash equivalents	\$ 144,127	\$ -	\$ 57,637	\$ 1735	\$ 10,236	\$ 56,060	\$ 1436	\$ 1052	\$ 6,233	\$ 9,452	\$ -	\$ 285	\$ -
Restricted cash	2,400	-	2,400	-	-	-	-	-	-	-	-	-	-
Patient accounts receivable, net	75,904	(5,436)	12,801	8,108	22,551	11,952	-	5,405	-	22,093	-	-	-
Estimated third-party payor settlements	5,406	-	6,340	-	66	-	-	-	-	-	-	-	-
Assets limited as to use—held by trustee	9,530	-	7,306	-	2,224	-	-	-	-	-	-	-	-
Inventories	13,325	-	10,89	-	2,585	4,045	-	260	-	2,245	-	-	-
Other accounts receivable	13,300	(442)	7,409	79	92	6,107	1,023	53	3,845	43	-	91	-
Other current assets	10,684	-	7,045	1596	344	1065	106	106	62	468	-	85	-
Total current assets	385,676	(6,878)	211,27	11,548	37,898	78,630	2,472	6,878	10,140	34,301	-	562	-
Assets limited as to use													
Funds held by trustee, net of current portion	3,955	-	3,865	-	-	-	-	-	-	-	-	-	-
Board-designated funds	404,248	-	336,323	-	33,980	-	33,945	-	-	-	-	-	-
Reinsurance trust assets	118,18	-	-	-	-	-	-	-	-	-	-	116,18	-
Property plant and equipment, net	650,449	-	508,793	2,900	45,795	37,981	4,093	2,814	772	37,281	-	-	-
Investments in unconsolidated affiliates	13,394	(1,1205)	16,595	-	406	3,598	-	-	-	-	-	-	-
Intangible assets, net of accumulated amortization	7,475	-	7,108	-	268	-	-	-	-	-	0	49	-
Due from unconsolidated affiliates and related parties	1387	(31)	15,575	(36,776)	(2,623)	(3,662)	(3,250)	(9,776)	(12,935)	(29,750)	-	-	(5,445)
Prepaid pension and postretirement assets	1943	-	1943	-	-	-	-	-	-	-	-	-	-
Other assets	7,693	(15,18)	2,570	350	-	4,542	1,209	140	-	-	-	-	-
Total assets	\$ 1,504,386	\$ (59,832)	\$ 1,365,238	\$ (119,18)	\$ 15,774	\$ 121,089	\$ 38,469	\$ (366)	\$ (2,623)	\$ 41,832	\$ -	\$ 2,227	\$ (5,445)
Liabilities and fund balance													
Current liabilities													
Short-term borrowings	\$ 15,645	\$ -	\$ 5,116	\$ -	\$ -	\$ 10,500	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Current portion of long-term debt	15,679	-	13,738	-	1894	1000	-	-	-	47	-	-	-
Accounts payable	70,573	(473)	56,430	2,265	1831	6,184	74	631	-	3,988	-	43	-
Accrued salaries and wages	40,569	-	22,740	2,872	4,977	1,61	-	142	-	7,617	-	-	-
Accrued interest	2,770	-	2,700	-	549	31	-	-	-	-	-	-	-
Estimated third-party payor settlements	2,857	-	2,407	-	450	-	-	-	-	-	-	-	-
Inured but not reported	25,335	(6,436)	4,853	-	457	52	-	-	14,576	-	-	11,723	-
Other current liabilities	20,853	(15,18)	12,359	892	2,413	4,395	-	-	7	1264	-	341	-
Total current liabilities	\$ 97,932	(8,427)	\$ 10,870	\$ 5,829	\$ 12,551	\$ 28,413	\$ 74	\$ 2,043	\$ 14,583	\$ 12,116	\$ -	\$ 1,117	\$ -
Accrued postretirement benefit cost	4,277	-	4,277	-	-	-	-	-	-	-	-	-	-
Accrued pension costs	83,193	-	71,411	-	1770	1770	-	9,343	-	729	-	-	-
Long-term debt, net of current portion	424,687	-	405,884	-	18,609	21	-	-	-	73	-	-	-
Pension underfunded liability—long-term	30,779	-	30,779	-	-	-	-	-	-	-	-	-	-
Other liabilities	6,973	-	2,870	661	-	-	-	-	-	3,442	-	-	-
Net assets													
Unrestricted net assets													
Network unrestricted net assets	738,022	(44,794)	723,583	(8,408)	84,524	78,749	29,166	(11,952)	(7,205)	24,872	-	120	(5,445)
Noncontrolling interests	11,254	(9,274)	6,512	-	-	14,188	-	-	-	-	-	-	-
Total unrestricted net assets	\$ 747,316	\$ (51,205)	\$ 730,105	\$ (8,408)	\$ 84,524	\$ 92,945	\$ 29,166	\$ (11,952)	\$ (7,205)	\$ 24,872	\$ -	\$ 120	\$ (5,445)
Temporarily restricted net assets	4,987	-	-	-	-	-	4,987	-	-	-	-	-	-
Permanently restricted net assets	4,242	-	-	-	-	-	4,242	-	-	-	-	-	-
Total net assets	\$ 756,545	\$ (51,205)	\$ 730,105	\$ (8,408)	\$ 84,524	\$ 92,945	\$ 38,385	\$ (11,952)	\$ (7,205)	\$ 24,872	\$ -	\$ 120	\$ (5,445)
Total liabilities and net assets	\$ 1,504,386	\$ (59,832)	\$ 1,365,238	\$ (119,18)	\$ 15,774	\$ 121,089	\$ 38,469	\$ (566)	\$ (2,623)	\$ 41,832	\$ -	\$ 2,227	\$ (5,445)

Community Health Network

Consolidating Statements of Operations and Changes in Net Assets (in 000's)

December 31, 2011

	Consolidated	Eliminations	CHI	CPI	CHA	VEI	Foundation	CHHS	ProHealth	TIHI	Westview	CHN	CHNW
Revenues and gains													
Net patient service revenue	\$ 1,332,983	\$ -	\$ 811,217	\$ 87,835	\$ 126,269	\$ 89,691	\$ -	\$ 27,794	\$ -	\$ 161,299	\$ 24,898	\$ -	\$ -
Provision for bad debts	72,765	352	48,952	3,277	8,065	-	-	-	-	9,129	2,930	-	-
Net patient service revenue less provision for bad debts	1,260,198	(352)	762,265	84,558	118,204	89,691	-	27,794	-	152,170	21,908	-	-
Service fee revenue	21,519	(13,323)	-	-	-	33,710	-	-	-	-	-	1,336	-
Other revenue	66,064	(660,812)	59,928	1,134	7,818	35,281	2,756	159	34,236	4,483	2,357	580,308	-
Equity in earnings of unconsolidated affiliates	10,956	(7,601)	13,299	-	489	3,198	-	-	-	-	-	-	-
Total unrestricted revenues and gains	1,358,739	(682,290)	835,491	85,692	126,491	165,885	2,756	27,913	34,236	156,683	24,265	1,336	580,308
Operating expenses													
Salaries and benefits	725,372	(579,500)	324,019	93,825	73,489	49,427	886	21,745	-	81,869	15,318	-	844,734
Supplies and other expenses	478,771	(91,937)	264,221	28,386	40,106	89,600	1,944	7,511	27,697	47,235	9,438	1,754	61,806
Management services	-	-	81,986	5,963	343	5,042	676	1,534	6,076	9,544	-	-	(110,774)
Depreciation and amortization	64,511	-	42,357	4,481	6,114	4,994	(26)	671	18	4,367	1,335	-	-
Provision for bad debts	1,209	-	-	-	-	(25)	223	964	-	-	36	-	11
Interest and financing costs	13,202	(3,220)	11,536	-	1,344	426	-	27	-	2,965	124	-	-
Total operating expenses	1,283,065	(674,697)	724,129	132,005	121,398	140,464	3,703	32,452	33,791	145,983	26,251	1,754	585,777
Income (loss) from operations	75,674	(7,801)	111,362	5,095	5,095	25,422	(947)	(4,539)	445	10,683	(1,996)	(419)	(15,469)
Realized and unrealized (losses) gains on investments net	(16,386)	-	(14,555)	-	(801)	-	(1,448)	-	-	-	-	418	-
Excess of net assets acquired in Westview acquisition	34,635	-	-	-	-	-	-	-	-	-	-	-	34,635
Other, net	(10)	(6,710)	10,683	(11)	-	(1)	-	-	-	-	13	-	(1,984)
Excess (deficiency) of revenues over (under) expenses before income taxes	93,914	(15,311)	107,480	(46,384)	4,294	25,421	(2,395)	(4,539)	445	10,683	(1,972)	-	17,183
Provision for income taxes	(3,958)	-	(89)	-	-	(2,868)	-	-	-	-	-	-	-
Excess (deficiency) of revenues over (under) expenses	96,872	(16,311)	107,579	(46,384)	4,294	28,289	(2,395)	(4,539)	445	10,683	(1,973)	-	17,183
Less: Excess of revenue attributable to noncontrolling interest	(14,532)	7,501	(5,892)	-	-	(16,641)	-	-	-	-	-	-	-
Excess (deficiency) of revenues over (under) expenses attributable to the Network	81,940	(9,710)	101,687	(46,384)	4,294	11,648	(2,395)	(4,539)	445	10,683	(1,973)	-	17,183
Pension over/(under) funding	(102,507)	-	(102,507)	-	-	-	-	-	-	-	-	-	-
Change in noncontrolling interest	444	322	(248)	-	-	370	-	-	-	-	-	-	-
Other changes, net	240	(72,700)	(18,100)	30,564	1	-	239	-	18,100	-	42,135	-	-
Increase (decrease) in total unrestricted net assets	(19,883)	(61,089)	(19,169)	(15,820)	4,295	12,019	(2,165)	(4,539)	18,545	10,683	40,163	-	17,183
Change in temporarily restricted net assets													
Restricted contributions received	1,383	-	-	-	-	-	1,383	-	-	-	-	-	-
Net assets released from restrictions	(1,522)	-	-	-	-	-	(1,522)	-	-	-	-	-	-
Investment income	(179)	-	-	-	-	-	(175)	-	-	-	-	-	-
Increase (decrease) in temporarily restricted net assets	(314)	-	-	-	-	-	(314)	-	-	-	-	-	-
Change in permanently restricted net assets													
Restricted contributions received	77	-	-	-	-	-	77	-	-	-	-	-	-
Other	(2)	-	-	-	-	-	(2)	-	-	-	-	-	-
Increase in permanently restricted net assets	75	-	-	-	-	-	75	-	-	-	-	-	-
Increases (decreases) in total net assets	(20,122)	(61,089)	(19,168)	(15,820)	4,295	12,019	(2,395)	(4,539)	18,545	10,683	40,163	-	17,183
Total net assets, beginning of year	765,545	(151,205)	730,105	(19,409)	84,524	92,845	38,395	(11,952)	(17,208)	24,672	-	120	(15,445)
Total net assets, end of year	\$ 736,423	\$ (232,293)	\$ 710,937	\$ (34,228)	\$ 88,819	\$ 104,864	\$ 36,000	\$ (16,491)	\$ 1,339	\$ 35,355	\$ 40,163	\$ 120	\$ 1,738

Community Health Network

Consolidating Statements of Operations and Changes in Net Assets (in 000's)

December 31, 2010

	Consolidated	Eliminations	CHI	CPI	CHA	VEI	Foundation	CHHS	ProHealth	TIHH	Westview	CHN	CHNW
Revenues and gains													
Net patient service revenue	\$ 123,955	\$	\$ 730,863	\$ 82,073	\$ 93,254	\$ 87,961	\$ -	\$ 29,988	\$ -	\$ 149,895	\$ -	\$ -	\$ -
Provision for bad debts	63,595	3,355	40,907	2,550	11,635	-	-	-	-	5,529	-	-	-
Net patient service revenue less provision for bad debts	149,550	(3,355)	689,456	79,523	12,169	87,961	-	28,988	-	144,367	-	-	-
Service fee revenue	23,987	(24,341)	-	-	-	45,437	-	-	-	-	-	2,871	-
Other revenue	69,936	(89,864)	46,052	540	8,028	3,197	2,731	239	55,939	2,762	0	-	9,392
Equity in earnings of unconsolidated affiliates	5,062	(7,124)	8,353	-	406	4,387	-	-	-	-	-	-	-
Total unrestricted revenues and gains	1258,535	(12,146)	754,401	80,454	28,053	85,702	2,731	29,237	55,939	147,219	-	2,871	9,392
Operating expenses													
Salaries and benefits	652,252	(11,789)	280,788	81,358	71,503	58,481	751	20,285	-	80,791	-	-	70,082
Supplies and other expenses	466,915	(95,811)	252,911	26,178	45,709	74,372	2,154	7,778	50,222	43,899	-	3,359	60,324
Management services	-	-	81,996	5,104	343	4,922	676	1534	6,073	9,544	-	-	(10,192)
Depreciation and amortization	70,248	-	43,741	2,046	6,955	4,948	70	575	6	5,765	-	-	-
Provision for bad debts	1684	-	-	-	-	452	174	124	-	-	-	-	(85)
Interest and financing costs	12,554	(3,371)	10,889	-	1,455	439	-	31	-	3,100	-	-	-
Total operating expenses	1218,553	(114,350)	585,325	113,596	225,986	143,674	3,825	31,435	56,333	143,219	-	3,359	20,198
Income (loss) from operations	44,982	(7,124)	68,076	(33,232)	(2,067)	25,068	(1,094)	(2,201)	(374)	4,000	-	(488)	(17,805)
Realized/unrealized (losses) gains on investments, net	5,160	-	43,148	-	3,896	-	4,336	-	-	-	-	488	-
Other, net	630	(4,000)	4,000	(28)	-	588	-	22	74	-	-	-	34
Excess (deficiency) of revenues over (under) expenses before income taxes	97,320	(11,244)	116,224	(33,260)	5,763	26,578	3,242	(2,179)	(300)	4,000	0	-	(17,722)
Provision for income taxes	4,991	-	-	-	-	4,991	-	-	-	-	0	-	-
Excess (deficiency) of revenues over (under) expenses	92,329	(11,244)	116,224	(33,260)	5,763	21,587	3,242	(2,179)	(300)	4,000	0	-	(17,722)
Less: Excess of revenues attributable to noncontrolling interest	(8,052)	7,124	(5,509)	-	-	(14,557)	-	-	-	-	-	-	-
Excess (deficiency) of revenues over (under) expenses attributable to the Network	79,277	(4,000)	110,715	(33,260)	5,763	7,030	3,242	(2,179)	(300)	4,000	-	-	(17,722)
Pension over/(under) funding	57,268	-	57,268	-	-	-	-	-	-	-	-	-	-
Change in noncontrolling interest	(860)	2,815	(462)	-	(3,274)	-	-	-	-	-	-	-	-
Other changes, net	363	(30,712)	-	30,712	-	-	222	(22)	1	-	-	-	62
Increase (decrease) in total unrestricted net assets	35,048	(31,898)	68,521	(2,548)	5,763	3,004	3,484	(2,201)	(255)	4,000	-	-	(10,560)
Change in temporarily restricted net assets													
Restricted contributions received	865	-	-	-	-	-	865	-	-	-	-	-	-
Net assets released from restrictions	(1529)	-	-	-	(1529)	-	-	-	-	-	-	-	-
Investment income	298	-	-	-	-	-	298	-	-	-	-	-	-
Increase (decrease) in temporarily restricted net assets	(366)	-	-	-	-	-	(366)	-	-	-	-	-	-
Change in permanently restricted net assets													
Restricted contributions received	\$ 55	- \$	- \$	- \$	- \$	- \$	\$ 55	- \$	- \$	- \$	- \$	- \$	- \$
Other	(1)	-	-	-	-	-	(1)	-	-	-	-	-	-
Increase in permanently restricted net assets	14	-	-	-	-	-	14	-	-	-	-	-	-
Increase (decrease) in total net assets	15,826	(3,896)	16,521	(2,548)	\$ 763	3,804	3,242	(2,201)	(289)	4,000	-	-	(10,560)
Total net assets, beginning of year	620,710	(18,205)	553,584	(5,960)	78,761	89,141	35,523	(9,751)	(8,907)	20,672	120	120	(4,895)
Total net assets, end of year	\$ 766,545	\$ (5,205)	\$ 730,105	\$ (8,408)	\$ 84,524	\$ 92,945	\$ 38,395	\$ (11,952)	\$ (7,206)	\$ 24,672	\$	\$ 120	\$ (5,445)

REVIEW/REVISION

DATE ACTION

12/13/05 Revised Section 4.1
02/03/06 Revised Section 3.5
06/16/06 Delete Section 1.11.5
11/01/06 Addition Section 3.9-3.12
01/15/07 Addition Section 6
01/29/07 Revised Section 3.5
03/29/07 Delete Attachment C and Section 1.11.3
01/29/08 Update Poverty Guidelines
02/12/08 Addition Section 3.3
02/02/09 Update Poverty Guidelines and 1.16.1
11/05/10 Revised
05/22/11 Revised 2.2 (5) Discount for deductible, co-payment and/or co-insurance

TITLE: FINANCIAL ASSISTANCE POLICY

EFFECTIVE DATE: 04/01/06

REPLACES: ADM B – 004
ADM B – 004A

TO BE READ WITH: Net.Finance – 001: Definitions

PURPOSE: To document the specific, Community Health Network, Financial Assistance Policy. To ensure policy and procedures exist for identifying those patients for whom service is to be rendered free of charge, or at a discount, based solely on ability to pay, financial condition and availability of third party funding. To clearly differentiate those patients eligible for Financial Assistance, based on established guidelines, from those patients with financial resources who are unwilling to pay.

PHILOSOPHY: Community Health Network, in keeping with its mission, serves the medical needs of the community, regardless of race, creed, color, sex, national origin, sexual orientation, handicap, residence, age, ability to pay, or any other classification or characteristic. We recognize the need to render care to the sick who do not possess the ability to pay. Medically Necessary health care services will be provided to these patients with no expected reimbursement, or at a reduced level of reimbursement, based upon established criteria, recognizing the need to maintain the dignity of the patient and family during the Process. We expect all Responsible Parties with the ability to pay, to meet their financial obligations in a timely and efficient manner, in accordance with our collection policies. The amount of free or discounted care considered will be reviewed and approved without jeopardizing our continued financial viability.

POLICY STATEMENT:

1. POLICY:

1.1 Provision of Financial Assistance

Annually, we will establish a percentage of total consolidated operating expenses for Financial Assistance as a component of the larger category of Community Benefits. Further, we will monitor our ratio of Community Benefit cost to total consolidated operating expense and benchmark against pre-determined components of the applicable market with a goal of providing Community Benefits in total at a ratio better than average within the applicable market served.

1.2 Non-discrimination.

We will render services to our patients who are in need of Medically Necessary Services regardless of the ability of the Responsible Party to pay for such services. The determination of full or partial Financial Assistance will be based on the ability to pay and financial condition and will not be based on race, creed, color, sex, national origin, sexual orientation, handicap, residence, age, or any other classification or characteristic.

1.3 Available Services

All available Medically Necessary health care services, inpatient and outpatient, will be available to all individuals under this Policy.

1.4 Determination of Eligibility.

The determination of eligibility for Financial Assistance should be made before providing services. If complete information on the patient's insurance or the Responsible Party's financial situation is unavailable prior to rendering services or at the time of services, or if the Responsible Party's financial condition changes, or if the patient requires Emergency Services, the determination of eligibility will be made after rendering services. All efforts will be made to establish eligibility for Financial Assistance before the patient leaves the facility/first patient visit concludes.

Notwithstanding the foregoing, in keeping with the Emergency Medical Treatment and Labor Act (EMTALA), as amended from time to time, no determination of eligibility will be attempted until after an appropriate medical screening examination and necessary stabilizing treatment have been provided.

1.5 Confidentiality:

The need for Financial Assistance may be a sensitive and deeply personal issue for the patient/family. Confidentiality of information and preservation of individual dignity will be maintained for all who seek Financial Assistance. Orientation and training of staff and the selection of personnel who will implement this Policy and procedure will be guided by these values. No information obtained in the Financial Assistance application may be released unless the patient/Responsible Party gives express written permission for such release.

1.6 Staff Information:

All employees in patient registration, Billing, collections, patient accounting, finance and Emergency Services areas will be fully versed in the Financial Assistance Policy, have access to the application forms, and be able to direct questions to the appropriate staff member(s).

1.7 Staff Training:

All staff with public and patient contact will be trained to understand the basic information related to the Financial Assistance Policy and will provide Responsible Parties with printed material explaining the Financial Assistance program.

1.8 Financial Assistance Representative:

Each corporation will designate an individual to approve Financial Assistance applications, coordinate outreach efforts and oversee Financial Assistance practices.

1.9 Financial Assistance Appeals Committee:

Each corporation will establish a Financial Assistance Appeals Committee or process that provides for at least three (3) members, excluding the Financial Assistance Representative, to review appeals from those whose applications have been denied or which do not provide for a level of Financial Assistance to which the Responsible Party believes he/she is eligible.

1.10 Physician Participation:

We will encourage and support physicians with admitting privileges and others who provide services to our patients to establish and implement Financial Assistance programs for the patients they see in connection with services rendered by us.

1.11 Notification:

1.11.1 Posters and Brochures:

A notice (Attachment A) of the availability of Financial Assistance will be posted in each patient registration and waiting area. Brochures (Attachment B) explaining the Financial Assistance program will be placed in each patient registration and waiting area. In the case of services rendered in the home, the brochure 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.

1.11.2 Oral Notification:

Every Responsible Party will be told that we have a Financial Assistance program in the appropriate language during any pre-admission, registration, admission or discharge Process.

1.11.3 The front of each Past Due Notice (first, second and third) will substantially meet the contents and language in Attachments C through E

1.11.4 "About Your Bill: Frequently Asked Questions." One is for those with a Third Party Payer and one is for those without a Third Party Payer. Copies of these documents will be available in patient registration areas and through the Business Offices and Patient Financial Counselors. These documents will substantially meet the content and language set forth in Attachment F.

1.11.5 We will make available a notice titled "Registering For Services: What You Need To Know". This notice will be available in patient registration areas and through the Business Offices and Patient Financial Counselors. This document will substantially meet the content and language set forth in Attachment G.

1.12 Uniformity

This Policy applies to all Community Health Network corporations that provide health care items and services to patients as adopted by the applicable Boards of Directors.

1.13 Reporting:

Reporting of Financial Assistance shall be in accordance with all applicable laws, rules and regulations including Indiana Code 16-21-9-7, as amended and recodified from time to time. Such report will be made available to the public upon request.

1.14 Corporate Responsibility.

Each corporation's principal executive officer or officers and the principal financial officer or officers, or persons performing similar functions, will certify in each annual report, that the signing officer has reviewed the report and based on the officer's knowledge, the report does not contain any untrue statements of a material fact or omits to state a material fact

1.15 Accounting:

Accounting for Financial Assistance will be in accordance with the Community Benefits Accounting Policy.

1.16 Internal Record Keeping:

1 16.1 Application for Financial Assistance:

The completed applications will be kept on file for at least five (5) years. A copy of the application and all correspondence regarding the application, approval, denial and/or appeal will be maintained in the patient's financial file.

All debt discharged shall be recorded in a manner in keeping with the resources available to each corporation/business unit and in a manner that permits access to such information for record keeping, reporting and analysis purposes.

1 16.2 Automatic Discounts for the Uninsured:

All automatic discounts for the Uninsured will be coded specifically as an "automatic discount for the Uninsured" in a manner in keeping with the resources available to each corporation/business unit and in a manner that permits access to such information for record keeping, reporting and analysis purposes.

1 16.3 Prohibition on Medical Record Documentation:

No records will be placed in or notations made in a patient's health (medical) record regarding financial matters, including whether the patient paid all or part of any medical Bill.

2. UNINSURED PATIENTS: CRITERIA TO BE ELIGIBLE FOR DISCOUNTS AND DISCOUNT AMOUNTS:

2.1 Patients who are Uninsured are automatically eligible for a discount from gross Charges. Such discount shall be applied to the patient's Bill as early in the Billing Process as possible. The Responsible Party will be provided with a notice that such discount has been applied which will be sent with the Statement. (See Attachment F, "About Your Bill: Frequently Asked Questions for Self-pay Patients")

2.2 Discounts from gross Charges for the Uninsured shall be as follows:

2.2.1 Gallahue Mental Health Center: In accordance with the Center's sliding scale discount policy as a grant funded business unit.

2.2.2 Community Family Practice: In accordance with the Practice's sliding scale discounts as a service partially funded by the Indiana Health Coverage Program (Medicaid) and Medicare.

2.2.3 Community Physicians of Indiana: Twenty percent (20%)

2.2.4 Hospitals: Thirty percent (30%), except/and as follows

- 2.2.4.1 Infertility/Related Services: Zero percent (0%) (1)
- 2.2.4.2 Cosmetic Surgery/Related Services: Zero percent (0%) (1)
- 2.2.4.3 Bariatric Surgery/Related Services: Zero percent (0%) (1)
- 2.2.4.4 MedCheck Services: Twenty percent (20%) with payment at time of service
- 2.2.4.5 Maternity Care Center: Thirty percent (30%)
- 2.2.4.6 Hook Rehabilitation Center: Thirty percent (30%)
- 2.2.4.7 SNF Units: Thirty percent (30%)
- 2.2.4.8 Community Health Network Employees Eligible for Discounts: in accordance with our Human Resources policies.
- 2.2.4.9 Physicians' Billing Service For Amounts Owned by Network: Twenty-percent (20%) with the exception of FMC and WCC residency programs
- 2.2.4.10 Community Business Innovations: Zero percent (0%)
- 2.2.4.11 Community Home Health Services: Thirty percent (30%)
- 2.2.4.12 Community Long Term Care: Zero percent (0%) (2)

(1) This policy (2.2) does not apply to these services because these services are packaged priced which already includes a discount.

(2) This policy (2.2) does not apply to Community Long Term Care because it has its own Board adopted policy regarding patients without insurance.

(3) This policy (2.2) does not apply to any portion of deductible, co-payment and/or co-insurance amounts regardless of the type of insurance policy and whether or not that policy is primary, secondary or tertiary.

- 2.3 When an Uninsured patient has been given a discount on an account(s) under this policy and the patient subsequently qualifies for free care for those accounts, total charges will be applied to the traditional charity care component of Community Benefit.

- 2.4 If we have extended a discount to the Uninsured patient and subsequently determine that third party funding is available, the discount may be reversed and the funding source Billed at full Billed Charges
- 2.5 While this policy provides for discounts from Charges for services that are excluded services under a patient's benefit plan and for Charges for services that are above the benefit limits of the patient's benefit plan, we have no obligation to extend such discounts unless we know in advance of the provision of services or the Responsible Party contacts us following the provision of services regarding payment for those services.

3. CRITERIA FOR ELIGIBILITY FOR FREE CARE:

- 3.1 In order to be eligible for free care or discharge of debt under this Policy the patient must be a U.S. citizen or a legally residing non-citizen.
- 3.2 Requests for consideration of discharge of debt may be proposed by sources other than the Responsible Party, such as the patient's physician(s), family members, community or religious groups, social services organizations, or Network personnel. We will inform the Responsible Party of such a request and it will be processed as any other such request.
- 3.2 The Responsible Party must complete an application (Attachment H), provide all requested information in a timely manner, fully participate in and cooperate with the Process and meet the eligibility requirements.
- 3.3 In an effort to screen 100% of patients for potential charity care eligibility, Community Hospital East, Community Hospital North, Community Hospital South and The Indiana Heart Hospital utilizes data from trusted third-party vendors to automatically estimate the financial condition of each patient. This data is collected from multiple sources using multiple methodologies including predictive modeling to maximize the accuracy of these financial estimates. To accomplish these tasks, the aforementioned hospitals use technology from MedeAnalytics; a leading provider of analytics software, based in Emeryville, CA. The MedeAnalytics platform enables the Community Health Network to automatically gather financial and demographic information for each patient from third-party data vendors including Axiom Corporation and Equifax, Inc. Each of these vendors provides an estimation of household size and income required to calculate federal poverty level.

Axiom Corporation aggregates census information, public records and self reported information to estimate the financial conditions of consumer households. Equifax, Inc. uses a different methodology based on available credit balances and monthly credit obligations to estimate income and household size. Each of these data vendors use sophisticated predictive modeling techniques to increase the accuracy of these estimates based on millions of historical records.

On a daily basis, all accounts with balances due from the patient (Inpatient and Outpatient) are checked against these third-party databases automatically, and segmented based on Federal Poverty Level and the specific guidelines of the Community Health Network financial assistance program. This approach is consistently applied, leveraging automated analytics technology, in an unbiased fashion to all accounts.

Patients who are very likely to qualify for financial assistance, based on third-party Federal Poverty Level estimates, receive a charity care adjustment according to Community Health Network charity care guidelines. Patients at higher Federal Poverty Level thresholds have the opportunity to complete a financial assistance application and meet with a financial counselor to determine payment and assistance options. This approach enables the Community Health Network to efficiently serve the community while using a consistent approach to identifying all patients with a need for financial assistance.

- 3.4 A Responsible Party's debt under this Policy includes gross or discounted Charges, and Charges for services not covered by a third party payer including deductible, co-payment and co-insurance amounts, and amounts for non-covered services including amounts for services beyond the benefit limits of the third party coverage
- 3.5 For discharge of one-hundred percent (100%) of debt, the Responsible Party has a family income level at or less than two-hundred percent (200%) of the Federal Poverty Guidelines, as adjusted by the Federal Government from time to time, **and** no other financial resources from which to make payment. As of August 10, 2010, two-hundred percent (200%) of the Federal Poverty Guidelines is as follows.

Family Size	Monthly Income	Annual Income
1	\$1,805	\$21,660
2	2,428	29,140
3	3,052	36,620
4	3,675	44,100
5	4,298	51,580
6	4,922	59,060
7	5,545	66,540
8	6,168	74,020

For each additional person, add \$7,480 annually.

- 3.6 Determining financial eligibility. We will determine eligibility using the Official Measure of Poverty published by the Census Bureau as adjusted from time to time.
 - 3.6.1 Family Size is as follows:

- 3.6.1 1 When the patient is a non-emancipated minor: biological mother and father and/or step parent(s) if child is adopted and all persons on the tax return(s), filer(s) and dependents of same; or, in the event that that another person not listed herein signed for financial responsibility, the person who signed plus the spouse and all dependents on that person(s) tax return(s).
- 3.6 1 2 When the patient is not a minor or is an emancipated minor: the patient, the spouse and the dependents of same on the tax return(s) of the patient and/or spouse; or, in the event that another person not listed herein signed for financial responsibility, the person who signed plus the spouse and all dependents on that person(s) tax return(s)
- 3.6.2 Family Income is that of those listed in Section 3.6.1 above as applicable.
- 3.6.3 Income includes total annual cash receipts before taxes from the following sources: Money income including earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, including that of the Responsible Party not residing with the patient, and other miscellaneous sources.
- 3.6.4 Income does not include the following: Non-cash benefits (such as food stamps and housing subsidies), and capital gains or losses.
- 3.6.5 Living expenses are not subtracted to determine income
- 3.7 We will assume that a Responsible Party who has filed bankruptcy and whose debts to us have been fully or partially discharged by the Court have met the criteria necessary for us to write-off the discharged debt to Charity Care.
- 3.8 We will assume that a deceased patient with no estate and with no other Responsible Party for payment has met the criteria necessary for us to write-off the discharged debt to Charity Care.
- 3.9 We will assume a homeless patient, with no evidence of assets through communication with the patient, credit reports and other appropriate means and with, to the best of our knowledge, no Responsible Party, financial assistance from a Government Benefit Plan or Government Sponsored Health Care for the Indigent for payment, has met the criteria necessary to write-off discharged debt to Charity Care
- 3.10 We will assume a patient whom we know to be an illegal alien, with no evidence of assets through communication with the patient, credit reports and any other appropriate means, who refuses to cooperate with us in applying for governmental

payment and/or with, to the best of our knowledge, no Responsible Party, financial assistance from a Government Benefit Plan or Government Sponsored Health Care for the Indigent for payment, has met the criteria necessary to write-off discharged debt to Charity Care.

- 3.11 With the exception of accounts already submitted to a collection agency, current debt on accounts not yet submitted to a collection agency and debt incurred on and between the initial date of application and the date of approval and within ninety (90) days following the date of approval will be subject to the terms of the approval or denial.

With respect to accounts already submitted to a collection agency: If the collection agency has not yet incurred attorney fees and/or court costs, the charges will be written-off to Charity Care. If the collection agency has incurred attorney fees and/or court costs and the application has been approved, the amount payable by the Responsible Party for health care services will be written-off to Charity Care. The Responsible Party will remain financially responsible for payment of the attorney fees and/or court costs.

- 3.12 When a Medicaid patient is admitted for in or outpatient services and has unpaid accounts for dates of service within ninety (90) days prior to the patient's Medicaid effective date; and to the best of our knowledge, there is no Responsible Party, financial assistance from a Government Benefit Plan or Government Sponsored Health Care for the Indigent for payment, we will assume the patient has met the criteria necessary to write-off the discharged debt to Charity Care.
- 3.13 If a patient has made a payment(s) on his/her account(s) and subsequently qualifies for free care for those account(s), we are not obligated to refund the payments made because the patient demonstrated the ability to make payment as evidenced by the payment having been made.

4. OTHER DISCHARGE OF DEBT

- 4.1 Responsible Parties who do not qualify for Financial Assistance under 3 above, and have medical/dental debt equal to or greater than twenty-five percent (25%) of annual income, as set forth on the Financial Assistance Application and determined through the Financial Assistance Application process, may be given a discount based on the totality of their circumstances. The amount of the discount will be at the discretion of the Financial Assistance Representative.
- 4.2 Responsible Parties who do not qualify for Financial Assistance under 3 and 4.1 above and whose debt to us exceeds their ability to pay, we may discount the Charges. The determination of ability to pay and the amount of the discount will be at the discretion of the Financial Assistance Representative.

Note: Sections 3.0 and 4.0 above are not applicable to Community Home Health Services and Community Long Term Care because they have their own Board adopted policies

5. OTHER FINANCIAL ASSISTANCE

At the discretion of the Financial Assistance Representative we may pay health insurance premiums, including COBRA premiums, to assist the patient in maintaining health insurance coverage so long as the patient is receiving services from us which are covered services under the patient's benefit plan

6. SPECIFIC BUSINESS UNIT EXCEPTIONS:

Notwithstanding the foregoing, certain Business Units within the Network are exempted from the provisions of Sections 3, 4 and 5 herein above due to the unique nature of that Business Unit. Set forth below are the Business Units and their specific financial assistance policy.

- 6.1 **MedChecks:** MedCheck accounts subject to Financial Assistance shall be limited to those for services rendered by MedCheck which are reasonably related to the hospital services for which Financial Assistance has been granted.

7. APPLICATION AND APPEALS PROCESS

7.1 APPLICATION PROCESS

- 7.1.1 An application and financial statement for Financial Assistance will be provided to any requesting party. This may be done in person or by mail. (Attachments H and I)
- 7.1.2 Assistance in completing the application will be offered and provided to the Responsible Party.
- 7.1.3 The Responsible Party ("applicant") will have fifteen (15) calendar days following the Initial Date of Request on the application to complete and return the application. The applicant may request an extension of fifteen (15) calendar days for good cause and such extension shall not be unreasonably denied. Failure to return a complete application within said fifteen (15) days or, if extended, thirty (30) days will result in denial of the application and no discharge of debt.
- 7.1.4 Upon receipt of a complete application, it will be approved or denied within thirty (30) business days following the date of receipt and the applicant, and the physician if appropriate, will be notified, by telephone, certified mail or regular mail with an assumption of receipt five (5) days following the date mailed, of the result, including the amount of debt to be discharged and, if any, the amount of the remaining debt and due date, no later than the next business day.

- 7.1.5 With the exception of accounts already submitted to a collection agency, current debt on accounts not yet submitted to a collection agency and debt incurred on and between the initial date of application and the date of approval and within ninety (90) days following the date of approval will be subject to the terms of the approval or denial.

With respect to accounts already submitted to a collection agency: If the collection agency has not yet incurred attorney fees and/or court costs, the charges will be written-off to Charity Care. If the collection agency has incurred attorney fees and/or court costs and the application has been approved, the amount payable by the Responsible Party for health care services will be written-off to Charity Care. The Responsible Party will remain financially responsible for payment of the attorney fees and/or court costs

- 7.1.6 The applicant will be given or mailed a copy of the application or a letter indicating approval or denial and, if approved, the amount of debt discharged, any balance due and the date due.

- 7.1.7 The applicable accounts will be adjusted.

8. APPEALS PROCESS

- 8.1 If the application is denied or the amount of debt to be discharged is unsatisfactory, or financial conditions have changed, the applicant may appeal the decision.
- 8.2 The appeal must be in writing and include the basis for the appeal.
- 8.3 The appeal must be received within fifteen (15) business days following the date the applicant received the decision. For purposes of this process, submission of additional information does not require review by the appeals committee.
- 8.4 The appeals committee will convene and make a decision within fifteen (15) business days following receipt of the appeal.
- 8.5 No later than five (5) business days later, the applicant, and physician if appropriate, will be notified of the results by telephone and by certified mail or regular mail with an assumption of receipt five (5) days following the date mailed. If the debt to be discharged has changed, the notice will include the total debt to be discharged and, if any, the balance due and date due.
- 8.6 The decision of the appeals committee will be final but does not preclude the filing of a new application for debt not subject to the application that was under consideration.

Formulated By: Jacquelyn D. Johnson
Team Leader, Managed Care and Legal Projects

Approved By:

Thomas P. Fischer
Thomas P. Fischer, CFO

Date:

6/28/11

REVIEW/REVISED

DATE ACTION

04/20/06 Minor

05/4/06 Major

TITLE: PAYMENT AND COLLECTION POLICY

EFFECTIVE DATE: 04/01/06

REPLACES: New

TO BE READ WITH: Net.Finance-001: Definitions

PURPOSE: To document the Community Health Network specific collection policy. This Policy applies to amounts payable by patients.

POLICY STATEMENT:

1. PAYMENT AND COLLECTION:

- 1.1 Each corporation and business unit within each corporation that Bills and collects payments from Responsible Parties will adopt a collection Process consistent with this Policy.
- 1.2 Payment is expected at the time of service or discharge unless other arrangements, including the assignment of insurance benefits, have been made.
- 1.3 If the patient is Uninsured, the Responsible Party is eligible for our discount for the Uninsured in accordance with our Financial Assistance Policy.
- 1.4 Responsible Parties may also be eligible for reduction of debt in accordance with our Financial Assistance Policy.
- 1.5 Charges for services to adopted patients or patients in the adoption process will not be subject to the Financial Assistance Policy until we have received evidence that the adoption is complete and we have verified any available third party benefits. At that time the Financial Assistance Policy will apply.
- 1.6 For Elective Services Uninsured Responsible Parties are expected to make a deposit payment of estimated Charges prior to receiving services as follows:

- 1.6.1 Inpatient Services: Twenty-five percent (25%)
- 1.6.2 Outpatient Services: Fifty percent (50%)
- 1.6.3 The amount of the deposit will be applied in full to the final Bill.
- 1.6.4 If the Responsible Party is unable to pay all or part of the deposit, the Responsible Party may make application for Financial Assistance in accordance with our Financial Assistance Policy.
- 1.6.5 When circumstances permit, acceptable payment arrangements for the balance of the Bill must be made prior to or on the day of services. Acceptable payment arrangements include assignment of third party benefits.
- 1.6.6 Responsible Parties may pre-pay their health care services. If the pre-payment made exceeds the amount of Billed Charges or the amount for which the Responsible Party is responsible in accordance with the Financial Assistance Policy, that amount will be applied to any other accounts on which a balance is due and remaining amount will be refunded to the patient.
- 1.6.7 Elective Services may be postponed or denied for failure of the patient to comply with applicable Network policies.
- 1.7 Acceptable payment methods are:
 - 1.7.1 Cash or check
 - 1.7.2 Charge Card accepted by the corporation/business unit.
 - 1.7.3 Ninety (90) days, same as cash in three (3) equal payments.
 - 1.7.4 Six (6) to eighteen (18) months interest free payment plan for those patients whose credit is approved by an outside lending institution. The application (See Attachment A) is taken by Network staff and approved by the lender.
 - 1.7.5 Extended Payment Arrangements up to sixty (60) months (interest free) depending on the balance of the account(s) and in accordance with the Finance Policy.
- 1.8 Patients with Third Party Benefits:

- 1.8.1 It is the Responsible Party's responsibility to provide all necessary information to establish eligibility for third party benefits and to make an informed decision regarding the assignment of those benefits to us. Responsible Parties who choose not to assign benefits to us will be considered Uninsured but are not eligible for the discount for the Uninsured under our Financial Assistance Policy.
- 1.8.2 The Responsible Party will be extended interest free credit for sixty (60) days subsequent to the date of Billing on the amount covered by verified and assigned third party benefits.
- 1.8.3 Health insurance plan deductible and co-insurance amounts may not be collected at the time of service. Responsible Parties will be expected to pay deductible and co-insurance amounts within thirty (30) days subsequent to the date of Billing. Deductible and co-insurance amounts are not eligible for the discount available to Uninsured patients under our Financial Assistance Policy.
- 1.8.4 Known health insurance plan co-payment amounts may be collected at the time of service.
- 1.8.5 The existence of third party benefits does not negate responsibility for timely payment of the Bill. Financial responsibility ultimately rests with the Responsible Party.
- 1.8.6 We will not send a Bill for amounts in dispute or under appeal with third party benefit companies until such dispute or appeal has been resolved.
- 1.8.7 We will not send a Bill for amounts due from a third party benefits company subject to the jurisdiction of a Court when the Court has ordered that providers may not Bill beneficiaries until such Court Order has expired or a new Order has been issued that permits providers to Bill beneficiaries.
- 1.8.8 We will not send a Bill until those third party benefits companies subject to Indiana Codes 27-8-5.7 and 27-13-36.2, both as amended or re-codified from time to time, have had the opportunity, as specified by the applicable Code, to respond to our Claim and the Processes afforded by the applicable Code have been completed.

- 1.8.9 We will not send a Bill for discounts taken by third party benefits companies in accordance with our contractual agreements with those companies.
- 1.8.10 We will not send a Bill for amounts payable by Workers' Compensation coverage in accordance with Indiana Code 22-3, as amended or re-codified from time to time. If we, or the patient, have filed a complaint with the Indiana Workers' Compensation Board, we will not send the patient a Bill for amounts subject to the complaint until the Board has ruled and indicated the amount, if any that is not compensable by the patient's Workers' Compensation coverage.
- 1.9 We will not send a Bill or hold Responsible Party financially responsible for amounts that have been discharged by a bankruptcy court.
- 1.10 Patient Expired – Estate
 - 1.10.1 We will not pursue payment on accounts of expired patients when we have documentation to prove no assets, estate, or potential to collect from any other Responsible Party.
 - 1.10.2 We will not pursue payment from an expired patient's account(s) when the amount of the claim is less than \$250 and there is no potential to collect from any other Responsible Party.
- 1.11 We will not place a lien on a home or other tangible or intangible asset until all reasonable avenues of collection have been exhausted including determining eligibility in accordance with the Financial Assistance Policy and offering and completing the Process of alternative payment arrangements. We may file such lien when the Responsible Party is non-responsive or refuses to participate in efforts to provide information or make payment arrangements.
- 1.12 We will not knowingly sue a Responsible Party who is unemployed. We will make reasonable efforts to determine if the Responsible Party is eligible under our Financial Assistance Policy and we will offer and complete the Process of alternative payment arrangements. We may sue the Responsible Party when the Responsible Party is non-responsive or refuses to participate in efforts to provide information or make payment arrangements.
- 1.13 We will not require an unemployed Responsible Party to pay, during the period of unemployment, an amount which would reduce the Responsible

Party's cash assets to less than two months of living expenses. Upon employment, we may require the Responsible Party to begin payments.

- 1.14 Our Collection Agencies will comply with our Financial Assistance and Payment and Collection Policies.

2. COLLECTION AGENCY REFERRALS AND RESTRICTIONS

- 2.1 In all cases, we will make all efforts to work with the patient/Responsible Party to determine an equitable payment arrangement considering the patient's financial and medical circumstances prior to referring an account(s) to a collection agency.
- 2.2 We will not send a Responsible Party to a collection agency without notifying and giving the Responsible Party an opportunity and adequate time to make application in accordance with our Financial Assistance Policy and the Process is complete or, to make alternative payment arrangements and that Process is complete.

3. AUDITING:

Each corporation and business unit within each corporation, will establish criteria for routine auditing and will routinely conduct audits to insure compliance with this Policy.

Formulated By: Jacquelyn D. Johnson
Team Leader, Managed Care and Legal Projects

Approved By:


Thomas P. Fischer, CFO

Date:

1/3/11

Additional Data

Software ID:
Software Version:
EIN: 35-0983617
Name: COMMUNITY HOSPITALS OF INDIANA INC

Form 990, Special Condition Description:

Special Condition Description
