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Part III

Statement of Program Service Accomplishments

Check if Schedule O contains a response or note to any line in this Part III

☐

1

Briefly describe the organization's mission

COMMUNITY HEALTH NETWORK, INC ("CHNW") IS A 501(C)(3) CORPORATION SERVING THE HEALTH RELATED NEEDS OF THE CITIZENS OF THE INDIANAPOLIS METROPOLITAN AREA AND CENTRAL INDIANA CHNW 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 CHNW'S MISSION IS TO A) PROMOTE THE HEALTH OF THE RESIDENTS OF CENTRAL INDIANA BY PROMOTING, SUPPORTING AND FURTHERING THE CHARITABLE PURPOSES OF COMMUNITY HOSPITAL SOUTH, INC , COMMUNITY HOSPITAL OF ANDERSON AND MADISON COUNTY, INC , COMMUNITY LTC, INC , COMMUNITY HOME HEALTH SERVICES, INC , AND INDIANA HEART HOSPITAL, LLC (COLLECTIVELY, THE "SUPPORTED ORGANIZATIONS"), AND THEIR RESPECTIVE SUBSIDIARIES AND AFFILIATES, TO CONSIDER, COORDINATE, AND FACILITATE THE ALIGNMENT OF INITIATIVES WITHIN THE COMMUNITY HEALTH NETWORK ("NETWORK") B) SERVE AS THE PARENT OF THE NETWORK, AN INTEGRATED DELIVERY SYSTEM, AND EXERCISE COMMON SUPERVISION

2

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

☐ Yes ☒ No

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?

☐ Yes ☒ No

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 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 \$ 477,981,168 including grants of \$) (Revenue \$ 806,270,996)
	COMMUNITY HEALTH NETWORK, INC OPERATES TWO ACUTE CARE FULL SERVICE HOSPITALS IN INDIANAPOLIS, INDIANA WITH 1,029 LICENSED BEDS IN 2013, THE HOSPITALS SERVED 29,532 INPATIENTS FOR A TOTAL OF 135,577 INPATIENT DAYS OF SERVICE THE TWO HOSPITALS ALSO PROVIDED 1,174,911 OUTPATIENT VISITS, WHICH INCLUDED 128,622 EMERGENCY VISITS AND 549,787 MENTAL HEALTH VISITS THE HOSPITALS OFFER 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 \$ 15,062,119 including grants of \$) (Revenue \$ 892,719)
	COMMUNITY HEALTH NETWORK, INC PROVIDES SHARED SERVICES TO THE ORGANIZATIONS COLLECTIVELY REFERRED TO AS THE COMMUNITY HEALTH NETWORK THESE SERVICES INCLUDE FINANCE AND ACCOUNTING, MATERIALS MANAGEMENT, PATIENT ACCOUNTING, TRANSCRIPTION SERVICES, MEDICAL RECORDS, LEGAL, HUMAN RESOURCES, INFORMATION TECHNOLOGY, AND BUSINESS DEVELOPMENT

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	493,043,287
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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 Yes	
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 for escrow or custodial account liability, 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 and XII 	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 and XII 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, Parts I and IV	14b	No
15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? If "Yes," complete Schedule F, Parts 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 other assistance to or for foreign individuals? If "Yes," complete Schedule F, Parts 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 (see instructions)	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 hospital facilities? If "Yes," complete Schedule H 	20a Yes	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? 	20b Yes	

Part IV

Checklist of Required Schedules (continued)

21	Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or government 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 or 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, line 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 lines 24b through 24d and complete Schedule K. If "No," go to line 25a</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	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? <i>If so, 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 employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? <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 direct or indirect 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, Part II, III, or IV, and Part V, line 1</i>	34	Yes	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	Yes	
b	If 'Yes' to line 35a, 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 11b 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 or note to any line in this Part V

		Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable.	1a	330
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, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return.	2a	6,556
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	Yes
b	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O.	3b	Yes
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, securities account, or other financial account)?	4a	Yes
b	If "Yes," enter the name of the foreign country: _____ 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 as charitable contributions?	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. See the instructions for additional information the organization must report on Schedule O.	13a	
b	Enter the 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 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 or note to any line 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	13	
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O		
b	Enter the number of voting members included in line 1a, above, who are independent	10	
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	No
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	No
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	No
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	No
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 this 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 <input type="checkbox"/> Other (explain in Schedule O)
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 during the tax year
20	State the name, physical address, and telephone number of the person who possesses the books and records of the organization ▶HOLLY A MILLARD 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS,IN 46256 (317) 355-5860

Part VII

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

Check if Schedule O contains a response or note to any line 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. 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 organization compensated any current officer, director, or trustee

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(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) BRYAN A MILLS DIRECTOR/PRE	55.00 5.00	X		X				1,133,983	0	121,280
(2) HANY HADDAD MD DIRECTOR	45.00	X						621,442	0	36,928
(3) KENNETH SHAVER MD DIRECTOR	5.00 40.00	X						0	271,486	35,863
(4) KATHRYN G BETLEY DIRECTOR	5.00	X						0	0	0
(5) JAMES MOREY DIRECTOR	5.00	X						0	0	0
(6) JEFFREY MOSSLER MD DIRECTOR	5.00	X						0	0	0
(7) MICHAEL PETERSON CHAIRMAN	5.00	X		X				0	0	0
(8) STEVEN R PLUMP DIRECTOR	5.00	X						0	0	0
(9) YVONNEE SHAHEEN SECRETARY	5.00	X		X				0	0	0
(10) KRISTIN T SHERMAN TREASURER	5.00	X		X				0	0	0
(11) CHARLES E STALEY DIRECTOR	5.00	X						0	0	0
(12) RUSSELL SWAN JR VICE CHAIRMA	5.00	X		X				0	0	0
(13) RONALD THIEME DIRECTOR	5.00	X						0	0	0
(14) THOMAS P FISCHER COO/CFO THRU	56.00 4.00			X				716,959	0	17,700
(15) TIMOTHY HOBBS MD CHIEF PHYSIC	50.00			X				665,527	0	163,770
(16) KYLE FISHER CEO - VEI	50.00			X				0	535,463	74,279
(17) MICHAEL C BLANCHET COO THRU JAN	50.00			X				523,766	0	309,439

Part VII

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees *(continued)*

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(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			
(18) ROBIN LEDYARD MD PRESIDENT -	55 00			X				363,889	0	64,884
(19) HOLLY A MILLARD CAO & INTERI	50 00			X				301,859	0	65,736
(20) JASON FAHRLANDER PRES - NORTH	50 00			X				250,482	0	15,048
(21) BARBARA SUMMERS PRES - NORTH	55 00			X				87,699	0	29,770
(22) SCOTT TEFFETELLER PRES - EAST	50 00			X				68,043	0	7,752
(23) JEFFERY KIRKHAM CFO CLINICAL	50 00 5 00				X			376,309	0	68,636
(24) FRANK COVINGTON MD MEDICAL DIRE	50 00					X		721,150	0	60,152
(25) MICHAEL VENTURINI MD PHYSICIAN	50 00					X		687,693	0	156,311
(26) WESLEY WONG MD CHIEF PHY IN	50 00					X		534,704	0	85,882
(27) KAREN ANN LLOYD VP - GENERAL	50 00					X		468,418	0	65,763
(28) THOMAS MALASTO CHIEF PATIEN	12 50 37 50					X		100,281	360,738	95,616
1b Sub-Total										
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)								7,622,204	1,167,687	1,474,809

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization▶290

		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>		No
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>	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>		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
MID AMERICA CLINICAL LABS 2560 NORTH SHADELAND AVENUE INDIANAPOLIS IN 46219	LAB SERVICES	10,010,686
PEPPER CONSTRUCTION CO OF INDIANA 1850 W 15TH STREET INDIANAPOLIS IN 46202	CONSTRUCTION	9,492,064
COMMUNITY IMAGING ASSOCIATES 7205 SHADELAND STATION INDIANAPOLIS IN 46256	X-RAY IMAGING	9,463,181
COMMUNITY HOSPITALS ONCOLOGY PHYSN PO BOX 17220 INDIANAPOLIS IN 46217	MEDICAL	8,332,152
AXIOMPORT 646 MASSACHUSETTS AVENUE INDIANAPOLIS IN 46204	ADVERTISING	4,314,860
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 ▶351	

Part VIII

Statement of Revenue

Check if Schedule O contains a response or note to any line in this Part VIII

			(A)	(B)	(C)	(D)
			Total revenue	Related or exempt function revenue	Unrelated business revenue	Revenue excluded from tax under sections 512-514
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns	1a			
	b	Membership dues	1b			
	c	Fundraising events	1c			
	d	Related organizations	1d	1,425,106		
	e	Government grants (contributions)	1e	8,830,963		
	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		10,256,069		
Program Service Revenue	2a	PATIENT SERVICES	Business Code			
			622110	750,277,735	750,277,735	
	b	REHAB JV	900099	8,117,500	8,117,500	
	c	RENT	561000	5,432,444	5,432,444	
	d	ONSIGHT HEALTH	900099	5,004,400	5,004,400	
	e	PROGRAM SERVICES	531120	892,719	892,719	
	f	All other program service revenue				
	g	Total. Add lines 2a-2f		769,724,798		
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts)		15,102,119		15,102,119
	4	Income from investment of tax-exempt bond proceeds				
	5	Royalties				
	6a	Gross rents	(i) Real	(ii) Personal		
	b	Less rental expenses				
	c	Rental income or (loss)				
	d	Net rental income or (loss)				
	7a	Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other		
			93,109,647	11,910		
	b	Less cost or other basis and sales expenses				
			76,369,109	227,193		
	c	Gain or (loss)				
			16,740,538	-215,283		
	d	Net gain or (loss)		16,525,255		16,525,255
	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	18,851,995	18,851,995		
b	JMH MANAGEMENT	900099	3,701,250		3,701,250	
c	EHR INCENTIVE PAYMENTS	900099	3,415,711	3,415,711		
d	All other revenue		15,922,097	15,171,211	750,886	
e	Total. Add lines 11a-11d		41,891,053			
12	Total revenue. See Instructions		853,499,294	807,163,715	4,452,136	31,627,374

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).

Check if Schedule O contains a response or note to any line 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.	6,010,901	872,757	5,138,144	
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.	290,191,093	213,004,688	77,186,405	
8	Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions).	14,980,345	7,208,296	7,772,049	
9	Other employee benefits.	48,964,499	34,903,547	14,060,952	
10	Payroll taxes.	20,134,647	14,696,043	5,438,604	
11	Fees for services (non-employees):				
a	Management.				
b	Legal.	2,559,796	237,594	2,322,202	
c	Accounting.	3,972,509	1,060,198	2,912,311	
d	Lobbying.	162,469		162,469	
e	Professional fundraising services. See Part IV, line 17.				
f	Investment management fees.	315,072		315,072	
g	Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	49,626,462	12,282,008	37,344,454	
12	Advertising and promotion.	325,627	315,423	10,204	
13	Office expenses.	21,680,047	19,141,289	2,538,758	
14	Information technology.	16,794,782	11,529,265	5,265,517	
15	Royalties.				
16	Occupancy.	25,896,661	19,309,748	6,586,913	
17	Travel.	1,238,950	929,834	309,116	
18	Payments of travel or entertainment expenses for any federal, state, or local public officials.				
19	Conferences, conventions, and meetings.	586,324	482,749	103,575	
20	Interest.	14,746,103		14,746,103	
21	Payments to affiliates.				
22	Depreciation, depletion, and amortization.	33,145,980	10,490,814	22,655,166	
23	Insurance.	7,382,840	54,849	7,327,991	
24	Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O):				
a	MEDICAL SUPPLIES	112,223,844	112,223,844		
b	HAF PROGRAM FEES	32,890,804	32,890,804		
c	DUES & SUBSCRIPTIONS	1,649,362	304,082	1,345,280	
d	PROPERTY TAX	1,267,036	455,283	811,753	
e	All other expenses	983,911	650,172	333,739	
25	Total functional expenses. Add lines 1 through 24e.	707,730,064	493,043,287	214,686,777	0
26	Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

Part X

Balance Sheet

Check if Schedule O contains a response or note to any line in this Part X

					(A)		(B)
					Beginning of year		End of year
Assets	1	Cash—non-interest-bearing			78,916,976	1	129,947,731
	2	Savings and temporary cash investments				2	
	3	Pledges and grants receivable, net				3	
	4	Accounts receivable, net			99,827,303	4	88,227,372
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L				5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L				6	
	7	Notes and loans receivable, net			20,417	7	110,000
	8	Inventories for sale or use			7,500,519	8	7,961,381
	9	Prepaid expenses and deferred charges			7,659,821	9	6,371,186
	10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	10a	879,382,551			
	b	Less accumulated depreciation	10b	505,590,176	371,863,758	10c	373,792,375
	11	Investments—publicly traded securities			387,998,155	11	432,672,540
	12	Investments—other securities See Part IV, line 11				12	
	13	Investments—program-related See Part IV, line 11			508,618,874	13	525,823,032
	14	Intangible assets			36,690,113	14	41,896,150
	15	Other assets See Part IV, line 11			182,935,979	15	281,997,229
	16	Total assets. Add lines 1 through 15 (must equal line 34)			1,682,031,915	16	1,888,798,996
Liabilities	17	Accounts payable and accrued expenses			110,190,431	17	84,934,107
	18	Grants payable				18	
	19	Deferred revenue				19	
	20	Tax-exempt bond liabilities			554,523,013	20	542,214,548
	21	Escrow or custodial account liability Complete Part IV of Schedule D				21	
	22	Loans and other 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			50,000,000	23	99,469,576
	24	Unsecured notes and loans payable to unrelated third parties				24	
	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			197,430,344	25	142,913,604
	26	Total liabilities. Add lines 17 through 25			912,143,788	26	869,531,835
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.						
	27	Unrestricted net assets			769,888,127	27	1,019,267,161
	28	Temporarily restricted net assets				28	
	29	Permanently restricted net assets				29	
	Organizations that do not follow SFAS 117 (ASC 958), 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			769,888,127	33	1,019,267,161
	34	Total liabilities and net assets/fund balances			1,682,031,915	34	1,888,798,996

Part XI Reconciliation of Net Assets

Check if Schedule O contains a response or note to any line in this Part XI

1	Total revenue (must equal Part VIII, column (A), line 12)	1	853,499,294
2	Total expenses (must equal Part IX, column (A), line 25)	2	707,730,064
3	Revenue less expenses Subtract line 2 from line 1	3	145,769,230
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	769,888,127
5	Net unrealized gains (losses) on investments	5	15,903,129
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	87,706,675
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	1,019,267,161

Part XII Financial Statements and Reporting

Check if Schedule O contains a response or note to any line 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? If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		No
2b	Were the organization's financial statements audited by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	Yes	
2c	If "Yes," to line 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	
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	
3b	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.

▶ Information about Schedule A (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2013

Open to Public Inspection

Name of the organization COMMUNITY HEALTH NETWORK 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 described in **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 33¹/₃% 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 33¹/₃% 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 See **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 - Non-functionally integrated

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 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 monetary support
			Yes	No	Yes	No	Yes	No	
Total									

Part II

Support Schedule for Organizations Described in Sections 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 (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(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 (or fiscal year beginning in) ▶	(a) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(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 Do not include gain or loss from the sale of capital assets (Explain in Part IV)						
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 2013 (line 6, column (f) divided by line 11, column (f))	14		
15 Public support percentage for 2012 Schedule A, Part II, line 14	15		
16a 33 1/3% support test—2013. 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—2012. If the organization did not check a 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—2013. 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—2012. 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 IIISupport Schedule for Organizations Described in Section 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) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(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) 2009	(b) 2010	(c) 2011	(d) 2012	(e) 2013	(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 2013 (line 8, column (f) divided by line 13, column (f))	15	
16 Public support percentage from 2012 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage		
17 Investment income percentage for 2013 (line 10c, column (f) divided by line 13, column (f))	17	
18 Investment income percentage from 2012 Schedule A, Part III, line 17	18	
19a 33 1/3% support tests—2013. 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—2012. 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.** Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; and Part III, line 12. Also complete this part for any additional information. (See instructions).

Facts And Circumstances Test

Return Reference	Explanation	
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SCHEDULE C

(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶ **Complete if the organization is described below. ▶ Attach to Form 990 or Form 990-EZ.**

▶ **See separate instructions. ▶ Information about Schedule C (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.**

OMB No 1545-0047

2013

Open to Public
Inspection

If the organization answered "Yes" to Form 990, Part IV, Line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then

- Section 501(c)(3) organizations Complete Parts I-A and B Do not complete Part I-C
- Section 501(c) (other than section 501(c)(3)) organizations Complete Parts I-A and C below Do not complete Part I-B
- Section 527 organizations Complete Part I-A only

If the organization answered "Yes" to Form 990, Part IV, Line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)) Complete Part II-A Do not complete Part II-B
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)) Complete Part II-B Do not complete Part II-A

If the organization answered "Yes" to Form 990, Part IV, Line 5 (Proxy Tax) or Form 990-EZ, Part V, line 35c (Proxy Tax), then

- Section 501(c)(4), (5), or (6) organizations Complete Part III

Name of the organization COMMUNITY HEALTH NETWORK INC	Employer identification number 35-0983617
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Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

1	Provide a description of the organization's direct and indirect political campaign activities in Part IV	
2	Political expenditures	▶ \$
3	Volunteer hours	

Part I-B Complete if the organization is exempt under section 501(c)(3).

1	Enter the amount of any excise tax incurred by the organization under section 4955	▶ \$
2	Enter the amount of any excise tax incurred by organization managers under section 4955	▶ \$
3	If the organization incurred a section 4955 tax, did it file Form 4720 for this year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4a	Was a correction made?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b	If "Yes," describe in Part IV	

Part I-C Complete if the organization is exempt under section 501(c), except section 501(c)(3).

1	Enter the amount directly expended by the filing organization for section 527 exempt function activities	▶ \$
2	Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities	▶ \$
3	Total exempt function expenditures Add lines 1 and 2 Enter here and on Form 1120-POL, line 17b	▶ \$
4	Did the filing organization file Form 1120-POL for this year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5	Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments For each organization listed, enter the amount paid from the filing organization's funds Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC) If additional space is needed, provide information in Part IV	

(a) Name	(b) Address	(c) EIN	(d) Amount paid from filing organization's funds If none, enter -0-	(e) Amount of political contributions received and promptly and directly delivered to a separate political organization If none, enter -0-

Part II-A

Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).

- A
- Check ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures)
- B
- Check ☐ if the filing organization checked box A and "limited control" provisions apply

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)		(a) Filing organization's totals	(b) Affiliated group totals												
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)															
b Total lobbying expenditures to influence a legislative body (direct lobbying)															
c Total lobbying expenditures (add lines 1a and 1b)															
d Other exempt purpose expenditures															
e Total exempt purpose expenditures (add lines 1c and 1d)															
f Lobbying nontaxable amount Enter the amount from the following table in both columns															
<table><tr><td>If the amount on line 1e, column (a) or (b) is:</td><td>The lobbying nontaxable amount is:</td></tr><tr><td>Not over \$500,000</td><td>20% of the amount on line 1e</td></tr><tr><td>Over \$500,000 but not over \$1,000,000</td><td>\$100,000 plus 15% of the excess over \$500,000</td></tr><tr><td>Over \$1,000,000 but not over \$1,500,000</td><td>\$175,000 plus 10% of the excess over \$1,000,000</td></tr><tr><td>Over \$1,500,000 but not over \$17,000,000</td><td>\$225,000 plus 5% of the excess over \$1,500,000</td></tr><tr><td>Over \$17,000,000</td><td>\$1,000,000</td></tr></table>		If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	Not over \$500,000	20% of the amount on line 1e	Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000	Over \$17,000,000	\$1,000,000		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:														
Not over \$500,000	20% of the amount on line 1e														
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000														
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000														
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000														
Over \$17,000,000	\$1,000,000														
g Grassroots nontaxable amount (enter 25% of line 1f)															
h Subtract line 1g from line 1a If zero or less, enter -0-															
i Subtract line 1f from line 1c If zero or less, enter -0-															
j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?		<input type="checkbox"/> Yes <input type="checkbox"/> No													

4-Year Averaging Period Under Section 501(h)
(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the instructions for lines 2a through 2f on page 4.)

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2010	(b) 2011	(c) 2012	(d) 2013	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

Part II-B

Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).

For each "Yes" response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.		(a)		(b)
		Yes	No	Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
a	Volunteers?		No	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	Yes		
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?		No	
e	Publications, or published or broadcast statements?		No	
f	Grants to other organizations for lobbying purposes?	Yes		18,717
g	Direct contact with legislators, their staffs, government officials, or a legislative body?	Yes		143,752
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?		No	
j	Total. Add lines 1c through 1i.			162,469
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

Part III-A

Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).

		Yes	No
1	Were substantially all (90% or more) dues received nondeductible by members?	1	
2	Did the organization make only in-house lobbying expenditures of \$2,000 or less?	2	
3	Did the organization agree to carry over lobbying and political expenditures from the prior year?	3	

Part III-B

Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No" OR (b) Part III-A, line 3, is answered "Yes."

1	Dues, assessments and similar amounts from members	1	
2	Section 162(e) nondeductible lobbying and political expenditures (do not include amounts of political expenses for which the section 527(f) tax was paid).		
a	Current year	2a	
b	Carryover from last year	2b	
c	Total	2c	
3	Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	3	
4	If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?	4	
5	Taxable amount of lobbying and political expenditures (see instructions)	5	

Part IV

Supplemental Information

Provide the descriptions required for Part I-A, line 1, Part I-B, line 4, Part I-C, line 5, Part II-A (affiliated group list), Part II-A, line 2, and Part II-B, line 1. Also, complete this part for any additional information.

Return Reference	Explanation
SCHEDULE C, PART II-B, LINE 1	LINE 1F - A PORTION OF THE DUES COMMUNITY HEALTH NETWORK, INC. ("CHNW") PAID TO THE INDIANA HOSPITAL ASSOCIATION IS ATTRIBUTABLE TO LOBBYING. LINE 1G - COMMUNITY HEALTH NETWORK, INC. RETAINS A LOBBYIST TO DISCUSS AND WORK WITH LEGISLATORS ON THE IMPACT OF PROPOSED LEGISLATION AND TO PROACTIVELY SUPPORT LEGISLATION THAT FURTHERS THE MISSION AND GOALS OF THE NETWORK. IN ADDITION, ONE EMPLOYEE OF CHNW ASSISTS WITH LOBBYING ACTIVITIES.

Part IV Supplemental Information (*continued*)[illegible]

SCHEDULE D
(Form 990)

Supplemental Financial Statements

OMB No 1545-0047

2013

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

► Complete if the organization answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b

► Attach to Form 990. ► See separate instructions. ► Information about Schedule D (Form 990) and its instructions is at www.irs.gov/form990.

Name of the organization COMMUNITY HEALTH NETWORK 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 type="checkbox"/> No</div>	
6	Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can 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 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 education) ☐ Preservation of an historically important land area

☐ Protection of natural habitat ☐ Preservation of a certified historic structure

☐ Preservation of open space

2

Complete lines 2a through 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, and not on a historic structure listed in the National Register

3

Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax 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 section 170(h)(4)(B)(ii)?

☐ Yes ☐ No

9

In Part XIII, 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 (ASC 958), 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 XIII, the text of the footnote to its financial statements that describes these items

b

If the organization elected, as permitted under SFAS 116 (ASC 958), 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 (ASC 958) relating to these items

a

Revenues included in Form 990, Part VIII, line 1

► \$

b

Assets included in Form 990, Part X

► \$

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

- 3

Using the organization's acquisition, 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 XIII
- 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 XIII and complete the following table
- c

Beginning balance

d

Additions during the year

e

Distributions during the year

f

Ending balance

	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 XIII Check here if the explanation has been provided in Part XIII

☐

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

- | | (a)Current year | (b)Prior year | b (c)Two years back | (d)Three years back | (e)Four years back |
|----|--|---------------|---------------------|---------------------|--------------------|
| 1a | Beginning of year balance | | | | |
| b | Contributions | | | | |
| c | Net investment earnings, gains, and 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 current year end balance (line 1g, column (a)) held as
- a

Board designated or quasi-endowment
- b

Permanent endowment
- c

Temporarily restricted endowment

The percentages in lines 2a, 2b, and 2c should equal 100%
- 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 XIII the intended uses of the organization's endowment funds
- Part VI Land, Buildings, and Equipment.** Complete if the organization answered 'Yes' to Form 990, Part IV, line 11a. 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 | | 5,138,659 | | 5,138,659 |
| b Buildings | | 480,663,051 | 195,974,386 | 284,688,665 |
| c Leasehold improvements | | 21,080,921 | 9,120,605 | 11,960,316 |
| d Equipment | | 364,945,469 | 293,402,238 | 71,543,231 |
| e Other | | 7,554,451 | 7,092,947 | 461,504 |
| Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c).) | | | | 373,792,375 |
- Schedule D (Form 990) 2013

Part XI

Reconciliation of Revenue per Audited Financial Statements With Revenue per Return

Complete if the organization answered 'Yes' to Form 990, Part IV, line 12a.

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 XIII)	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 XIII)	4b		
c	Add lines 4a and 4b		4c	
5	Total revenue Add lines 3 and 4c. (This must equal Form 990, Part I, line 12)		5	

Part XII

Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.

Complete if the organization answered 'Yes' to Form 990, Part IV, line 12a.

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 XIII)	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 XIII)	4b		
c	Add lines 4a and 4b		4c	
5	Total expenses Add lines 3 and 4c. (This must equal Form 990, Part I, line 18)		5	

Part XIII

Supplemental Information

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, line 2, Part XI, lines 2d and 4b, and Part XII, lines 2d and 4b. Also complete this part to provide any additional information.

Return Reference	Explanation

[illegible]

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.
► Information about Schedule H (Form 990) and its instructions is at *www.irs.gov/form990*.

OMB No 1545-0047

2013

Open to Public Inspection

Name of the organization
COMMUNITY HEALTH NETWORK INC

Employer identification number
35-0983617

Part I

Financial Assistance and Certain Other Community Benefits at Cost

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

7

Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)		45,931	29,658,202		29,658,202	4 190 %
b Medicaid (from Worksheet 3, column a)		60,962	137,037,826	135,596,407	1,441,419	0 200 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs		106,893	166,696,028	135,596,407	31,099,621	4 390 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	33	98	19,355,655	3,252,995	16,102,660	2 270 %
f Health professions education (from Worksheet 5)	8		10,640,629	1,736,840	8,903,789	1 260 %
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)	2		1,368,212	52,831	1,315,381	0 190 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)	6	200	6,630		6,630	
j Total Other Benefits	49	298	31,371,126	5,042,666	26,328,460	3 720 %
k Total. Add lines 7d and 7j	49	107,191	198,067,154	140,639,073	57,428,081	8 110 %

Part IICommunity Building Activities

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1Physical improvements and housing						
2Economic development	1	900	81,271		81,271	0 010 %
3Community support	5	1,075	4,062		4,062	
4Environmental improvements						
5Leadership development and training for community members						
6Coalition building	2	183	1,992		1,992	
7Community health improvement advocacy	12	92,403	5,197,239	111,408	5,085,831	0 720 %
8Workforce development	2		810,969	79,436	731,533	0 100 %
9Other						
10Total	22	94,561	6,095,533	190,844	5,904,689	0 830 %

Part IIIBad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

1Did the organization report bad debt expense in accordance with Heathcare Financial Management Association Statement No. 15?

1Yes

Yes

2Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.

28,443,282

3Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.

3

4Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.

Section B. Medicare

5Enter total revenue received from Medicare (including DSH and IME).

5137,999,145

6Enter Medicare allowable costs of care relating to payments on line 5.

6150,629,180

7Subtract line 6 from line 5. This is the surplus (or shortfall).

7-12,630,035

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.

☐ Cost accounting system

☒ Cost to charge ratio

☐ Other

Section C. Collection Practices

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

9aYes

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.

9bYes

Yes

Part IVManagement Companies and Joint Ventures

(owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1COMMUNITY IMAGING	PROVIDE MEDICAL IMAGING SERVICES	50 000 %		50 000 %
2EAST CAMPUS SURG CTR	PROVIDE OUTPATIENT SURGERY SERVICES	51 000 %		49 000 %
3HAMILTON SURGERY CTR	PROVIDE OUTPATIENT SURGERY SERVICES	11 000 %		49 000 %
4IN SPECIALTY GROUP	PROVIDE SPECIALTY PHYSICIAN SERVICES	70 000 %		30 000 %
5INDPLS ENDOSCOPY CTR	PROVIDE MEDICAL SERVICES	19 000 %		49 000 %
6NORTHPOINT PEDIATRIC	PROVIDE PHYSICIANS SERVICES	51 000 %		49 000 %
7SOUTH CAMPUS SURG CT	PROVIDE OUTPATIENT SURGERY SERVICES	6 000 %		47 000 %
8				
9				
10				
11				
12				
13				

Section A. Hospital Facilities

Name, address, primary website address,
and state license number

Schedule H (Form 990) 2013

Part V

Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or facility reporting group

If reporting on Part V, Section B for a single hospital facility only: line number of hospital facility (from Schedule H, Part V, Section A)

	Yes	No
Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)		
1 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9 If "Yes," indicate what the CHNA report describes (check all that apply)	1 Yes	
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 CHNA 20 <u>12</u>		
3 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in 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 CHNA 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 CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	5 Yes	
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>WWW.ECOMMUNITY.COM</u>		
b <input checked="" type="checkbox"/> Other website (list url) <u>WWW.COMMUNITYANDERSON.COM</u>		
c <input checked="" type="checkbox"/> Available upon request from the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Part VI)		
6 If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year)		
a <input checked="" type="checkbox"/> Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA		
b <input checked="" type="checkbox"/> Execution of the implementation strategy		
c <input checked="" type="checkbox"/> Participation in the development of a community-wide plan		
d <input checked="" type="checkbox"/> Participation in the execution of a community-wide 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 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 type="checkbox"/> Other (describe in Part VI)		
7 Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	7	No
8a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	8a	No
b If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?	8b	
c If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$_____		

Part V

Facility Information (continued)

Financial Assistance Policy		Yes	No
9	Did the hospital facility have in place during the tax year a written financial assistance policy that Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care?	9	Yes
10	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 000000000000% If "No," explain in Part VI the criteria the hospital facility used	10	Yes
11	Used FPG to determine eligibility for providing discounted care? If "Yes," indicate the FPG family income limit for eligibility for discounted care 300 000000000000% If "No," explain in Part VI the criteria the hospital facility used	11	Yes
12	Explained the basis for calculating amounts charged to patients? If "Yes," indicate the factors used in determining such amounts (check all that apply)	12	Yes
a	<input checked="" type="checkbox"/> Income level		
b	<input type="checkbox"/> Asset level		
c	<input checked="" type="checkbox"/> Medical indigency		
d	<input checked="" type="checkbox"/> Insurance status		
e	<input checked="" type="checkbox"/> Uninsured discount		
f	<input checked="" type="checkbox"/> Medicaid/Medicare		
g	<input checked="" type="checkbox"/> State regulation		
h	<input type="checkbox"/> Residency		
i	<input checked="" type="checkbox"/> Other (describe in Part VI)		
13	Explained the method for applying for financial assistance?	13	Yes
14	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)	14	Yes
a	<input checked="" type="checkbox"/> The policy was posted on the hospital facility's website		
b	<input type="checkbox"/> The policy was attached to 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 on admission to the hospital facility		
f	<input checked="" type="checkbox"/> The policy was available upon request		
g	<input checked="" type="checkbox"/> Other (describe in Part VI)		
Billing and Collections			
15	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?	15	Yes
16	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
a	<input type="checkbox"/> Reporting to credit agency		
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 Section C)		
17	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 individual's eligibility under the facility's FAP? If "Yes," check all actions in which the hospital facility or a third party engaged	17	No
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 Section C)		

Part V

Facility Information (continued)

- 18
- Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply)
- a

☒

Notified individuals of the financial assistance policy on admission
- b

☒

Notified individuals of the financial assistance policy prior to discharge
- c

☒

Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills
- d

☒

Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy
- e

☐

Other (describe in Section C)

Policy Relating to Emergency Medical Care

		Yes	No
19	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		
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)		

Charges to Individuals Eligible for Assistance under the FAP (FAP-Eligible Individuals)

20	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 its 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)		
21	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? If "Yes," explain in Part VI		No
22	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? If "Yes," explain in Part VI		No

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

[illegible]

Part V

Facility Information (continued)

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility
(list in order of size, from largest to smallest)

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

Provide the following information

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

Form and Line Reference	Explanation
PART I, LINE 6A - RELATED ORGANIZATION INFORMATION	A COMMUNITY BENEFIT REPORT IS COMPLETED FOR THE COMMUNITY HEALTH NETWORK, INCLUDING COMMUNITY HEALTH NETWORK, INC AND OTHER TAX-EXEMPT AFFILIATES OF THE NETWORK
PART I, LINE 7 - COSTING METHODOLOGY EXPLANATION	A COST TO CHARGE RATIO WAS UTILIZED TO DETERMINE COSTS FOR LINES A THROUGH C THE COST TO CHARGE RATIO WAS DERIVED FROM WORKSHEET 2 LINES E THROUGH I OF THE TABLE ARE BASED ON ACTUAL INCURRED EXPENSES PART II COMMUNITY BUILDING ACTIVITIES SEE ATTACHED IRS SCHEDULE H SUPPLEMENTAL INFORMATION REPORT

Form and Line Reference	Explanation
PART III, LINE 2 - BAD DEBT EXPENSE METHODOLOGY	<p>THE COST TO CHARGE RATIO UTILIZED FOR PURPOSES OF REPORTING BAD DEBT COSTS WAS DERIVED FROM WORKSHEET 2 AND IS BASED ON THE ORGANIZATION'S AUDITED FINANCIAL STATEMENTS COMMUNITY HEALTH NETWORK, 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 PART III, LINE 4 - BAD DEBT EXPENSE EXPLANATION THE AUDITED FINANCIAL STATEMENTS CONTAIN THE FOLLOWING TEXT WITHIN THE FOOTNOTES TO DESCRIBE BAD DEBT EXPENSE THE NETWORK'S ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR DOUBTFUL ACCOUNTS AND CONTRACTUAL ADJUSTMENTS 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 CONTRACTUAL ADJUSTMENTS AND PROVISION FOR BAD DEBTS FOR RECEIVABLES ASSOCIATED WITH SERVICES PROVIDED TO PATIENTS WHO HAVE THIRD PARTY COVERAGE, THE NETWORK ANALYZES CONTRACTUALLY DUE AMOUNTS AND PROVIDES AN ALLOWANCE FOR CONTRACTUAL ADJUSTMENTS FOR RECEIVABLES ASSOCIATED WITH SELF-PAY PATIENTS, INCLUDING PATIENT DEDUCTIBLES AND CO- INSURANCE, 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 ADJUSTED THROUGH THE ALLOWANCE FOR DOUBTFUL ACCOUNTS FOR CHNW, CHS, VEI AND CHVH, ACCOUNTS THAT ARE SENT TO COLLECTION COMPANIES REMAIN AS ACCOUNTS RECEIVABLE ON THE BALANCE SHEET THESE ACCOUNTS ARE NOT WRITTEN OFF UNLESS RETURNED FROM THE COLLECTION COMPANY, HOWEVER ARE FULLY RESERVED WITHIN THE ALLOWANCE FOR DOUBTFUL ACCOUNTS AS SUCH THE ALLOWANCE FOR DOUBTFUL ACCOUNTS IS SIGNIFICANT FOR ACCOUNTS RECEIVABLE THAT HAVE BEEN FULLY RESERVED 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 AND DISCOUNTS RECOGNIZED IN THE PERIOD FROM THESE MAJOR PAYOR SOURCES, IS AS FOLLOWS FOR THE YEARS ENDED DECEMBER 31, 2013 AND 2012, RESPECTIVELY THIRD PARTY PAYORS SELF-PAY TOTAL ALL PAYORS 2013 PATIENT SERVICE REVENUE(NET OF CONTRACTUAL ALLOWANCES AND DISCOUNTS) 1,666,086 94,024 1,760,110 =====</p> <p>===== 2012 PATIENT SERVICE REVENUE(NET OF CONTRACTUAL ALLOWANCES AND DISCOUNTS) 1,580,962 73,759 1,654,721 =====</p> <p>===== THE NETWORK MAINTAINS RECORDS TO IDENTIFY AND MONITOR THE LEVEL OF CHARITY CARE IT PROVIDES THE NETWORK PROVIDES 100% CHARITY CARE TO PATIENTS WHOSE INCOME LEVEL IS BELOW 200% OF THE FEDERAL POVERTY LEVEL PATIENTS WITH INCOME LEVELS RANGING FROM 200% - 300% OF THE CURRENT YEAR'S FEDERAL POVERTY LEVEL WILL QUALIFY FOR PARTIAL ASSISTANCE DETERMINED BY A SLIDING SCALE THE NETWORK USES COST AS THE MEASUREMENT BASIS FOR CHARITY CARE DISCLOSURE PURPOSES WITH THE COST BEING IDENTIFIED AS THE DIRECT AND INDIRECT COSTS OF PROVIDING THE CHARITY CARE CHARITY CARE AT COST WAS 83,731000 AND 58,163000 FOR THE YEARS ENDED DECEMBER 31, 2013 AND 2012, RESPECTIVELY CHARITY CARE COST WAS ESTIMATED ON THE APPLICATION OF THE ASSOCIATED COST-TO-CHARGE RATIOS BEGINNING JUNE 2012, THE STATE OF INDIANA OFFERED VOLUNTARY PARTICIPATION IN THE STATE OF INDIANA'S HOSPITAL ASSESSMENT FEE ("HAF") PROGRAM, RETROACTIVE TO JULY, 1, 2011 THE STATE OF INDIANA IMPLEMENTED THIS PROGRAM TO UTILIZE SUPPLEMENTAL REIMBURSEMENT PROGRAMS FOR THE PURPOSE OF PROVIDING REIMBURSEMENT TO PROVIDERS TO OFFSET A PORTION OF THE COST OF PROVIDING CARE TO MEDICAID AND INDIGENT PATIENTS THIS PROGRAM IS DESIGNED WITH INPUT FROM CENTERS FOR MEDICARE AND MEDICAID SERVICES AND IS FUNDED WITH A COMBINATION OF STATE AND FEDERAL RESOURCES, INCLUDING FEES OR TAXES LEVIED ON THE PROVIDERS AS A RESULT OF PARTICIPATING IN THE HAF PROGRAM, FOR THE YEAR ENDED DECEMBER 31, 2012, THE NETWORK RECOGNIZED REIMBURSEMENTS OF 78,197000 AND FEES OF 43,453000 RELATED TO THE PERIOD JULY 1, 2011 THROUGH JUNE 30, 2012 THE NETWORK RECOGNIZES REVENUES AND RELATED FEES ASSOCIATED WITH THE HAF PROGRAM IN THE PERIOD IN WHICH AMOUNTS ARE ESTIMABLE AND COLLECTION OR PAYMENT IS REASONABLY ASSURED REIMBURSEMENT UNDER THE PROGRAM IS REFLECTED WITHIN NET PATIENT SERVICE REVENUE AND THE FEES PAID FOR PARTICIPATION IN THE HAF PROGRAM ARE RECORDED IN SUPPLIES AND OTHER EXPENSES WITHIN THE CONSOLIDATED STATEMENT OF OPERATIONS AND CHANGES IN NET ASSETS THE FEES AND REIMBURSEMENTS ARE SETTLED MONTHLY THE HAF PROGRAM RUNS ON AN ANNUAL CYCLE FROM JULY 1 TO JUNE 30 AND WAS ORIGINALLY EFFECTIVE UNTIL JUNE 30, 2013 THE PROGRAM WAS SUBSEQUENTLY RENEWED ON MARCH 21, 2014 EFFECTIVE THROUGH JUNE 30, 2017 WITH A RETROACTIVE EFFECTIVE DATE OF JULY 1, 2013 AS A RESULT OF THE RETROACTIVE DATE OF JULY 1, 2013, THE NETWORK HAS ACCRUED BOTH THE ESTIMATED REIMBURSEMENT AND EXPENSE FOR THE PERIOD JULY 1, 2013 THROUGH DECEMBER 31, 2013 IN ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS ON THE DECEMBER 31, 2013 BALANCE SHEET THE CONSOLIDATED BALANCE SHEET AT DECEMBER 31, 2013 INCLUDES 46,036000 AND 35,240000 IN ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS RECEIVABLE AND PAYABLE, RESPECTIVELY, RELATED TO THE HAF PROGRAM 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</p>
PART III, LINE 8 - MEDICARE EXPLANATION	<p>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 28,214,481 AS SUCH, THE TOTAL MEDICARE SHORTFALL FOR ALL MEDICARE PROGRAMS IS 40,844,516 MEDICARE SHORTFALLS SHOULD BE CONSIDERED AS COMMUNITY BENEFIT BECAUSE MEDICARE REPRESENTS 38 88% OF THE OVERALL PAYER MIX FOR COMMUNITY HEALTH NETWORK, INC</p>

Form and Line Reference	Explanation
PART III, LINE 9B - COLLECTION PRACTICES EXPLANATION	SEE ATTACHED FINANCIAL ASSISTANCE POLICY
ADDITIONAL INFORMATION	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) 355-5860 PART VI, ITEM 6 - AFFILIATED HEALTH CARE SYSTEM COMMUNITY HEALTH NETWORK, INC ("CHNW") IS PART OF AN AFFILIATED HEALTH CARE SYSTEM SEE THE ATTACHED IRS 990 SCHEDULE H SUPPLEMENTAL INFORMATION REPORT FOR HOW CHNW IS INVOLVED IN PROMOTING THE HEALTH OF THE COMMUNITY IT SERVES PART VI, ITEM 7 - STATE FILING OF COMMUNITY BENEFIT REPORT INDIANA

Additional Data

Software ID:

Software Version:

EIN: 35-0983617

Name: COMMUNITY HEALTH NETWORK INC

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

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

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

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

Name and address	Type of Facility (describe)
1 COMMUNITY REGIONAL CANCER CENTER 1400 N RITTER AVENUE 340 INDIANAPOLIS,IN 46219	HEALTH CARE
2 COMMUNITY IMAGING CENTER NORTH 8181 CLEARVISTA PKWY INDIANAPOLIS,IN 46256	HEALTH CARE
3 COMMUNITY BREAST CARE 8040 CLEARVISTA 290 INDIANAPOLIS,IN 46256	HEALTH CARE
4 SLEEP WAKE DISORDERS 7250 CLEARVISTA DRIVE 350 INDIANAPOLIS,IN 46256	HEALTH CARE
5 COMMUNITY IMAGING CTR NOBLESVILLE 9669 E 146TH STREET 140 NOBLESVILLE,IN 46060	HEALTH CARE
6 CHE SLEEP WAKE DISORDERS 1400 N RITTER AVENUE 481 INDIANAPOLIS,IN 46219	HEALTH CARE
7 REHAB & SPORTS MEDICINE 2040 N SHADELAND AVENUE INDIANAPOLIS,IN 46219	HEALTH CARE
8 MATERNAL FETAL MEDICINE 7120 E CLEARVISTA DRIVE 5900 INDIANAPOLIS,IN 46256	HEALTH CARE
9 COMMUNITY NEUROSURGERY 1400 N RITTER AVENUE 231 INDIANAPOLIS,IN 46219	HEALTH CARE
10 HRC OP THERAPY 8501 E 56TH STREET 140 INDIANAPOLIS,IN 46216	HEALTH CARE
11 REHAB & SPORTS MEDICINE 6922 HILLSDALE COURT INDIANAPOLIS,IN 46250	HEALTH CARE
12 FAMILY PRACTICE CENTER 10122 E 10TH STREET 100 INDIANAPOLIS,IN 46229	HEALTH CARE
13 GALLAHUE ADDICTIONS 2040 N SHADELAND AVENUE SUITE 200 INDIANAPOLIS,IN 46219	HEALTH CARE
14 GMHC LAWRENCE OP 6950 HILLSDALE COURT INDIANAPOLIS,IN 46250	HEALTH CARE
15 WARREN OP OFFICE 2040 N SHADELAND AVENUE SUITE 200 INDIANAPOLIS,IN 46219	HEALTH CARE
16 MEDCHECK CASTLETON 8177 CLEARVISTA PKWY INDIANAPOLIS,IN 46256	HEALTH CARE
17 REHAB & SPORTS MEDICINE 13121 OLIO ROAD 140 FISHERS,IN 46037	HEALTH CARE
18 GALLAHUE MENTAL HEALTH SERVICES 145 GREEN MEADOWS DRIVE GREENFIELD,IN 46140	HEALTH CARE
19 GALLAHUE MENTAL HEALTH SERVICES 2040 N SHADELAND AVENUE SUITE 250 INDIANAPOLIS,IN 46219	HEALTH CARE
20 COMMUNITY IMAGING CENTER 11911 N MERIDIAN STREET 175 CARMEL,IN 46032	HEALTH CARE
21 GALLAHUE MENTAL HEALTH SERVICES 7 E HENDRICKS STREET SHELBYVILLE,IN 46176	HEALTH CARE
22 GALLAHUE MENTAL HEALTH SERVICES 2201 HILLCREST DRIVE ANDERSON,IN 46012	HEALTH CARE
23 COMMUNITY SPINE CENTER 7120 E CLEARVISTA DRIVE 1500 INDIANAPOLIS,IN 46256	HEALTH CARE
24 COMMUNITY GENERAL SURGEONS 1400 N RITTER AVENUE 330 INDIANAPOLIS,IN 46219	HEALTH CARE
25 SLEEP WAKE DISORDERS 11911 N MERIDIAN STREET 140 CARMEL,IN 46032	HEALTH CARE
26 MEDCHECK CARMEL 1911 N MERIDIAN STREET 150 CARMEL,IN 46032	HEALTH CARE
27 MEDCHECK GREENWOOD 1664 W SMITH VALLEY ROAD SUITE B GREENWOOD,IN 46142	HEALTH CARE
28 MEDCHECK EAST 1703 N POST ROAD INDIANAPOLIS,IN 46219	HEALTH CARE
29 ORTHOPEDIC SURGEONS OF CENTRAL IN 1400 N RITTER AVENUE 510 INDIANAPOLIS,IN 46219	HEALTH CARE
30 COMM OCCUPATIONAL HEALTH CENTER 1709 N POST ROAD INDIANAPOLIS,IN 46219	HEALTH CARE
31 DAY THERAPY 6950 HILLSDALE COURT INDIANAPOLIS,IN 46250	HEALTH CARE
32 COMMUNITY BARIATRICS SURGEONS 7250 CLEARVISTA SUITE 355 INDIANAPOLIS,IN 46256	HEALTH CARE
33 FORGE AHEAD CLUBHOUSE 1640 N RITTER AVENUE INDIANAPOLIS,IN 46201	HEALTH CARE
34 OUTPATIENT WORK COMP REHAB 1911 N MERIDIAN STREET 170 CARMEL,IN 46032	HEALTH CARE
35 WORK COMP REHAB 1713 N POST ROAD INDIANAPOLIS,IN 46219	HEALTH CARE
36 WORK COMP REHAB 6922 HILLSDALE COURT INDIANAPOLIS,IN 46250	HEALTH CARE
37 HRC NEUROPSYCH SERVICES 7250 CLEARVISTA DRIVE 327 INDIANAPOLIS,IN 46256	HEALTH CARE
38 HRC NEUROPSYCHOLOGY 8501 E 56TH STREET 140 INDIANAPOLIS,IN 46216	HEALTH CARE
39 MEDCHECK ANDERSON 1030 S SCATTERFIELD ROAD ANDERSON,IN 46012	HEALTH CARE
40 OCCUPATIONAL HEALTH 8177 CLEARVISTA PKWY INDIANAPOLIS,IN 46256	HEALTH CARE
41 SHELBYVILLE GROUP HOME 18 E MECHANIC STREET SHELBYVILLE,IN 46176	HEALTH CARE
42 NORTH RIVER CROSS ORTHOPEDICS 18051 RIVER ROAD NOBLESVILLE,IN 46062	HEALTH CARE
43 COMMUNITY SLEEP SPECIALISTS 7250 CLEARVISTA DRIVE 330 INDIANAPOLIS,IN 46256	HEALTH CARE
44 GREENFIELD OCCUPATIONAL HEALTH 124 W MUSKEGAN DRIVE GREENFIELD,IN 46140	HEALTH CARE
45 WOMEN'S & CHILDREN'S CARE CENTER 2040 N SHADELAND AVENUE SUITE 300 INDIANAPOLIS,IN 46219	HEALTH CARE
46 OLIO ROAD IMAGING CENTER 13121 OLIO ROAD 110 FISHERS,IN 46037	HEALTH CARE
47 REHAB & SPORTS MEDICINE 10122 E 10TH STREET 225 INDIANAPOLIS,IN 46229	HEALTH CARE
48 YOUTH DAY PROGRAM 6950 HILLSDALE COURT INDIANAPOLIS,IN 46250	HEALTH CARE
49 COMM REPRODUCTIVE ENDOCRINOLOGY 7250 CLEARVISTA DRIVE SUITE 365 INDIANAPOLIS,IN 46256	HEALTH CARE
50 ASSISTED FERTILITY 8040 CLEARVISTA PKWY 510 INDIANAPOLIS,IN 46256	HEALTH CARE
51 OCCUPATIONAL HEALTH 1030 S SCATTERFIELD ROAD ANDERSON,IN 46012	HEALTH CARE
52 REHAB & SPORTS MEDICINE 11911 N MERIDIAN STREET 170 CARMEL,IN 46032	HEALTH CARE
53 REHAB & SPORTS MEDICINE 740 W GREEN MEADOWS DRIVE 120 GREENFIELD,IN 46140	HEALTH CARE
54 COMMUNITY IMAGING CENTER 740 W GREEN MEADOWS DRIVE 120 GREENFIELD,IN 46140	HEALTH CARE
55 EVENING THERAPY 6950 HILLSDALE COURT INDIANAPOLIS,IN 46250	HEALTH CARE
56 COMMUNITY SLEEP SPECIALISTS 1400 N RITTER AVENUE SUITE 410 INDIANAPOLIS,IN 46219	HEALTH CARE
57 MEDCHECK EXPRESS FISHERS 8300 E 96TH STREET FISHERS,IN 46038	HEALTH CARE
58 MEDCHECK EXPRESS NOBLESVILLE 16865 CLOVER ROAD NOBLESVILLE,IN 46060	HEALTH CARE
59 CHN BARIATRIC SERVICES 7250 CLEARVISTA DRIVE 355 INDIANAPOLIS,IN 46256	HEALTH CARE
60 MEDCHECK EXPRESS INDIANAPOLIS 10617 E WASHINGTON STREET INDIANAPOLIS,IN 46229	HEALTH CARE
61 LIFECHECK 7250 CLEARVISTA DRIVE 227 INDIANAPOLIS,IN 46256	HEALTH CARE
62 BEHAVIORAL MEDICINE 6950 HILLSDALE COURT INDIANAPOLIS,IN 46250	HEALTH CARE
63 GMHC OUTPATIENT ADDICTION TREATMENT 145 GREEN MEADOWS DRIVE GREENFIELD,IN 46140	HEALTH CARE
64 MEDCHECK NOBLESVILLE 9669 E 146TH STREET 100 NOBLESVILLE,IN 46060	HEALTH CARE
65 HOOK REHAB SILP HOME 9716 E 16TH STREET INDIANAPOLIS,IN 46229	HEALTH CARE
66 BREAST HEALTH NAVIGATORS 1550 E COUNTY LINE ROAD 325 INDIANAPOLIS,IN 46227	HEALTH CARE
67 GMHC HANCOCK INTENSIVE ADDICTION TR 145 GREEN MEADOWS DRIVE GREENFIELD,IN 46140	HEALTH CARE

Schedule J
(Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 23.
▶ Attach to Form 990. ▶ See separate instructions.

▶ Information about Schedule J (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2013

Open to Public Inspection

Name of the organization
COMMUNITY HEALTH NETWORK INC

Employer identification number
35-0983617

Part I

Questions Regarding Compensation

	Yes	No
<div><div>1a</div><div>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</div><div><div><div><input type="checkbox"/> First-class or charter travel</div><div><input type="checkbox"/> Travel for companions</div><div><input type="checkbox"/> Tax idemnification and gross-up payments</div><div><input type="checkbox"/> Discretionary spending account</div></div><div><div><input type="checkbox"/> Housing allowance or residence for personal use</div><div><input type="checkbox"/> Payments for business use of personal residence</div><div><input type="checkbox"/> Health or social club dues or initiation fees</div><div><input type="checkbox"/> Personal services (e g , maid, chauffeur, chef)</div></div></div></div>		
<div><div>b</div><div>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 of the expenses described above? If "No," complete Part III to explain</div></div>	1b	
<div><div>2</div><div>Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?</div></div>	2	
<div><div>3</div><div>Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director Check all that apply Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III</div><div><div><div><input checked="" type="checkbox"/> Compensation committee</div><div><input checked="" type="checkbox"/> Independent compensation consultant</div><div><input type="checkbox"/> Form 990 of other organizations</div></div><div><div><input type="checkbox"/> Written employment contract</div><div><input checked="" type="checkbox"/> Compensation survey or study</div><div><input checked="" type="checkbox"/> Approval by the board or compensation committee</div></div></div></div>		
<div><div>4</div><div>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</div></div>		
<div><div>a</div><div>Receive a severance payment or change-of-control payment?</div></div>	4a	Yes
<div><div>b</div><div>Participate in, or receive payment from, a supplemental nonqualified retirement plan?</div></div>	4b	Yes
<div><div>c</div><div>Participate in, or receive payment from, an equity-based compensation arrangement?</div></div> <div>If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III</div>	4c	No
<div><div></div><div>Only 501(c)(3) and 501(c)(4) organizations only must complete lines 5-9.</div></div>		
<div><div>5</div><div>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</div></div>		
<div><div>a</div><div>The organization?</div></div>	5a	Yes
<div><div>b</div><div>Any related organization?</div></div> <div>If "Yes," to line 5a or 5b, describe in Part III</div>	5b	No
<div><div>6</div><div>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</div></div>		
<div><div>a</div><div>The organization?</div></div>	6a	No
<div><div>b</div><div>Any related organization?</div></div> <div>If "Yes," to line 6a or 6b, describe in Part III</div>	6b	No
<div><div>7</div><div>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</div></div>	7	Yes
<div><div>8</div><div>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 Regulations section 53 4958-4(a)(3)? If "Yes," describe in Part III</div></div>	8	No
<div><div>9</div><div>If "Yes" to line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53 4958-6(c)?</div></div>	9	

Part II **Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees.** Use duplicate copies if additional space is 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, applicable column (D) and (E) amounts for that individual

(A) Name and Title		(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 as deferred in prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
See Additional Data Table								

Part III Supplemental Information

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II

Also complete this part for any additional information

Return Reference	Explanation
SCHEDULE J, PAGE 1, PART I, LINE 4	MICHAEL C BLANCHET 504,000 0 0
SCHEDULE J, PART III	PART I, LINE 4B - SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN BRYAN A MILLS PARTICIPATED IN A SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN DURING 2013, MR MILLS DID NOT RECEIVE A PAYMENT FROM SUCH PLAN PART I, LINE 5A - COMPENSATION CONTINGENT UPON REVENUES OF ORGANIZATION DR FRANK COVINGTON, DR HANY HADDAD, AND DR MICHAEL VENTURINI ARE ELIGIBLE TO PARTICIPATE IN CHNW'S INCENTIVE COMPENSATION PLAN CHNW 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, CHNW (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 PART I, LINE 7 - NON-FIXED PAYMENTS PROVIDED COMMUNITY HEALTH NETWORK, 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

Additional Data

Software ID:
Software Version:
EIN: 35-0983617
Name: COMMUNITY HEALTH NETWORK INC

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

(A) Name		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) 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 compensation				
BRYAN A MILLS DIRECTOR/PRES & CEO	(i) (ii)	912,524	123,211	98,248	90,730	30,550	1,255,263	123,211
HANY HADDAD MD DIRECTOR	(i) (ii)	502,388	100,000	19,054	15,300	21,628	658,370	100,000
KENNETH SHAVER MD DIRECTOR	(i) (ii)	190,880		80,606	15,300	20,563	307,349	
THOMAS P FISCHER COO/CFO THRU NOV	(i) (ii)	580,157	84,337	52,465	15,300	2,400	734,659	84,337
TIMOTHY HOBBS MD CHIEF PHYSICIAN EXEC	(i) (ii)	549,579	68,003	47,945	140,711	23,059	829,297	68,003
KYLE FISHER CEO - VEI	(i) (ii)	417,977	55,936	61,550	50,415	23,864	609,742	55,936
MICHAEL C BLANCHET COO THRU JANUARY	(i) (ii)	18,864		504,902	299,500	9,939	833,205	504,000
ROBIN LEDYARD MD PRESIDENT - EAST	(i) (ii)	298,689	30,502	34,698	34,849	30,035	428,773	30,502
HOLLY A MILLARD CAO & INTERIM CFO	(i) (ii)	249,410	29,901	22,548	35,600	30,136	367,595	
JASON FAHRLANDER PRES - NORTH REGION	(i) (ii)	115,370	135,000	112	7,514	7,534	265,530	
JEFFERY KIRKHAM CFO CLINICAL ENTERPR	(i) (ii)	300,184	37,125	39,000	38,499	30,137	444,945	37,125
FRANK COVINGTON MD MEDICAL DIRECTOR	(i) (ii)	442,147	28,292	250,711	36,932	23,220	781,302	28,294
MICHAEL VENTURINI MD PHYSICIAN	(i) (ii)	552,248	67,207	68,238	128,285	28,026	844,004	
WESLEY WONG MD CHIEF PHY INTEGRTN	(i) (ii)	415,688	65,936	53,080	50,056	35,826	620,586	
KAREN ANN LLOYD VP - GENERAL COUNSEL	(i) (ii)	375,618	52,661	40,139	46,379	19,384	534,181	
THOMAS MALASTO CHIEF PATIENT EXPRNC	(i) (ii)	97,220 291,660	59,896	3,061 9,182	15,685 47,055	8,219 24,657	124,185 432,450	59,896

Schedule K
(Form 990)

Supplemental Information on Tax Exempt Bonds

OMB No 1545-0047

2013

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990. ▶ See separate instructions.
▶ Information about Schedule K (Form 990) and its instructions is at www.irs.gov/form990.

Name of the organization
COMMUNITY HEALTH NETWORK 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	INDIANA FINANCE AUTHORITY	35-1602316	45471AAM4	06-30-2009	100,000,000	SOUTH HOSP EXPANSION		X		X		X
B	INDIANA FINANCE AUTHORITY	35-1602316	45471AKA9	11-27-2012	404,346,943	SEE PART VI		X		X		X
C	INDIANA FINANCE AUTHORITY	35-1602316		11-27-2012	74,250,000	SEE PART VI		X		X		X

Part II Proceeds

		A		B		C		D	
1	Amount of bonds retired	62,540,000		6,110,000		1,585,000			
2	Amount of bonds legally defeased								
3	Total proceeds of issue	100,013,940		405,037,305		74,250,000			
4	Gross proceeds in reserve funds								
5	Capitalized interest from proceeds								
6	Proceeds in refunding escrows	134,864,877		134,864,877					
7	Issuance costs from proceeds	842,000		4,254,900		270,000			
8	Credit enhancement from proceeds	499,875							
9	Working capital expenditures from proceeds								
10	Capital expenditures from proceeds	98,672,065		59,509,354					
11	Other spent proceeds	115,807,619		115,807,619		73,980,000			
12	Other unspent proceeds	90,600,555		90,600,555					
13	Year of substantial completion	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 of bond-financed property?	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	0 630 %		0 630 %		0 970 %			
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	0 630 %		0 630 %		0 970 %			
7	Does the bond issue meet the private security or payment test?	X		X		X			
8a	Has there been a sale or disposition of any of the bond financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?		X		X		X		
b	If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of								
c	If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9	Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?	X		X		X			

Part IV

Arbitrage

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
1	Has the issuer filed Form 8038-T?		X		X		X		
2	If "No" to line 1, did the following apply?								
a	Rebate not due yet?		X	X			X		
b	Exception to rebate?	X			X	X			
c	No rebate due?		X		X		X		
	If you checked "No rebate due" in line 2c, provide in Part VI the date the rebate computation was performed								
3	Is the bond issue a variable rate issue?	X			X	X			
4a	Has the organization or the governmental issuer entered into a qualified 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 the hedge terminated?								

Part IV Arbitrage (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
5a Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X		X		
b Name of provider								
c Term of GIC								
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6 Were any gross proceeds invested beyond an available temporary period?		X		X		X		
7 Has the organization established written procedures to monitor the requirements of section 148?	X		X		X			

Part V Procedures To Undertake Corrective Action

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has 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?								

Part VI Supplemental Information. Provide additional information for responses to questions on Schedule K (see instructions).

Return Reference	Explanation
SCHEDULE K - PURPOSE OF ISSUE DESCRIPTION	INDIANA FINANCE AUTHORITY PART I, LINE B, COLUMN (F) ADVANCE REFUND THE INDIANA HEALTH FACILITY FINANCING AUTHORITY HOSPITAL REVENUE BONDS, SERIES 2005A (COMMUNITY HEALTH NETWORK PROJECT) ISSUED ON MAY 4, 2005, CURRENTLY REFUND THE HOSPITAL AUTHORITY OF MADISON COUNTY HOSPITAL REVENUE REFUNDING BONDS, SERIES 1988A (COMMUNITY HOSPITAL OF ANDERSON PROJECT) ISSUED ON APRIL 21, 1988, CURRENTLY REFUND THE INDIANA HEALTH FACILITY FINANCING AUTHORITY HOSPITAL REVENUE BONDS, SERIES 1992 (COMMUNITY HOSPITALS PROJECT) ISSUED ON JANUARY 14, 1992, CURRENTLY REFUND THE INDIANA HEALTH FACILITY FINANCING AUTHORITY HOSPITAL REVENUE BONDS, SERIES 1993 (COMMUNITY HOSPITAL OF ANDERSON PROJECT) ISSUED ON JUNE 16, 1993, CURRENTLY REFUND THE INDIANA HEALTH FACILITY FINANCING AUTHORITY HOSPITAL REVENUE REFUNDING AND IMPROVEMENT BONDS, SERIES 1995 (COMMUNITY HOSPITALS PROJECT) ISSUED ON JANUARY 4, 1996, CURRENTLY REFUND THE INDIANA HEALTH FACILITY FINANCING AUTHORITY ADJUSTABLE RATE HOSPITAL REVENUE BONDS, SERIES 1997A (COMMUNITY HOSPITALS PROJECT) ISSUED ON AUGUST 7, 1997, CURRENTLY REFUND THE INDIANA HEALTH FACILITY FINANCING AUTHORITY ADJUSTABLE RATE HOSPITAL REVENUE BONDS, SERIES 1997B (COMMUNITY HOSPITALS PROJECT) ISSUED ON AUGUST 7, 1997, CURRENTLY REFUND THE INDIANA HEALTH FACILITY FINANCING AUTHORITY ADJUSTABLE RATE HOSPITAL REVENUE BONDS, SERIES 2005C (COMMUNITY HEALTH NETWORK PROJECT) ON MAY 4, 2005 AND CONSTRUCTION OF A CANCER CENTER AT SOUTH AND NORTH, RENOVATION OF THE EMERGENCY DEPARTMENT AT EAST AND THE CONSTRUCTION OF TWO HYBRID OPERATING SUITES AT COMMUNITY HEART AND VASCULAR HOSPITAL INDIANA FINANCE AUTHORITY PART I, LINE C, COLUMN (F) CURRENT REFUNDING OF THE INDIANA HEALTH FACILITY FINANCING AUTHORITY ADJUSTABLE RATE HOSPITAL REVENUE BONDS, SERIES 2005B (COMMUNITY HEALTH NETWORK PROJECT) ISSUED ON MAY 4, 2005 AND CURRENT REFUNDING OF THE INDIANA FINANCE AUTHORITY ADJUSTABLE RATE HOSPITAL REVENUE BONDS, SERIES 2009B (COMMUNITY HEALTH NETWORK PROJECT) ISSUED ON JUNE 30, 2009
SCHEDULE K - ADDITIONAL INFORMATION	INDIANA FINANCE AUTHORITY PART II, LINE 3, COLUMN A - DIFFERENCES IN ISSUE PRICE EXPLANATION ISSUE PRICE 100,000,000 INTEREST EARNED 13,940 INDIANA FINANCE AUTHORITY PART II, LINE 3, COLUMN B - DIFFERENCES IN ISSUE PRICE EXPLANATION ISSUE PRICE 404,346,943 ESCROW INTEREST 398,294 PROJECT INTEREST 292,068 PART III, LINE 7 COLUMNS A, B, AND C - THE BONDS ARE NOT PRIVATE ACTIVITY BONDS BECAUSE THEY DO NOT MEET THE PRIVATE BUSINESS USE TEST PART IV, LINE 2C COLUMN A - DATE REBATE COMPUTATION PERFORMED THE 2009A BONDS AND THE 2009B BONDS MET THE 18 MONTH SPENDING EXCEPTION AS OF 12/30/10 PART IV, LINE 2C COLUMN C - DATE REBATE COMPUTATION PERFORMED THE 2012B BONDS MET THE 6 MONTH SPENDING EXCEPTION AS OF 12/31/12

Schedule L
(Form 990 or 990-EZ)

Transactions with Interested Persons

OMB No 1545-0047

2013

Open to Public Inspection

► Complete if the organization answered "Yes" on Form 990, Part IV, lines 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.

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

► Information about Schedule L (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

Name of the organization
COMMUNITY HEALTH NETWORK 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) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected?	
				Yes	No

2 Enter the amount of tax incurred by 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-EZ, Part V, line 38a, or Form 990, Part IV, line 26, or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?	(i) Written agreement?	
			To	From			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 assistance	(d) Type of assistance	(e) Purpose 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	200,777	WAGES		No
(2) VISIONARY ENTERPRISES INC	SHARE BD MEMBER	136,659,219	SERVICE REV/RENT		No

Part V Supplemental Information

Provide additional information for responses to questions on Schedule L (see instructions)

Return Reference	Explanation
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SCHEDULE O
(Form 990 or 990-EZ)**Supplemental Information to Form 990 or 990-EZ****2013****Open to Public
Inspection****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.****▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at
www.irs.gov/form990.**Name of the organization
COMMUNITY HEALTH NETWORK INC**Employer identification number**

35-0983617

**Return
Reference****Explanation**FORM 990 -
ORGANIZATION'S
MISSION

COMMUNITY HEALTH NETWORK, INC ("CHNW") IS A 501(C)(3) CORPORATION SERVING THE HEALTH RELATED NEEDS OF THE CITIZENS OF THE INDIANAPOLIS METROPOLITAN AREA AND CENTRAL INDIANA CHNW 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 CHNW'S MISSION IS TO A) PROMOTE THE HEALTH OF THE RESIDENTS OF CENTRAL INDIANA BY PROMOTING, SUPPORTING AND FURTHERING THE CHARITABLE PURPOSES OF COMMUNITY HOSPITAL SOUTH, INC, COMMUNITY HOSPITAL OF ANDERSON AND MADISON COUNTY, INC, COMMUNITY LTC, INC, COMMUNITY HOME HEALTH SERVICES, INC, AND INDIANA HEART HOSPITAL, LLC (COLLECTIVELY, THE "SUPPORTED ORGANIZATIONS"), AND THEIR RESPECTIVE SUBSIDIARIES AND AFFILIATES, TO CONSIDER, COORDINATE, AND FACILITATE THE ALIGNMENT OF INITIATIVES WITHIN THE COMMUNITY HEALTH NETWORK ("NETWORK") B) SERVE AS THE PARENT OF THE NETWORK, AN INTEGRATED DELIVERY SYSTEM, AND EXERCISE COMMON SUPERVISION AND CONTROL OVER THE NETWORK BY INTEGRATING, COORDINATING, AND MANAGING THE DELIVERY OF CAPITAL, RESOURCES, AND SERVICES THROUGHOUT THE NETWORK IN FURTHERANCE OF ITS ROLE AS THE PARENT, THE CORPORATION WILL BE RESPONSIBLE FOR CARRYING OUT A NUMBER OF SIGNIFICANT MANAGEMENT, GOVERNANCE, AND OPERATIONAL FUNCTIONS ON BEHALF OF THE ENTIRE NETWORK, THE SUPPORTED ORGANIZATIONS, AND THEIR RESPECTIVE SUBSIDIARIES AND AFFILIATES

Return Reference	Explanation
FORM 990	<p>FORM 990, PART I, LINE 4 - INDEPENDENT VOTING MEMBERS THE BOARD OF DIRECTORS FOR CHNW IS ALSO THE BOARD OF DIRECTORS FOR THE FOLLOWING ORGANIZATIONS COMMUNITY HOME HEALTH SERVICES, INC , COMMUNITY HOSPITAL SOUTH, INC , AND INDIANA HEART HOSPITAL, LLC WITH REGARD TO EXECUTIVE COMPENSATION, CHNW REVIEWS AND APPROVES EXECUTIVE COMPENSATION THROUGH THE DELIBERATIONS OF THE NETWORK EXECUTIVE COMPENSATION COMMITTEE COMPOSED OF INDEPENDENT OUTSIDE DIRECTORS LIKEWISE, CHNW REVIEWS AND MANAGES CONFLICT OF INTEREST TRANSACTIONS THROUGH THE DELIBERATIONS OF A NETWORK AUDIT COMMITTEE COMPOSED OF INDEPENDENT OUTSIDE DIRECTORS FORM 990, PART I, LINE 5 - NUMBER OF EMPLOYEES AS OF JANUARY 1, 2012, CHNW BECAME THE EMPLOYER FOR VARIOUS RELATED ENTITIES THE TOTAL EMPLOYEES REPORTED ON FORM W-3, TRANSMITTAL OF WAGE AND TAX STATEMENTS FILED FOR 2013 WAS 13,384</p>

Return Reference	Explanation
FORM 990, PART VI	FORM 990, PART VI, LINE 2 - RELATED PARTY INFORMATION AMONG OFFICERS THE FOLLOWING DIRECTORS SERVED AS DIRECTORS OF VISIONARY ENTERPRISES, INC , A TAXABLE AFFILIATE OF CHNW KYLE FISHER BRYAN A MILLS DR JEFFREY A MOSSLER AND KYLE FISHER RECEIVED COMPENSATION FROM VEI THE FOLLOWING DIRECTORS SERVED AS A DIRECTOR OR OFFICER OF COMMUNITY PHYSICIANS OF INDIANA, INC ("CPI") TIMOTHY HOBBS, M D JEFFREY KIRKHAM BRYAN A MILLS AND KENNETH SHAVER, M D RECEIVED COMPENSATION FROM CPI

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

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 12C	<p>CHNW HAS DELEGATED AUTHORITY FOR AUDIT AND COMPLIANCE TO THE AUDIT COMMITTEE, WHICH IS COMPOSED OF INDEPENDENT DIRECTORS. 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 CHNW. 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 CHNW, 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 CHNW.</p>

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 15A	<p>CHNW HAS ADOPTED AN EXECUTIVE COMPENSATION AND INTERMEDIATE SANCTIONS POLICY. THE PURPOSE OF THE POLICY IS TO ENSURE THAT CHNW'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 CHNW'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 2013, THE NETWORK EXECUTIVE COMPENSATION COMMITTEE FOLLOWED THIS PROCESS FOR ALL SENIOR EXECUTIVE LEADERS.</p>

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 15B	SALARIES WERE COMPARED AGAINST COMPARATIVE SALARY MARKET DATA FOR ALL POSITIONS REPRESENTING MANAGERS, CHIEF EXECUTIVE OFFICERS, CHIEF FINANCIAL OFFICERS, AND HUMAN RESOURCES REPRESENTATIVES FOR ALL NETWORK ENTITIES

Return Reference	Explanation
FORM 990, PAGE 6, PART VI, LINE 19	<p>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) CHNW 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) CHNW 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. CHNW DOES FILE THE 990 TAX RETURN ON AN ANNUAL BASIS WHICH IS AVAILABLE UPON REQUEST AND/OR AVAILABLE ON A DELAYED BASIS ON GUIDESTAR.ORG. D) COMMUNITY HEALTH NETWORK, INC. AND AFFILIATES PROVIDE ANY DOCUMENT OPEN TO PUBLIC INSPECTION UPON REQUEST.</p>

Return Reference	Explanation
FORM 990, PART XI, LINE 9	INCREASE IN ISC - EAST EQUITY INVESTMENT 785,602 INCREASE IN UNRESTRICTED PENSION 86,921,101 MISCELLANEOUS DECREASE 28 TOTAL 87,706,675

SCHEDULE R
(Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships
▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.**
▶ **Attach to Form 990.** ▶ **See separate instructions.**
▶ **Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.**

OMB No 1545-0047

2013

Open to Public Inspection

Name of the organization
COMMUNITY HEALTH NETWORK 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 (if applicable) 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 entity?	
						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) Dispropportionate 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	(i) Section 512 (b)(13) controlled entity?	
								Yes	No
(1) CHN ASSURANCE COMPANY LTD PO BOX 1051GT GRAND CAYMAN, GRAND CAYMAN CJ 98-0418913	INSURANCE	CJ	NA	C CORP		13,855,207	100 000 %	Yes	
(2) MIDWEST RACQUETBALL INC 3500 S LAFOUNTAIN STREET KOKOMO, IN 46902 35-1396016	HLTH	IN	N/A					Yes	
(3) PILLARS COMMUNITY HOUSING INC 3500 S LAFOUNTAIN STREET KOKOMO, IN 46902 16-1652666	HOUSING	IN	N/A					Yes	
(4) VISIONARY ENTERPRISES INC 6626 EAST 75TH STREET INDIANAPOLIS, IN 46250 35-1538433	MGMT SRVS	IN	N/A					Yes	
(5) VEI MICHIGAN INC 940 N MAIN STREET ANN HARBOR, MI 48104 30-0097377	MGMT SRVS	IN	N/A					Yes	
(6) WESTVIEW DELIVERY SYSTEM INC 3630 GUION ROAD INDIANAPOLIS, IN 46222 35-1910292	MGMT SRVS	IN	N/A					Yes	

Part V

Transactions With Related Organizations

Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.

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

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?		Yes	No
a Receipt of (i) interest (ii) annuities (iii) royalties or (iv) rent from a controlled entity	1a	Yes	
b Gift, grant, or capital contribution to related organization(s)	1b	Yes	
c Gift, grant, or capital contribution from related organization(s)	1c	Yes	
d Loans or loan guarantees to or for related organization(s)	1d		No
e Loans or loan guarantees by related organization(s)	1e		No
f Dividends from related organization(s)	1f		No
g Sale of assets to related organization(s)	1g		No
h Purchase of assets from related organization(s)	1h		No
i Exchange of assets with related organization(s)	1i		No
j Lease of facilities, equipment, or other assets to related organization(s)	1j		No
k Lease of facilities, equipment, or other assets from related organization(s)	1k	Yes	
l Performance of services or membership or fundraising solicitations for related organization(s)	1l		No
m Performance of services or membership or fundraising solicitations by related organization(s)	1m		No
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n		No
o Sharing of paid employees with related organization(s)	1o		No
p Reimbursement paid to related organization(s) for expenses	1p	Yes	
q Reimbursement paid by related organization(s) for expenses	1q	Yes	
r Other transfer of cash or property to related organization(s)	1r	Yes	
s Other transfer of cash or property from related organization(s)	1s	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 related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
See Additional Data Table			

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

Provide additional information for responses to questions on Schedule R (see instructions)

Return Reference	Explanation
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Additional Data

Software ID:

Software Version:

EIN: 35-0983617

Name: COMMUNITY HEALTH NETWORK 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 section 501(c) (3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
(1) COMMUNITY HEALTH NETWORK FOUNDATION 7240 SHADELAND STATION SUITE 125 INDIANAPOLIS, IN 46256 51-0181688	SUPPORT	IN	501C3	11B	CHNW	Yes	
(1) COMMUNITY HLTH SERVICES OF INDIANA 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 45-4817436	HLTH CARE	IN	501C3	3	CHNW	Yes	
(2) COMMUNITY HOME HEALTH SERVICES INC 9894 EAST 121ST STREET FISHERS, IN 46037 35-0953467	HLTH CARE	IN	501C3	9	CHNW	Yes	
(3) COMM HOSP OF ANDERSON & MADISON CTY 1515 NORTH MADISON AVENUE ANDERSON, IN 46011 35-1069822	HOSPITAL	IN	501C3	3	CHNW	Yes	
(4) COMMUNITY HOSP ANDERSON FDN INC 1515 NORTH MADISON AVENUE ANDERSON, IN 46011 86-1053152	SUPPORT	IN	501C3	11A	CHA	Yes	
(5) COMMUNITY HOSPITAL SOUTH INC 1402 E COUNTY LINE ROAD SOUTH INDIANAPOLIS, IN 46227 35-1088640	HOSPITAL	IN	501C3	3	CHNW	Yes	
(6) COMMUNITY HOWARD REGIONAL HEALTH 3500 S LAFOUNTAIN STREET KOKOMO, IN 46902 35-1865344	HOSPITAL	IN	501C3	3	CHNW	Yes	
(7) COMM HOWARD REGIONAL HEALTH FDN PO BOX 9011 KOKOMO, IN 46904 23-7309596	SUPPORT	IN	501C3	7	NA		No
(8) COMMUNITY LTC INC 1031 MONTICELLO DRIVE ANDERSON, IN 46011 35-1877441	HLTH CARE	IN	501C3	9	CHA	Yes	
(9) COMMUNITY PHYSICIANS OF IN INC 7240 SHADELAND STATION SUITE 300 INDIANAPOLIS, IN 46256 20-5392766	PHY SRV	IN	501C3	9	CHNW	Yes	
(10) HEALTH INSTITUTE OF INDIANA INC 3660 GUION ROAD INDIANAPOLIS, IN 46222 35-2022402	FITNESS	IN	501C3	9	IOH	Yes	
(11) INDIANA HEART HOSPITAL LLC 8075 NORTH SHADELAND AVENUE INDIANAPOLIS, IN 46250 35-2123783	HOSPITAL	IN	501C3	3	CHNW	Yes	
(12) INDIANAPOLIS OSTEOPATHIC HOSP INC 3630 GUION ROAD INDIANAPOLIS, IN 46222 35-1094734	HOSPITAL	IN	501C3	3	CHNW	Yes	
(13) WESTVIEW HOSPITAL FOUNDATION INC 3630 GUION ROAD INDIANAPOLIS, IN 46222 31-1036451	SUPPORT	IN	501C3	11A	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) Disproprtionate allocations?		(i) Code V-UBI amount in Box 20 of K-1 (Form 1065)	(j) General or Managing Partner?		(k) Percentage ownership
							Yes	No		Yes	No	
BROWNSBURG OFFICE CENTER 2 LLP 321 E NORTHFIELD BROWNSBURG, IN 46112 35-1929859	LEASING	IN	N/A					No			No	
CHNJMH VENTURES LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 46-2356266	DIAG/REHAB	IN	CHNW	RELATED	-1,358,527	3,251,205		No			No	51 000 %
COMMUNITY ENDOSCOPY CENTER LLC 1601 N MADISON AVENUE SUITE 300 ANDERSON, IN 46011 61-1464136	HLTH CARE	IN	N/A					No			No	
COMM HEALTH NETWORK REHAB HOSP LLC 7343 CLEARVISTA DRIVE INDIANAPOLIS, IN 46256 45-3414249	REHAB	IN	CHNW	RELATED	-1,084,140	-534,250		No		Yes		51 000 %
EAST CAMPUS SURGERY CENTER LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-2028517	SURGERY	IN	CHNW	RELATED	6,025,577	7,756,694		No			No	51 000 %
HAMILTON SURGERY CENTER LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 35-2061413	SURGERY	IN	NA	RELATED	526,708	2,008,967		No			No	11 000 %
HOWARD COMMUNITY SURGERY CTR LLC 3500 S LAFOUNTAIN STREET KOKOMO, IN 46904 35-2118748	SURGERY	IN	N/A					No			No	
HOWARD REGIONAL SPECIALTY CARE LLC 680 SOUTH FOURTH STREET LOUISVILLE, KY 40202 37-1501021	REHAB	IN	N/A					No			No	
INDIANA SPECIALTY GROUP LLC 7240 SHADELAND STATION SUITE 300 INDIANAPOLIS, IN 46256 35-1976258	HLTH CARE	IN	CHNW	RELATED	704,837	4,317,601		No			No	70 000 %
INDIANAPOLIS ENDOSCOPY CENTER LLC 7353 E 21ST STREET INDIANAPOLIS, IN 46219 35-2010874	HLTH CARE	IN	NA	RELATED	2,106,305	7,896,454		No			No	18 880 %
MICHIGAN SURGERY INVESTMENT LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 32-0147008	SURG CTRS	IN	VEI	UNRELATED	-150,414	1,161,291		No			No	40 000 %
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	VEI	RELATED	7,083,470	6,726,918		No			No	49 000 %
NORTHPOINT PEDIATRICS LLC 8101 CLEARVISTA PARKWAY SUITE 185 INDIANAPOLIS, IN 46256 35-1960566	HLTH CARE	IN	CHNW	RELATED	94,172	346,237		No			No	51 000 %
NORTHWEST SURGERY CENTER LLC 7330 SHADELAND STATION SUITE 200 INDIANAPOLIS, IN 46256 20-8754071	SURGERY	IN	N/A					No			No	

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 in Box 20 of K-1 (Form 1065)	(j) General or Managing Partner?		(k) Percentage ownership
							Yes	No		Yes	No	
PILLARS HOUSING LP 3500 S LAFOUNTAIN STREET KOKOMO, IN 46902 16-1652671	HOUSING	IN	N/A					No			No	
SOUTH CAMPUS SURGERY CENTER LLC 1550 EAST COUNTY LINE ROAD INDIANAPOLIS, IN 46227 35-2038072	SURGERY	IN	NA	RELATED	1,093,130	2,682,494		No			No	6 040 %

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

(a) Name of other organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
COMMUNITY HEALTH NETWORK FOUNDATION	C	1,425,106	BOOK VALUE
COMMUNITY HEALTH NETWORK FOUNDATION	S	259,956	BOOK VALUE
COMM HEALTH NETWORK REHAB HOSP LLC	B	6,534,353	BOOK VALUE
COMM HEALTH NETWORK REHAB HOSP LLC K-1 DISTRIBUTION	S	229,500	BOOK VALUE
COMMUNITY HOME HEALTH SERVICES INC	P	66,899	BOOK VALUE
COMMUNITY HOME HEALTH SERVICES INC	Q	586,983	BOOK VALUE
COMMUNITY HOME HEALTH SERVICES INC	R	4,721,264	BOOK VALUE
COMM HOSP OF ANDERSON & MADISON CTY	A	495,096	BOOK VALUE
COMM HOSP OF ANDERSON & MADISON CTY	Q	170,393	BOOK VALUE
COMM HOSP OF ANDERSON & MADISON CTY	R	1,551,368	BOOK VALUE
COMM HOSP OF ANDERSON & MADISON CTY	S	1,249,312	BOOK VALUE
COMMUNITY HOSPITAL SOUTH INC	S	43,919,758	BOOK VALUE
COMMUNITY HOWARD REGIONAL HLTH INC	R	14,290,967	BOOK VALUE
COMMUNITY PHYSICIANS OF IN INC	R	108,193,597	BOOK VALUE
CHN ASSURANCE COMPANY LTD	P	5,559,766	BOOK VALUE
CHN ASSURANCE COMPANY LTD	S	3,621,012	BOOK VALUE
CHNJMH VENTURES LLC	B	2,468,000	BOOK VALUE
EAST CAMPUS SURGERTY CENTER LLC PLUS K-1 DISTRIBUTION	S	5,115,715	BOOK VALUE
HAMILTON SURGERY CENTER LLC	S	450,340	BOOK VALUE
INDIANA HEART HOSPITAL LLC	A	3,161,620	BOOK VALUE
INDIANA HEART HOSPITAL LLC	Q	673,404	BOOK VALUE
INDIANA HEART HOSPITAL LLC	S	31,331,405	BOOK VALUE
INDIANAPOLIS ENDOSCOPY CENTER LLP K-1 DISTRIBUTION	S	2,027,201	BOOK VALUE
INDIANAPOLIS OSTEOPATHIC HOSPITAL	R	14,036,179	BOOK VALUE
MICHIGAN SURGERY INVESTMENT LLC	A	261,538	BOOK VALUE

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

(a) Name of other organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
MICHIGAN SURGERY INVESTMENT LLC	S	262,255	BOOK VALUE
NORTH CAMPUS SURGERY CENTER LLC K-1 DISTRIBUTION	S	9,800,000	BOOK VALUE
SOUTH CAMPUS SURGERY CENTER LLC K-1 DISTRIBUTION	S	1,058,644	BOOK VALUE
VISIONARY ENTERPRISES INC	A	1,094,287	BOOK VALUE
VISIONARY ENTERPRISES INC	K	3,829,958	BOOK VALUE
VISIONARY ENTERPRISES INC	P	45,237,372	BOOK VALUE
VISIONARY ENTERPRISES INC	Q	80,955,429	BOOK VALUE
VISIONARY ENTERPRISES INC	R	5,542,173	BOOK VALUE

TY 2013 GeneralDependencySmall**Name:** COMMUNITY HEALTH NETWORK INC**EIN:** 35-0983617**Business Name or Person Name:****Taxpayer Identification Number:****Form, Line or Instruction****Reference:****Regulations Reference:****Description:** CHI 5471 STATEMENTS

Attachment Information: COMMUNITY HOSPITALS OF INDIANA, INC. 35-0983617 YEAR ENDED: DECEMBER 31, 2013 FORM 5471 STATEMENTS: STATEMENT 1 - FORM 5471, PAGE 2, SCHEDULE C, LINE 16 - OTHER DEDUCTIONS DESCRIPTION US DOLLAR INCURRED LOSSES 4,489,292 NET INVESTMENT LOSSES 565,145 ACQUISITION COSTS 282,973 GENERAL & ADMINISTRATIVE EXP 222,356 TOTAL 5,559,766 STATEMENT 2 - FORM 5471, PAGE 3, SCHEDULE F, LINE 4 - OTHER CURRENT ASSETS BEGINNING END DESCRIPTION OF YEAR OF YEAR PREPAID EXPENSES 38,500 55,937 STATEMENT 3 - FORM 5471, PAGE 3, SCHEDULE F, LINE 12 - OTHER ASSETS BEGINNING END DESCRIPTION OF YEAR OF YEAR REINSURANCE TRUST ASSETS 13,752,752 11,950,631 RETROSPECTIVE PREMIUMS RECEIVABLE 0 1,056,500 ACCRUED INVESTMENT INCOME 108,861 90,177 DEFERRED ACQUISITION COSTS 49,579 45,001 FD HLD BY INDEP CLAIMS ADMIN 89,185 287,474 TOTAL 14,000,377 13,429,783 STATEMENT 4 - FORM 5471, PAGE 3, SCHEDULE F, LINE 17 - OTHER LIABILITIES BEGINNING END DESCRIPTION OF YEAR OF YEAR UNEARNED PREMIUMS RESERVE 720,413 721,057 PROV FOR LOSSES & LOSS ADJ 10,851,421 12,969,420 RESERVE FOR RETROSPECTIVE PREM CR 2,671,989 0 TOTAL 14,243,823 13,690,477 STATEMENT 5 - FORM 5471, PAGE 4, SCHEDULE H, LINE 2H - OTHER ADJUSTMENTS DESCRIPTION US DOLLAR DEFERRED ACQUISITION COSTS 4,578 INCURRED LOSSES 4,489,292 UNDERWRITING INCOME -5,559,766 TOTAL -1,065,896



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

**Consolidated Financial Statements
December 31, 2013 and 2012**

Community Health Network, Inc. and Affiliates

Index

December 31, 2013 and 2012

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Independent Auditor's Report

To the Board of Directors of Community Health Network, Inc

We have audited the accompanying consolidated financial statements of Community Health Network, Inc and Affiliates (the "Network"), which comprise the consolidated balance sheets as of December 31, 2013 and 2012, and the related consolidated statements of operations and changes in net assets and of cash flows for the years then ended

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America, this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error

Auditor's Responsibility

Our responsibility is to express an opinion on the consolidated financial statements based on our audits. We conducted our audits 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 consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Network's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Network's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.



Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Community Health Network, Inc. and Affiliates at December 31, 2013 and 2012, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

PricewaterhouseCoopers LLP

Indianapolis, IN
April 16, 2014

Community Health Network, Inc. and Affiliates
Consolidated Balance Sheets (in 000's)
Years Ended December 31, 2013 and 2012

	2013	2012
Assets		
Current assets		
Cash and cash equivalents	\$ 253,514	\$ 190,039
Patient accounts receivable, less allowance for doubtful accounts of \$295,102 and \$461,849 in 2013 and 2012	204,734	228,127
Estimated third-party payor settlements receivable	55,622	15,024
Current portion of assets limited as to use—held by trustee	38,172	89,697
Inventories	27,313	25,647
Other accounts receivable	32,567	27,324
Other current assets	12,099	16,474
Total current assets	624,021	592,332
Assets limited as to use		
Funds held by trustee, net of current portion	65,500	36,900
Board-designated funds	540,184	475,013
Reinsurance trust assets	11,951	13,753
Property, plant and equipment, net	792,055	789,162
Investments in unconsolidated affiliates	32,027	20,470
Capitalized software, net of accumulated amortization	59,659	56,421
Deferred financing costs, net of accumulated amortization	6,791	7,115
Other assets	12,229	13,101
Total assets	\$ 2,144,417	\$ 2,004,267
Liabilities and net assets		
Current liabilities		
Short-term borrowings	\$ 50,000	\$ 50,000
Current portion of long-term debt	27,248	16,240
Accounts payable	72,032	81,449
Accrued salaries and wages	78,171	66,610
Estimated third-party payor settlements payable	50,352	10,738
Incurred but not reported liabilities	34,370	32,210
Other current liabilities	28,970	23,654
Total current liabilities	341,143	280,901
Accrued postretirement benefit cost	-	5,010
Accrued pension	11,120	25,742
Long-term debt, net of current portion	632,756	609,520
Pension underfunded liability	104,796	191,717
Interest rate swap liabilities	4,667	8,757
Other liabilities	8,552	20,330
Total liabilities	1,103,034	1,141,977
Net assets		
Unrestricted net assets		
Network unrestricted net assets	1,011,580	835,284
Noncontrolling interest	18,220	16,801
Total unrestricted net assets	1,029,800	852,085
Temporarily restricted net assets	7,148	5,834
Permanently restricted net assets	4,435	4,371
Total net assets	1,041,383	862,290
Total liabilities and net assets	\$ 2,144,417	\$ 2,004,267

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, 2013 and 2012

	2013	2012
Revenues and gains		
Net patient service revenue	\$ 1,760,110	\$ 1,654,721
Provisions for bad debts	86,538	76,269
Net patient service revenue less provision for bad debts	1,673,572	1,578,452
Service fee revenue	25,551	23,552
Other revenue	32,875	43,168
Other revenue - electronic health record incentive payments	13,321	10,455
Gain on contribution to joint venture	8,118	-
Earnings from unconsolidated affiliates	9,932	11,204
Total unrestricted revenues and gains	1,763,369	1,666,831
Operating expenses		
Salaries, benefits and pension	999,551	931,255
Supplies and other expenses	608,562	580,066
Depreciation and amortization	81,045	75,390
Interest and financing costs- loss on early extinguishment of debt	-	17,871
Interest and financing costs	20,062	14,562
Total operating expenses	1,709,220	1,619,144
Income from operations	54,149	47,687
Realized and unrealized gains on investments, net	57,342	64,756
Unrealized gain on interest rate swaps	4,090	710
Excess of net assets acquired in Howard acquisition	-	87,291
Other, net	(1,101)	1,248
Excess of revenues over expenses and noncontrolling interests before income taxes	114,480	201,692
Provision for income taxes	7,464	5,215
Excess of revenues over expenses	107,016	196,477
Excess of revenues attributable to noncontrolling interest	(17,879)	(15,555)
Excess of revenues over expenses attributable to the Network	\$ 89,137	\$ 180,922

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, 2013 and 2012

	2013	2012
Change in unrestricted net assets		
Excess of revenues over expenses attributable to the Network	\$ 89,137	\$ 180,922
Over (under) funding of pension assets, net	86,921	(60,374)
Change in noncontrolling interest	1,419	5,063
Other changes, net	<u>238</u>	<u>(959)</u>
Increase in total unrestricted net assets	<u>177,715</u>	<u>124,652</u>
Change in temporarily restricted net assets		
Increase in temporarily restricted net assets	<u>1,314</u>	<u>1,161</u>
Change in permanently restricted net assets		
Increase in permanently restricted net assets	<u>64</u>	<u>54</u>
Increase in total net assets	179,093	125,867
Total net assets, beginning of year	<u>862,290</u>	<u>736,423</u>
Total net assets, end of year	<u>\$ 1,041,383</u>	<u>\$ 862,290</u>

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, 2013 and 2012

	2013	2012
Cash flows from operating activities		
Increase in net assets	\$ 179,093	\$ 125,867
Adjustments to reconcile increase in net assets to net cash provided by operating activities		
Depreciation and amortization	81,045	75,390
Provision for bad debts	86,653	76,583
Deferred tax benefit	3,158	3,264
Write off of deferred financing costs	-	5,871
Excess of net assets acquired in the Howard acquisition, before non-controlling interest	-	(89,954)
Gain on contribution to joint venture	(8,118)	-
Earnings from unconsolidated affiliates	(9,932)	(11,204)
Unrealized gains on investments	(26,099)	(41,260)
Other non cash charges, net	-	3,592
Change in underfunded pension/postretirement liabilities/assets	(91,931)	60,374
Distributions received from unconsolidated affiliates	10,976	11,673
Change in prepaid pension cost	(14,622)	(26,729)
Investment income received	(20,744)	8,805
Other adjustments	180	988
Changes in operating assets and liabilities		
Patient accounts receivable	(63,260)	(108,406)
Other assets	(4,612)	(5,805)
Accounts payable	(15,079)	(15,672)
Estimated third-party payor settlements	(984)	2,078
Other liabilities	7,259	22,314
Net cash provided by operating activities	<u>112,983</u>	<u>97,769</u>
Cash flows from investing activities		
Purchases of property, plant and equipment	(72,612)	(75,386)
Purchases of capitalized software	(8,960)	(26,137)
Proceeds from sale of property, plant and equipment	(6)	196
Sales (Purchases) of investments, net	507	(129,895)
Investments in unconsolidated affiliates	(4,483)	(315)
Cash acquired in the acquisition of Howard and its affiliates	-	25,015
Due to unconsolidated affiliates and related parties, net	-	(335)
Net cash used in investing activities	<u>(85,554)</u>	<u>(206,857)</u>
Cash flows from financing activities		
Proceeds from issuance of debt	50,000	485,451
Repayments of debt	(15,756)	(347,964)
Deferred financing costs	-	(4,564)
Changes in restricted contributions and investment income	1,802	1,899
Cash flows provided by financing activities	<u>36,046</u>	<u>134,822</u>
Net increase in cash and cash equivalents	<u>63,475</u>	<u>25,734</u>
Cash and cash equivalents, beginning of year	<u>190,039</u>	<u>164,305</u>
Cash and cash equivalents, end of year	<u>\$ 253,514</u>	<u>\$ 190,039</u>
Supplemental disclosures of cash flow information		
Cash paid during the year for		
Interest	\$ 20,109	\$ 29,495
Income taxes	\$ 3,694	\$ 2,390
Non cash disclosures of cash flow information		
Acquisition of property, plant and equipment included in accounts payable at December 31	\$ 5,662	\$ 4,962

The accompanying notes are an integral part of these financial statements

Community Health Network, Inc. and Affiliates

Notes to Consolidated Financial Statements (in 000's)

December 31, 2013 and 2012

1. Organization and Summary of Significant Accounting Policies

Organization

Community Health Network, Inc ("CHNw"), 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 consists of eight acute care and/or specialty hospitals, seven immediate care centers, over 500 primary care and specialty employed physicians, forty ambulatory care centers, ten freestanding surgery centers, seven outpatient imaging centers, two ambulatory centers, and four long term care facilities.

Effective June 2013, the Network contributed its Hook Rehabilitation business to a rehabilitation hospital joint venture with CRH of Indianapolis, LLC in return for a 51% ownership interest. The Network accounts for its investment in the joint venture under the equity method of accounting.

In April 2013, the Network made a capital contribution in return for a 33.3% ownership interest in Accountable Care Consortium, LLC ("ACC"). The Network accounts for its investment in ACC under the equity method of accounting.

Effective December 2012, Community LTC, Inc ("Community LTC") transferred ownership in the licenses and operations of four of its long term care facilities to Johnson Memorial Hospital ("Johnson"). Community LTC continues to manage the facilities and own the assets associated with the facilities.

Effective July 2012, the Network affiliated with Howard Regional Health System, Inc. and its affiliates (collectively "Howard"). The intent of the affiliation is to provide for the continuous operation of a general acute care hospital and related facilities in Howard County, Indiana. The affiliation was accounted for as an acquisition and thus the net assets and operations of Howard are included in the Network's consolidated financial statements beginning July 1, 2012. See Note 14.

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, and when applicable, entities that are not wholly owned 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 ("CHI").
- Indiana Heart Hospital, LLC ("CHVH") d/b/a Community Heart and Vascular Hospital, a non-profit corporation which operates a specialty hospital specializing in cardiac care as well as provides cardiac services to CHNw,
- 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 ("Westview"), 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

Community Health Network, Inc. and Affiliates

Notes to Consolidated Financial Statements (in 000's)

December 31, 2013 and 2012

center of Westview Westview Hospital Foundation, Inc ("Westview Foundation") is a non-profit corporation organized to support the activities of Westview,

- Community Howard Regional Health, Inc , ("Howard") a non-profit corporation which provides acute health care services to residents in Howard County, Indiana and surrounding areas Midwest Racquetball, Inc d/b/a Kokomo Sports Center is a for profit sports facility of Howard, Community Howard Regional Health Foundation ("Howard Foundation") is a non-profit corporation organized to support the activities of Howard,
- 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,
- 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 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, LLC ("ProHealth"), 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, ProHealth is a pass-through taxable entity that is consolidated into VEI for income tax purposes,
- CHN Assurance Company, Ltd ("Captive") is a company incorporated under the law of the Cayman Islands and a 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 does not require a letter of credit for the policy years beginning March 1, 2013 and 2014, respectively
- The Network also consolidates its interest in the following wholly owned entities
 - South Campus Surgery Center, LLC ("SCSC")
 - North Campus Surgery Center, LLC ("NCSC")
 - East Campus Surgery Center, LLC ("ECSC")
 - Hamilton Surgery Center, LLC ("Noblesville")
 - Howard Community Surgery Center, LLC ("Howard Surgery")
 - Northwest Surgery Center, LLC ("Northwest")
 - Community LTC, Inc ("LTC")
 - Howard Regional Specialty Care, LLC ("Howard Rehab")

Significant intercompany accounts and transactions have been eliminated

Community Health Network, Inc. and Affiliates

Notes to Consolidated Financial Statements (in 000's)

December 31, 2013 and 2012

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 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 immaterial reclassifications have been made to the 2012 financial statements to conform to the 2013 presentation.

Revision of Previously Reported Data

In connection with the preparation of our consolidated financial statements, we made an adjustment to our December 31, 2012 balance sheet to reflect the proper classification of our pension underfunded liability. Previously, we had reported \$20,660 as a current liability. This amount has been adjusted to be appropriately classified as a long-term liability. The adjustment was immaterial to our consolidated balance sheet and there was no impact to our consolidated statement of operations and changes in net assets or our consolidated statement of cash flows.

Cash and Cash Equivalents

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, 2013 and 2012, cash and cash equivalents include \$86,249 and \$68,035, respectively, of overnight sweep transaction agreements.

Allowance for Doubtful Accounts and Contractual Adjustments

The Network's accounts receivable are reduced by an allowance for doubtful accounts and contractual adjustments. 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 contractual adjustments and provision for bad debts. For receivables associated with services provided to patients who have third party coverage, the Network analyzes contractually due amounts and provides an allowance for contractual adjustments. For receivables associated with self-pay patients, including patient deductibles and co-insurance, the Network records a provision for bad debts in the period of service on the basis of its past experience, which indicates many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is adjusted through the allowance for doubtful accounts. For CHNw,

Community Health Network, Inc. and Affiliates

Notes to Consolidated Financial Statements (in 000's)

December 31, 2013 and 2012

CHS, VEI and CHVH, accounts that are sent to collection companies remain as accounts receivable on the balance sheet. These accounts are not written off unless returned from the collection company, however are fully reserved within the allowance for doubtful accounts. As such the allowance for doubtful accounts is significant for accounts receivable that have been fully reserved.

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, mutual funds, marketable equity securities and hedge fund of funds and are stated at fair value. The investments are classified as trading securities. The trading securities classification is based on the Network's investment strategy and investment philosophies which permit investment managers to execute purchases and sales of investments without prior approval of Network management. All unrestricted unrealized 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 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

Community Health Network, Inc. and Affiliates

Notes to Consolidated Financial Statements (in 000's)

December 31, 2013 and 2012

estimates are accounted for on a prospective basis by depreciating the assets current carrying values over their revised remaining useful lives

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.

Deferred Financing Costs

Costs associated with the issuance of long-term debt 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.

Discounts and premiums associated with long-term debt are reported as a direct deduction from, or addition to, the face amount of the long-term debt. The discounts/premiums are accreted/amortized using the effective interest method over the life of the related debt. The related income or expense is included in interest expense in the consolidated statement of operations.

Capitalized Software

The costs of obtaining or developing internal-use software, including external direct costs for materials and services and directly related payroll costs are capitalized. Amortization begins when the internal-use software is ready for its intended use. The software costs are amortized over the estimated useful lives of the software. The estimated useful lives range from 5-10 years. Costs incurred during the preliminary project stage and post-implementation stage as well as maintenance and training costs are expensed as incurred.

Self-Insured Risk

A substantial portion of the Network's professional and general liability risks, excluding 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 \$12,337 and \$13,841 at December 31, 2013 and 2012, respectively. These amounts are recorded and included in the incurred but not reported liabilities on the consolidated balance sheets.

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.

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

Community Health Network, Inc. and Affiliates

Notes to Consolidated Financial Statements (in 000's)

December 31, 2013 and 2012

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 operating expenses on the consolidated statements of operations and changes in net assets.

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 \$22,840 and \$17,966 at December 31, 2013 and 2012, respectively. These amounts are recorded and included in incurred but not reported liabilities on the consolidated balance sheets for the Network. Incurred but not reported claims reserves 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.

Derivative Instruments

The Network records derivative instruments on the consolidated balance sheet as either an asset or a liability as measured at its fair value. Changes in a derivatives' fair value are recorded each period either in revenues in excess of expenses or unrestricted net assets, depending on what type of hedge the derivative is designated as and whether or not the hedged transaction is effective or not. Changes in the fair value of derivative instruments recorded to unrestricted net assets are reclassified into earnings in the period affected by the underlying hedged item. Any portion of the fair value of a derivative instrument deemed ineffective is recognized in current earnings.

The Network had two interest rate swaps outstanding at December 31, 2013 and 2012. See Note 7 for further discussion of the two swap transactions.

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 related to uninsured patients in the period the services are provided.

Patient service revenue, net of contractual allowances and discounts recognized in the period from these major payor sources, is as follows for the years ended December 31, 2013 and 2012, respectively:

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements (in 000's)
December 31, 2013 and 2012

2013	Third Party Payors	Self-Pay	Total All Payors
Patient service revenue (net of contractual allowances and discounts)	\$ 1,666,086	\$ 94,024	\$ 1,760,110
2012	Third Party Payors	Self-Pay	Total All Payors
Patient service revenue (net of contractual allowances and discounts)	\$ 1,580,962	\$ 73,759	\$ 1,654,721

Charity Care

The Network maintains records to identify and monitor the level of charity care it provides. The Network provides 100% charity care to patients whose income level is below 200% of the Federal Poverty Level. Patients with income levels ranging from 200% - 300% of the current year's Federal Poverty Level will qualify for partial assistance determined by a sliding scale. The Network uses cost as the measurement basis for charity care disclosure purposes with the cost being identified as the direct and indirect costs of providing the charity care.

Charity care at cost was \$83,731 and \$58,163 for the years ended December 31, 2013 and 2012, respectively. Charity care cost was estimated 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.

The following is a summary of pledge receivables as of December 31, 2013 and 2012:

	2013	2012
Pledge receivables in less than one year	\$ 668	\$ 388
Pledge receivables in one to five years	305	277
Pledge receivables in more than five years	19	27
	<u>992</u>	<u>692</u>
Less: allowable for doubtful accounts	<u>(117)</u>	<u>(109)</u>
	<u>\$ 875</u>	<u>\$ 583</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

Community Health Network, Inc. and Affiliates

Notes to Consolidated Financial Statements (in 000's)

December 31, 2013 and 2012

("CMS") has chosen to take a phased approach to defining meaningful use (through three stages), using criteria that becomes more stringent over time

The definitions 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

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 incentive 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 assured 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. The Network recognized \$13,321 and \$10,455 for the years ended December 31, 2013 and 2012, respectively.

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Acquisition Costs

The Network records acquisitions costs as incurred as operating expenses

Tax Status

CHNw, CHS, CHA, CHHS, CPI, CHVH, Westview and Howard are exempt from federal income taxes under Section 501(c) (3) of the Internal Revenue Code (the "Code"), and the Foundation, Westview Foundation and the Howard Foundation are exempt from federal income taxes under Section 501a(c) (3) of the Code. VEI is a for-profit taxable entity and is subject to federal and state income taxes. ProHealth, NCSC, SCSC, ECSC, Noblesville, Howard Surgery, Northwest and MSI, which are wholly owned subsidiaries of VEI, 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 is 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 (level 2) and related interest approximates \$620,755 and \$633,515 as compared to carrying values of \$660,004 and \$625,760 as of December 31, 2013 and 2012, respectively. See Note 6 for additional information regarding the bond financing completed in November 2012.

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,
- 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

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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 16, 2014, the date the Network consolidated financial statements were issued. All material matters are disclosed in the footnotes to the consolidated financial statements.

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 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, 2011 except for Westview's cost report which has been audited through August 31, 2010 (Westview's prior fiscal year-end) and Howard's stub cost report which has been audited through December 31, 2011 (Howard's stub period-end before the affiliation with the Network). 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 \$886 and \$12,637 for the years ended December 31, 2013 and 2012, respectively. Medicare patients account for approximately 41.6% and 40.1% of gross patient charges for years ended December 31, 2013 and 2012, respectively.

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- 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 13.5% and 12.8% of gross patient charges for years ended December 31, 2013 and 2012, 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 2013. 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, 2013 and 2012, 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. There is no deferred revenue related to DSH at December 31, 2013 or 2012.

Beginning June 2012, the State of Indiana offered voluntary participation in the State of Indiana's Hospital Assessment Fee ("HAF") program, retroactive to July 1, 2011. The State of Indiana implemented this program to utilize supplemental reimbursement programs for the purpose of providing reimbursement to providers to offset a portion of the cost of providing care to Medicaid and indigent patients. This program is designed with input from Centers for Medicare and Medicaid Services and is funded with a combination of state and federal resources, including fees or taxes levied on the providers.

As a result of participating in the HAF program, for the year ended December 31, 2012, the Network recognized reimbursements of \$78,197 and fees of \$43,453 related to the period July 1, 2011 through June 30, 2012.

The Network recognizes revenues and related fees associated with the HAF program in the period in which amounts are estimable and collection or payment is reasonably assured. Reimbursement under the program is reflected within net patient service revenue and the fees paid for participation in the HAF program are recorded in supplies and other expenses within the consolidated statement of operations and changes in net assets. The fees and reimbursements are settled monthly.

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The HAF program runs on an annual cycle from July 1 to June 30 and was originally effective until June 30, 2013. The program was subsequently renewed on March 21, 2014 effective through June 30, 2017 with a retroactive effective date of July 1, 2013. As a result of the retroactive date of July 1, 2013, the Network has accrued both the estimated reimbursement and expense for the period July 1, 2013 through December 31, 2013 in estimated third-party payor settlements on the December 31, 2013 balance sheet. The consolidated balance sheet at December 31, 2013 includes \$46,036 and \$35,240 in estimated third-party payor settlements receivable and payable, respectively, related to the HAF program.

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, 2013 and 2012:

	2013	2012
Gross patient service revenue	\$ 4,633,501	\$ 3,924,938
Deductions from gross patient service revenue		
Medicare/Medicaid contractual adjustments	1,889,198	1,340,367
Other contractual adjustments	802,166	813,877
Charity discounts for patient care	182,027	115,973
Net patient service revenue	<u>1,760,110</u>	<u>1,654,721</u>
Provision for bad debts	<u>86,538</u>	<u>76,269</u>
Net patient service revenue less provision for bad debts	<u>\$ 1,673,572</u>	<u>\$ 1,578,452</u>

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, 2013 and 2012 is as follows:

	2013	2012
Medicare	26%	23%
Medicaid	9%	13%
Managed care and commercial insurance	45%	44%
Patients	20%	20%
	<u>100%</u>	<u>100%</u>

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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, 2013 and 2012

	2013	2012
Cash and cash equivalents	\$ 4,621	\$ 22,623
Fixed Income and U S Treasury obligations	89,193	103,974
Mutual Funds	9,858	-
	<u>103,672</u>	<u>126,597</u>
Less amount classified as current assets to meet current obligations	<u>38,172</u>	<u>89,697</u>
Noncurrent asset	<u>\$ 65,500</u>	<u>\$ 36,900</u>

2013 Description	Fair Value Measurements at Reporting Date			
	Total	Level 1	Level 2	Level 3
Cash and cash equivalents	\$ 4,621	\$ 4,621	\$ -	\$ -
Fixed Income and U S Treasury obligations	89,193	-	89,193	-
Mutual Funds	9,858	9,858	-	-
Total	<u>\$ 103,672</u>	<u>\$ 14,479</u>	<u>\$ 89,193</u>	<u>\$ -</u>

2012 Description	Fair Value Measurements at Reporting Date			
	Total	Level 1	Level 2	Level 3
Cash and cash equivalents	\$ 22,623	\$ 22,623	\$ -	\$ -
Fixed Income and U S Treasury obligations	103,974	-	103,974	-
Total	<u>\$ 126,597</u>	<u>\$ 22,623</u>	<u>\$ 103,974</u>	<u>\$ -</u>

The Hospital Revenue Bond Agreements (see Note 6) 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. The funds reflected in current assets relate to construction costs anticipated to be incurred during 2014.

Investment income for 2013 and 2012 related to funds held by trustee consists of the following

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	2013	2012
Interest and dividend income	\$ 404	\$ 68
Unrealized gain	2,190	(3)
Net realized gain on sales of investment securities	1,176	620
Total investment income	<u>\$ 3,770</u>	<u>\$ 685</u>

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, 2013 and 2012.

	2013 Cost	2013 Market
Cash and cash equivalents	\$ 118	\$ 118
Equity securities	488	648
Corporate bonds	206	199
Mutual funds	449,452	484,386
Hedge fund of funds/REITS/Other	48,073	54,833
	<u>\$ 498,337</u>	<u>\$ 540,184</u>

	2012 Cost	2012 Market
Cash and cash equivalents	\$ 13,576	\$ 13,576
Equity securities	24,543	30,603
Corporate bonds	59	56
Mutual funds	393,271	410,384
Hedge fund of funds/REITS/Other	21,951	20,394
	<u>\$ 453,400</u>	<u>\$ 475,013</u>

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2013		Fair Value Measurement at Reporting Date			
Description	Total	Level 1	Level 2	Level 3	
Cash and cash equivalents	\$ 118	\$ 118	\$ -	\$ -	
Equity securities	648	648	-	-	
Corporate bonds	199	-	199	-	
Mutual funds	484,386	484,386	-	-	
Hedge fund of funds/REITS/Other	54,833	-	327	54,506	
Total	<u>\$ 540,184</u>	<u>\$ 485,152</u>	<u>\$ 526</u>	<u>\$ 54,506</u>	

2012		Fair Value Measurement at Reporting Date			
Description	Total	Level 1	Level 2	Level 3	
Cash and cash equivalents	\$ 13,576	\$ 13,576	\$ -	\$ -	
Equity securities	30,603	30,603	-	-	
Corporate bonds	56	-	56	-	
Mutual funds	410,384	410,384	-	-	
Hedge fund of funds/REITS/Other	20,394	-	-	20,394	
Total	<u>\$ 475,013</u>	<u>\$ 454,563</u>	<u>\$ 56</u>	<u>\$ 20,394</u>	

	Rollforward of Level 3 Investments
Balance as of January 1, 2012	\$ 18,824
Purchases	3,056
Investment loss-realized/unrealized	(1,486)
Balance as of December 31, 2012	<u>\$ 20,394</u>
Balance as of January 1, 2013	\$ 20,394
Purchases	28,850
Investment loss-realized/unrealized	5,262
Balance as of December 31, 2013	<u>\$ 54,506</u>

As a practical expedient, the Network is permitted under US GAAP to estimate the fair value of investments in investment companies that have a calculated value of their capital account or net asset value ("NAV") at the measurement date using the reported NAV without further adjustment unless the entity expects to sell the investment at a value other than NAV or if the NAV is not calculated in accordance with US GAAP. The Network's investments in mutual funds and hedge fund of funds are fair valued based on the most current NAV.

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

- 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.

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- b) The funds designated as level 2 inputs represent fixed income securities 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
- c) The funds designated as level 3 inputs represent 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.

The following table presents liquidity information for the financial instruments carried at net asset value at December 31, 2013 and 2012

Investment Type	Redemption Frequency	Notice Period
Mutual Funds	Daily	N/A
Hedge Fund of funds	Quarterly	70 days

Investment income for 2013 and 2012 related to Board-designated funds consists of the following

	2013	2012
Interest and dividend income	\$ 14,476	\$ 14,235
Unrealized gain	19,819	41,260
Net realized gain on sales of investment securities	19,842	8,234
Total investment income	<u>\$ 54,137</u>	<u>\$ 63,729</u>

The Network's investment expenses for the years ended December 31, 2013 and 2012 were \$394 and \$532, respectively

Reinsurance Trust Assets

The assets in the trust 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, 2013 and 2012

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	2013 Cost	2013 Market	2012 Cost	2012 Market
Corporate bonds	\$ 11,819	\$ 11,592	\$ 7,724	\$ 8,011
Federal Government Agency mortgage backed securities	157	156	5,001	5,186
Cash and cash equivalents held in trust	203	203	556	556
	<u>\$ 12,179</u>	<u>\$ 11,951</u>	<u>\$ 13,281</u>	<u>\$ 13,753</u>

2013	Fair Value Measurements at Reporting Date			
Description	2013	Level 1	Level 2	Level 3
Federal Government Agency and mortgage backed securities	\$ 156	\$ -	\$ 156	\$ -
Corporate bonds	11,592	-	11,592	-
Cash and cash equivalents held in trust	203	203	-	-
Total	<u>\$ 11,951</u>	<u>\$ 203</u>	<u>\$ 11,748</u>	<u>\$ -</u>

2012	Fair Value Measurements at Reporting Date			
Description	2012	Level 1	Level 2	Level 3
Federal Government Agency and mortgage backed securities	\$ 5,186	\$ -	\$ 5,186	\$ -
Corporate bonds	8,011	-	8,011	-
Cash and cash equivalents held in trust	556	556	-	-
Total	<u>\$ 13,753</u>	<u>\$ 556</u>	<u>\$ 13,197</u>	<u>\$ -</u>

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

- 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
- The fair value of investments in money market funds (included in cash and cash equivalents within the tables above) is determined based on the net asset value per share provided by the administrators of the funds

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Investment income for 2013 and 2012 related to reinsurance trust assets consists of the following

	2013	2012
Interest income	\$ 409	\$ 388
Net realized/unrealized gains on investment securities	(974)	(46)
Total investment income	<u>\$ (565)</u>	<u>\$ 342</u>

4. Property, Plant and Equipment

Property, plant and equipment and accumulated depreciation consist of the following at December 31, 2013 and 2012

	Estimated Useful Lives	2013	2012
Land and land improvements	0-20 years	\$ 38,700	\$ 38,395
Buildings and improvements	10-90 years	929,175	904,320
Equipment	3-20 years	624,018	615,131
Construction in progress		29,744	19,650
		<u>1,621,637</u>	<u>1,577,496</u>
Less Accumulated depreciation		<u>829,582</u>	<u>788,334</u>
		<u>\$ 792,055</u>	<u>\$ 789,162</u>

Depreciation expense was \$75,207 and \$74,177 for 2013 and 2012, respectively

Property, plant and equipment include \$1,338 and \$1,578 of capitalized interest at December 31, 2013 and 2012, 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, 2013 and 2012

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	Surgery Centers	MACL	Other	Total
Balance, December 31, 2011	\$ 10,762	\$ 4,671	\$ 4,846	\$ 20,279
Capital contributions	-	-	315	315
Distributions	(6,714)	(1,540)	(3,419)	(11,673)
Equity in net income	6,193	2,657	2,354	11,204
Other	-	-	345	345
Balance, December 31, 2012	\$ 10,241	\$ 5,788	\$ 4,441	\$ 20,470
Capital contributions	490	-	3,993	4,483
Distributions	(6,683)	(1,725)	(2,568)	(10,976)
Equity in net income	6,850	2,749	333	9,932
Gain on contribution to JV	-	-	8,118	8,118
Balance, December 31, 2013	\$ 10,898	\$ 6,812	\$ 14,317	\$ 32,027

Summarized and aggregated financial statement information for the surgery centers, MACL and the other unconsolidated affiliates is as follows

	Surgery Centers	MACL	Other	Total
Total assets	\$ 21,459	\$ 44,535	\$ 66,241	\$ 132,235
Total liabilities	8,954	13,571	30,176	52,701
Net assets	12,505	30,964	36,065	79,534
Revenues	58,112	108,905	77,788	244,805
Operating income	15,731	12,475	9,965	38,171
Net income	15,370	12,493	8,176	36,039
Network's equity in net income of unconsolidated affiliates	6,850	2,749	8,451	18,050

6. Debt

Short-term Borrowings

Short-term borrowings represent outstanding borrowings under bank lines of credit. At December 31, 2013 and 2012 the following amounts were outstanding:

	Maximum Borrowings	Outstanding Balance	
		2013	2012
CHI	\$ 50,000	\$ 50,000	\$ 50,000
CHA	2,000	-	-
		\$ 50,000	\$ 50,000

The bank lines of credit are due on demand. 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-

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average effective rates on CHI's short term borrowings were 0.84% and 1.72% for the years ended December 31, 2013 and 2012, respectively

In January 2014, CHI subsequently paid down its line of credit. At January 31, 2014, there was no balance outstanding on CHI's \$50.0 million line of credit.

Long-term debt

Long-term debt at December 31, 2013 and 2012 is summarized as follows:

	Obligated Entity	2013	2012
Indiana Finance Authority, Adjustable Rate Hospital Revenue Bonds, Series 2012A Interest payable monthly (ranging from 2.0% - 5.0%) Due May 1, 2013 to May 1, 2028 4.00% term bonds due May 1, 2025 5.00% term bonds due May 1, 2042 Unamortized premium	CHNw	\$ 106,700 88,930 174,455 27,135 \$ 397,220	\$ 112,810 88,930 174,455 28,074 \$ 404,269
Indiana Finance Authority, Adjustable Rate Hospital Revenue Bonds Series 2012B, Interest payable monthly (1.05% rate at 12/31/13) Due November 27, 2012 to November 27, 2039	CHNw	\$ 72,665 \$ 72,665	\$ 74,250 \$ 74,250
Indiana Finance Authority, Adjustable Rate Hospital Revenue Bonds, Series 2009A Interest payable monthly (0.5% rate at 12/31/13) Due July 1, 2009 to July 1, 2039 Unamortized discount	CHNw	\$ 37,455 (126) \$ 37,329	\$ 38,335 (131) \$ 38,204

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	Obligated Entity	2013	2012
Indiana Finance Authority, Adjustable Rate Hospital Revenue Bonds, Series 2005A and 2005B, Interest payable monthly (0.03% - 0.05% effective rate at December 31, 2013) due January 1, 2007 to January 1, 2035	Howard	\$ 44,470	\$ 45,420
Indiana Health Facility Financing Authority, Adjustable Rate Hospital Revenue Bonds, Series 2000A and 2000B Interest payable monthly (0.05% effective rate at December 31, 2013) due July 1, 2002 to July 1, 2028	CHNw	\$ 35,000	\$ 37,800
Fifth Third Bank, Term Loan, interest payable quarterly (1.50% effective rate at December 31, 2013), Due December 31, 2014	WV	\$ 5,680	\$ 6,108
Salin Bank Notes, interest payable monthly (3.16% effective rate at December 31, 2013), Due September 8, 2025	Howard	\$ 8,799	\$ 9,406
BMO Harris Bank, Term Loan, Interest payable monthly (1.33%) or (3.27%) Due November 18, 2020	CHNw	\$ 49,470	\$ -
Other long-term debt		\$ 9,371	\$ 10,303
		\$ 660,004	\$ 625,760
Less Current portion of long-term debt		27,248	16,240
Long-term debt, net of current portion		<u>\$ 632,756</u>	<u>\$ 609,520</u>

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Series 2012A and 2012B

On November 27, 2012, the Indiana Finance Authority ("IFA") issued Hospital Revenue Bonds, Series 2012A and Adjustable Rate Hospital Revenue Bonds, Series 2012B, in the aggregate amount of \$450,445 for the purpose of making a loan to CHNw. 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 CHNw. The Series 2012 A and Series 2012 B bonds are subject to redemption prior to their stated maturity at the option of CHNw 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.

Proceeds from the issuance of the Series 2012A and Series 2012B bonds were used to refinance the following series of bonds: 1988, 1993, 1992, 1995, 1997A and B, 2005A, B and C, and 2009B.

Series 2009A and 2009B

On June 30, 2009, the Indiana Finance Authority ("IFA") issued Adjustable Rate Hospital Revenue Bonds, Series 2009A and 2009B, 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 mentioned above, the Series 2009B was refunded with proceeds of Series 2012B. As a result, the letter of credit is no longer outstanding. As credit support for the 2009A bonds, the Network has an outstanding letter of credit with a bank for a maximum aggregate principal draw amount of \$37,455 plus accrued interest as of December 31, 2013. The letter of credit expires for the Series 2009A on September 9, 2015. The Series 2009A bonds are subject to redemption prior to their stated maturity at the option of CHNw on a thirty day notice in whole or in part, at redemption price equal to 100% of the principal amount plus interest at the date of redemption.

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 CHNw. 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 credit support for the 2005B and 2005C bonds, the Network had two outstanding letters of credit with banks for a maximum aggregate principal draw amount of \$34,000. The Series 2005B and Series 2005C bonds were refunded with proceeds from the Series 2012A and Series 2012B bonds. The Series 2005A bonds were advanced refunded with proceeds from the Series 2012A bonds and were legally defeased.

Series 2005A and 2005B - Howard

On July 1, 2012, Howard affiliated with the Network and its results since that date are consolidated with the Network as of December 31, 2013 and 2012. As a result, Howard's outstanding bonds are now reflected on the Network's consolidated balance sheet as of December 31, 2013 and 2012.

On January 1, 2005, the Indiana Finance Authority ("IFA") issued Adjustable Rate Hospital Revenue Bonds, Series 2005A and Series 2005B, in the aggregate amount of \$50,000 for the purpose of making a loan to Howard. 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 Howard. As of December 31, 2013, the outstanding letters of credit with the bank associated with this debt is the principal amount of \$44,470 plus accrued interest. The letters of credit expires November 13, 2015. The Series 2005A and Series 2005B bonds are subject to redemption prior to their stated maturity at the option of CHNw on a thirty day notice in

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whole or in part, at redemption price equal to 100% of the principal amount plus interest at the date of redemption

Howard has interest rate swap agreements related to its Series 2005A and Series 2005B bonds. Through the swaps, Howard pays a fixed rate on a portion of the Series 2005A and Series 2005B bonds. The swaps mature on January 1, 2035 consistent with the maturity date of the bonds. See Note 7 for further disclosure related to the interest rate swaps.

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 CHNw. As of December 31, 2013, the outstanding letter of credit with the bank associated with this debt is the principal amount of \$35,000 plus accrued interest. The letter of credit expires September 9, 2015. The Series 2000A and 2000B bonds are subject to redemption at the option of CHNw on a thirty day notice at a redemption price equal to 100% of the principal amount plus interest at the date of redemption.

Term Loan - Westview

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.

Salin Bank Notes

On September 8, 2005, Howard entered into promissory notes with Salin Bank. The notes bear interest at a five year fixed interest rate equal to the five year U.S. Treasury rate constant plus 1.75%. The interest rate is adjusted every five years on the anniversary date of the loans. The loans mature September 8, 2025. The notes are secured by a pledge of unrestricted receivables.

Term Loan - CHNw

On November 18, 2013, CHNw entered into a Master Note Obligation, Series 2013-TL to evidence and secure payments between CHNw and BMO Harris Bank. The loan was made to secure costs associated with the Network's electronic medical record information system. Principal and interest payments are due monthly. The loan matures November 18, 2020.

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. The Series 1997A and Series 1997B bonds were refunded with proceeds from the Series 2012A bonds.

Community Health Network, Inc. and Affiliates
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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 Series 1995 bonds were refunded with proceeds from the Series 2012A bonds. A bank purchased the tendered bonds for par value. Simultaneously, CHNw 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 0.30 percent. The 1995 swap was terminated on November 27, 2012 consistent with when the Series 1995 bonds were refunded.

Series 1993, 1992, 1992A, and 1988A

With respect to the Series 1993, 1992, 1992A, and 1988A Hospital Revenue Bonds, there were loan agreements between CHNw, CHA and the conduit issuing authorities with similar terms as described for the Series 1995 Hospital Revenue Bonds except the bonds were 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.

Series 1998, 1993, 1992A and 1988 bonds were refunded with proceeds from the Series 2012A bonds. The Series 1992 bonds matured on May 1, 2012.

A bank purchased the tendered bonds at 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 0.40 percent. The 1992 interest rate swap was terminated on November 27, 2012 consistent with when the Series 1992 bonds were refunded. The 1992A interest rate swap was terminated on May 1, 2012 when the outstanding principal on the Series 1992A bonds was paid.

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, 2013.

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

2014	\$ 27,248
2015	21,053
2016	21,457
2017	21,985
2018	21,823
Thereafter	519,429
	<hr/>
	632,995
Plus: Unamortized premium, net	27,009
	<hr/>
	\$ 660,004

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements (in 000's)
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For 2013 and 2012, interest cost incurred and capitalized in connection with the construction of capital assets aggregated \$520 and \$520, respectively

7. Derivative Instruments

Howard has two interest rate swap agreements outstanding on its Series 2005A and Series 2005B bonds. The terms and fair values (level 2) of the outstanding swaps are as follows:

As of December 31, 2013

Original Notional	Current Notional	Effective Date	Fixed Rate	Rate	Fair Value	Termination Date
\$ 30,000	\$ 26,680	October 3, 2005	3.550%	0.12%	\$ (3,500)	January 1, 2035
10,000	8,895	October 3, 2005	3.550%	0.12%	(1,167)	January 1, 2035
					<u>\$ (4,667)</u>	

As of December 31, 2012

Original Notional	Current Notional	Effective Date	Fixed Rate	Rate	Fair Value	Termination Date
\$ 30,000	\$ 27,250	October 3, 2005	3.550%	0.11%	\$ (6,567)	January 1, 2035
10,000	9,085	October 3, 2005	3.550%	0.11%	(2,190)	January 1, 2035
					<u>\$ (8,757)</u>	

The swaps were entered into as a means to manage interest rate risk on Howard's variable rate bond debt. The intention of the swap agreements were to effectively change Howard's variable interest rate on the Series 2005A and 2005B bonds to a fixed rate of 3.55%. The variable rate on the swaps is 70% of the USD-LIBOR BBA and resets monthly. The swaps have been deemed ineffective and have been dedesignated as hedges. As such, Howard accounts for changes in the fair value of the swaps on a marked to market basis each month with the unrealized gains/loss from the changes in the fair value of the swaps being recorded in the Network's non operating income/loss section of the consolidated statement of operations. The net interest activity from the monthly settlement of the swaps is recorded in interest expense in the statement of operations.

The following amounts have been recorded in the Network's consolidated statement of operations as of December 31, 2013 and 2012:

	2013	2012
Non Operating Income (Expenses)		
Net unrealized gains (losses) on changes in fair value of interest rate swaps	<u>\$ 4,090</u>	<u>\$ 710</u>
Income from Operations		
Interest expense, net	<u>\$ 1,216</u>	<u>\$ 616</u>

Community Health Network, Inc. and Affiliates

Notes to Consolidated Financial Statements (in 000's)

December 31, 2013 and 2012

8. Employee Benefit Plans

Defined Benefit and Other Postretirement Benefit Plans

The Network has defined benefit retirement plans covering substantially all employees of CHNw, CHA, CHHS and CHVH. 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 and Westview plans.

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, CHVH 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. CHNw made contributions to the plan of \$12,830 and \$24,574 during 2013 and 2012, respectively.

The Replacement Plan is a defined benefit plan. The fair value of the plan assets was \$13,072 and \$10,153 at January 1, 2013 and January 1, 2012, respectively. 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 2013 and 2012. No contributions were made during 2013. During 2012, CHNw made contributions to the plan of \$2,100.

In August 2013, the Network terminated its postretirement benefit plan which offered retiree health insurance benefits. As a result of terminating the plan, the Network recognized a one time gain of \$5,700 in its consolidated statement of operations.

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements (in 000's)
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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	
	2013	2012	2013	2012
Service cost	\$ 3,635	\$ 1,757	\$ -	\$ 359
Interest cost	25,365	25,922	\$ -	164
Expected return on plan assets	(34,360)	(32,171)	-	-
Amortization of net (gain) loss	4,481	2,284	-	(42)
Net pension (income) expense	<u>\$ (879)</u>	<u>\$ (2,208)</u>	<u>\$ -</u>	<u>\$ 481</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	
	2013	2012	2013	2012
Change in benefit obligation				
Benefit obligation, beginning of period	\$ 659,806	\$ 572,407	\$ -	\$ 3,578
Service cost	3,635	1,757	-	359
Interest cost	25,365	25,922	-	164
Amendments	-	-	-	2,560
Actuarial gain (loss)	(93,942)	81,073	-	845
Participant contributions	-	-	-	13
Expenses paid - actual	(3,569)	(3,554)	-	-
Benefits paid - actual	<u>(19,469)</u>	<u>(17,799)</u>	<u>-</u>	<u>(21)</u>
Benefit obligation, end of period	<u>\$ 571,826</u>	<u>\$ 659,806</u>	<u>\$ -</u>	<u>\$ 7,498</u>

	Pension Benefits		Postretirement Benefits	
	2013	2012	2013	2012
Change in plan assets				
Fair value of plan assets, beginning of year	\$ 448,955	\$ 389,601	\$ -	\$ -
Actual return on plan assets	20,370	54,032	-	-
Contributions	12,830	26,675	-	21
Expenses paid - actual	(3,569)	(3,554)	-	-
Benefit paid - actual	<u>(19,469)</u>	<u>(17,799)</u>	<u>-</u>	<u>(21)</u>
Fair value of plan assets, end of year	<u>\$ 459,117</u>	<u>\$ 448,955</u>	<u>\$ -</u>	<u>\$ -</u>

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements (in 000's)
December 31, 2013 and 2012

	Pension Benefits		Postretirement Benefits	
	2013	2012	2013	2012
Reconciliation of Funded status				
Accrued pension cost, net	\$ (7,913)	\$ (21,622)	\$ -	\$ (5,010)
Prepaid pension (liability) asset	(104,796)	(189,229)	-	(2,488)
(Under) funded status	(112,709)	(210,851)	-	(7,498)
Unrecognized net actuarial loss (gain)	105,048	189,567	-	(190)
Unrecognized prior service (cost) credit	(252)	(338)	-	2,678
Accrued pension cost, net	\$ (7,913)	\$ (21,622)	\$ -	\$ (5,010)

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	
	2013	2012	2013	2012
Projected benefit obligation	\$ 571,826	\$ 659,806	\$ -	\$ -
Accumulated benefit obligation	\$ 571,826	\$ 659,806	\$ -	\$ 7,498
Fair value of plan assets	\$ 459,117	\$ 448,955	\$ -	\$ -

Actuarial Assumptions

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

	Pension Benefits		Postretirement Benefits	
	2013	2012	2013	2012
Discount rate	5 03%	3 91%	-	3 91%

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

	Pension Benefits		Postretirement Benefits	
	2013	2012	2013	2012
Discount rate	3 91%	4 61%	-	4 61%
Expected long-term rate of return on plan assets	7 8%-8 0%	8 2%-8 4%	-	-

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.

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements (in 000's)
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Assumed Health Care Costs

In establishing the net periodic postretirement benefit expense and year end benefit obligation, a 6.9% annual rate of increase in per capital cost of covered health benefits was assumed for 2012. The rate was assumed to decrease gradually to 4.5% and 4.5% over a 15-year period and an 18-year period for 2012. 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 \$882 in 2012. 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 postretirement benefit cost of \$85 in 2012. As previously disclosed, the postretirement benefit plan terminated during 2013.

Plan Assets

The weighted-average allocation of the defined benefit plans at December 31, 2013 and 2012, by asset category are as follows:

	Retirement Plan			Replacement Plan		
	2013	2012	2012	2013	2012	2012
	Target Allocation	Actual Allocation	Actual Allocation	Target Allocation	Actual Allocation	Actual Allocation
Equity securities ^(a)	14%	14%	44%	46%	49%	43%
Fixed income securities ^(a)	55%	54%	33%	19%	18%	33%
Real estate ^(a)	6%	6%	6%	8%	8%	7%
Other	25%	26%	17%	27%	25%	17%
Total	100%	100%	100%	100%	100%	100%

(a) Includes mutual funds

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.

The following tables present the fair values of the plan assets at December 31, 2013 and 2012. Refer to Note 3 for explanations of fair value designation.

Community Health Network, Inc. and Affiliates
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2013 Description	Fair Value Measurements at Reporting Date			
	2013	Level 1	Level 2	Level 3
Cash and Cash Equivalents	\$ 38,383	\$ 38,383	\$ -	\$ -
Corporate bonds	100,846	-	100,846	-
Mutual Funds	166,347	166,347	-	-
U S Treasury Obligations	102,334	-	102,334	-
Hedge Fund of Funds	51,207	-	-	51,207
Total	<u>\$ 459,117</u>	<u>\$ 204,730</u>	<u>\$ 203,180</u>	<u>\$ 51,207</u>

2012 Description	Fair Value Measurements at Reporting Date			
	2012	Level 1	Level 2	Level 3
Cash and Cash Equivalents	\$ 2,154	\$ 2,154	\$ -	\$ -
Equity securities	29,718	29,718	-	-
Corporate bonds	72,665	-	72,665	-
Mutual Funds	253,030	253,030	-	-
U S Treasury Obligations	71,855	-	71,855	-
Hedge Fund of Funds	19,533	-	-	19,533
Total	<u>\$ 448,955</u>	<u>\$ 284,902</u>	<u>\$ 144,520</u>	<u>\$ 19,533</u>

	Rollforward of Level 3 Investments
Balance as of January 1, 2012	\$ 18,031
Purchases	-
Investment gain-realized/unrealized	1,502
Balance as of December 31, 2012	<u>\$ 19,533</u>
Balance as of January 1, 2013	\$ 19,533
Purchases	26,320
Investment gain-realized/unrealized	5,354
Balance as of December 31, 2013	<u>\$ 51,207</u>

Community Health Network, Inc. and Affiliates

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Cash Flows

The Network expects to make a contribution of \$12,310 to the CHNw Retirement Plan in fiscal 2014

Estimated Future Benefit Payments

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

	Pension Benefits
2014	\$ 22,294
2015	\$ 24,053
2016	\$ 25,825
2017	\$ 27,653
2018	\$ 29,274
2019-2023	\$ 168,813

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 the entire 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 approximated \$37,523 and \$32,024 for 2013 and 2012, respectively.

Effective July 1, 2012, Howard's two existing defined contribution plans were merged into the Network's defined contribution plans. The assets transferred into the Network's 401k plan were \$21,588. The assets transferred into the Network's 403b plan were \$11,988. All employees of Howard became CHNw employees effective with the affiliation date of July 1, 2012 and participate in the Network's 401k plan.

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.

CHVH 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. CHVH matches 50% of participant contributions up to 5% of the participants' compensation.

Community Health Network, Inc. and Affiliates

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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 distributed the assets of the plan during 2012.

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.

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.

Effective January 1, 2014, VEI, CHVH and Westview merged their respective 401(k) plans into the Network's 401(k) plan.

9. Income Taxes

For 2013 and 2012, federal taxable income originating in the Network's for-profit entities was approximately \$15,800 and \$10,300, respectively. Income tax expense of \$7,464 and \$5,215 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.

At December 31, 2013, VEI has unused federal income tax operating loss carry forwards of approximately \$1,177, which expire at various dates through 2017.

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 \$42,561 and \$45,618 for 2013 and 2012, respectively.

Community Health Network, Inc. and Affiliates
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Future minimum rental payments for each of the next five years at December 31, 2013 are as follows

2014	\$ 38,103
2015	28,287
2016	23,444
2017	20,100
2018	18,498
Thereafter	89,105
	<u>\$ 217,537</u>

11. Functional Expenses

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

	2013	2012
Nursing services	\$ 308,920	\$ 301,090
Other professional services	725,033	640,103
General services	113,421	103,572
Fiscal services	254,419	248,213
Administrative services	133,738	145,099
Employee health and welfare	151,671	141,265
Health service claims expense	(79,089)	(68,021)
Depreciation and amortization	81,045	75,390
Interest	20,062	32,433
	<u>\$ 1,709,220</u>	<u>\$ 1,619,144</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, 2013 and 2012 are available for the following purposes:

	2013	2012
Medical education	\$ 2,175	\$ 2,119
Clinical/patient support	1,494	1,163
Capital improvements	3,479	2,552
	<u>\$ 7,148</u>	<u>\$ 5,834</u>

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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, 2013 and 2012 are as follows, with a description of how the investment income is to be used:

	2013	2012
Medical education	\$ 2,455	\$ 2,405
Clinical/patient support	264	258
Capital improvements	1,716	1,708
	<u>\$ 4,435</u>	<u>\$ 4,371</u>

The Network is an income beneficiary of certain irrevocable trusts. The aggregated income (loss) from these trusts was \$735 and \$897 for the years ended December 31, 2013 and 2012, respectively.

13. Commitments and Contingencies

Community Hospital of Anderson and Madison County

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

Pending Litigation

Claims for employment matters, 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, 2013 that may result in the assertion of additional claims, and other claims may be asserted arising from services provided to patients in the past. We do not believe that claims and lawsuits individually or in aggregate will have a material adverse effect on the Network's future consolidated financial position, results from operations, or cash flows.

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Management believes that the Network is in compliance with applicable government laws and regulations. Regulatory inquiries are made in the normal course of business and compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time. Violations of these regulations could result in the imposition of significant fines and penalties, as well as having a significant effect on reported income from operations or cash flows.

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, 2013, the Network had purchase commitments for various equipment and services of \$48,311.

Community Health Network, Inc. and Affiliates
Notes to Consolidated Financial Statements (in 000's)
December 31, 2013 and 2012

14. Acquisitions

On July 1, 2012, the Network affiliated with Howard. 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 958-805, *Not for Profit Entities: Mergers and Acquisitions* ("ASC 958"). The Network recognized the fair value of Howard's assets and liabilities in its consolidated financial statements as of July 1, 2012 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. Howard's profit and losses are reflected in the Network's accompanying consolidated statements of operations beginning on July 1, 2012.

The fair value of the assets and liabilities acquired as of July 1, 2012 is as follows:

	Preliminary Allocation	Final Allocation Adjustments	Adjusted Allocation
Cash and cash equivalents	\$ 25,015	\$ -	\$ 25,015
Patient accounts receivable, net	10,882	-	10,882
Other current assets	19,640	-	19,640
Property, plant and equipment	126,173	(1,676)	124,497
Other long term assets	3,788	-	3,788
Total assets	185,498	(1,676)	183,822
Current liabilities	24,551	-	24,551
Long term debt	69,317	-	69,317
Total liabilities	93,868	-	\$ 93,868
Excess in fair value of net assets acquired before noncontrolling interest	\$ 91,630	\$ (1,676)	\$ 89,954
Noncontrolling interest	2,663	-	2,663
Excess in fair value of net assets acquired net of noncontrolling interest	\$ 88,967	\$ (1,676)	\$ 87,291

During 2013, the Network finalized and adjusted the purchase price allocation. The December 31, 2012 balance sheet and statement of operations and changes in net assets have been revised for the above adjustments in accordance with ASC 805, *Business Combinations*.

Community Benefit Report

Fiscal Year 2013

2013 Community Benefit Report & Strategy Supplemental Information IRS 990 Schedule H

Part 1:
**SCHEDULE H
(Form 990)**

Department of the Treasury
Internal Revenue Service
Name of the organization

Hospitals

- Complete if the organization answered "Yes" to Form 990, Part IV, question 20.
► Attach to Form 990. ► See separate instructions.
► Information about Schedule H (Form 990) and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2013

Open to Public
Inspection

Employer identification number

COMMUNITY HEALTH NETWORK, INC.
35-0983617
Part I Financial Assistance and Certain Other Community Benefits at Cost

		Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	X	
b If "Yes," was it a written policy?	1b	X	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year			
<input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities			
<input type="checkbox"/> Generally tailored to individual hospital facilities			
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year			
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care	3a	X	
<input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____%			
b Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care	3b	X	
<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 _____%			
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care			
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	X	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	X	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	X	
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		X
6a Did the organization prepare a community benefit report during the tax year?	6a	X	
b If "Yes," did the organization make it available to the public?	6b	X	

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

Financial Assistance Policy

Financial Assistance information is available on our website

Community Health Network

**COMMUNITY HEALTH NETWORK
NETWORK POLICY & PROCEDURE
TITLE: Financial Assistance Program
Policy #: NETFIN003**

APPROVED FOR:

☒ COMMUNITY HEALTH NETWORK FOUNDATION, INC. ☒ COMMUNITY PHYSICIAN NETWORK
☒ COMMUNITY HEALTH NETWORK, INC. ☒ INDIANA PROHEALTH NETWORK, INC.
☒ COMMUNITY HOSPITAL SOUTH, INC. ☒ VISIONARY ENTERPRISES, INC.
☒ COMMUNITY HOSPITALS OF INDIANA, INC. ☒ COMMUNITY HEART AND VASCULAR HOSPITAL
(ATTACHED INITIAL PEACT AND THE DATE POLICY CHANGED, ARE EXCLUDED FROM THIS POLICY (SEE SECTION 1.13))

Original Date	04/01/2006		
Effective Date	01/01/2012		
Revised/Reviewed	Change Summary	Revised/Reviewed	Change Summary
12/13/05	Revised Section 4.1	1/29/2007	Revised Section 3.5
07/03/06	Revised Section 3.5	3/29/2007	Delete Attachment C and Section 1.11.3
06/16/06	Delete Section 1.11.5	1/29/2008	Update Poverty Guidelines
11/01/06	Addition Section 3.9.3.12	2/12/2008	Addition Section 3.3
01/15/07	Addition Section 6	2/7/2009	Update Poverty Guidelines and 1.16.1
1/29/2007	Revised Section 3.5	11/5/2010	Revised
3/29/2007	Delete Attachment C and Section 1.11.3	1/1/2012	Major Revision: Sliding Scale/ policy, restructure

POLICY

It is the policy of the Community Health Network, Inc. ("Community") and its affiliates that anyone who identifies themselves as unable to pay all or a part of their medical care maintains the right to apply for financial assistance. A financial clearance process will be followed by associates of Community to determine if a patient meets the network's definition of a medically indigent patient or may qualify for other forms of financial assistance. Charity is not considered a substitute for personal responsibility. Patients are expected to cooperate with the network's procedures and fulfill documentation requirements required for qualification for the assistance program. In addition, patients will be expected to contribute to the cost of their care based on their ability to pay. Individuals with the financial capacity to afford insurance will be encouraged to do so in order to ensure access to future healthcare services, protect their overall health, protect their assets, and lower the costs of care for the citizens of the Community Health Network service area.

PURPOSE

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

The 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 that 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.

Community Health Network

COMMUNITY HEALTH NETWORK NETWORK POLICY & PROCEDURE

TITLE: Financial Assistance Program

DEFINITIONS

Applicant: Patient or Guarantor requesting screening for the financial assistance program at Community may specify an individual or a family in the case of multiple wage earners within the same home that fulfill the definition of "Family" below

Charity Care: Services that are delivered, but are never expected to be reimbursed. These services represent the facility's policy to provide free or discounted care to qualifying members of the service area

Family: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to the Internal Revenue Service, if the patient claims someone else as a dependant on their income tax return, they may be considered as dependant for the purposes of the provision of financial assistance

Family Income: Family Income is determined using the census bureau definition, which uses the following income when computing federal poverty guidelines

- Includes earnings, unemployment compensation, workers' compensation, social security, Supplemental Security income, public assistance, veteran's 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, and other miscellaneous sources,
- Non-cash benefits (such as food stamps and housing subsidies) do not count,
- Determined on a **before** tax basis,
- Excludes capital gains and losses,
- If a person lives with a family, includes the income of all family members (non-relatives, such as housemates, do not count)
- Community will follow a medical debt provision when calculating the monthly income for a patient seeking qualification for financial assistance. The financial counselor will calculate **Adjusted Family Income** by subtracting existing current medical payments from gross income. The patient's bill will be adjusted (*see section E*) according to the adjusted income and family size. Alternatively, 5% of total current (<60 days) outstanding balances may be deducted from their income

Medically Indigent- A medically indigent patient is defined as one whose income is sufficient to cover basic living expenses, but cannot pay for medical services. The term may also be applied to persons with adequate incomes who are faced with unexpected, catastrophically high medical bills

Uninsured: The patient has no level of insurance or other third party assistance to assist with meeting payment obligations for healthcare services

Underinsured: The patient has some level of health insurance, but the out-of-pocket expenses still exceed his/her financial capability

Community Health Network**COMMUNITY HEALTH NETWORK
NETWORK POLICY & PROCEDURE****TITLE: Financial Assistance Program****1. Additional Policy Terms****1.1 Provision of Financial Assistance**

Annually, the Community Health Network will establish a percentage of total consolidated operating expenses to be allotted 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. Specifically, the following healthcare services fall within the scope of the financial assistance program at Community:

1.3.1 Emergency Medical Services provided in Emergency department setting at any Community Health Network hospital (RC 150.451),

1.3.2 Services delivered in any setting that if delayed would result in an adverse change in the health status of a patient,

1.3.3 Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting,

1.3.4 Medically necessary services, as rendered or referred by a physician and evaluated on a case-by-case basis by Community Health Network. Such necessary services delivered in a non-emergency setting may be performed at the discretion of Community and its physicians at a pre-determined site of service/level of care in order to be deemed eligible for financial assistance.

1.4 Excluded Services

All services provided to a patient that are deemed elective or not medically necessary will not be subject to any financial assistance discounting. This would include, but is not limited to the following service types:

1.4.1 Cosmetic procedures (plastics)

1.4.2 Bariatric procedures

1.4.3 Infertility Services

1.4.4 Certain orthopedic procedures as determined by the network.

1.5 Determination of Eligibility.

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. In non-emergency situations the determination of eligibility for Financial Assistance will ideally 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. The collection process will not be hindered during the financial assistance program adjudication process.

Community Health Network**COMMUNITY HEALTH NETWORK
NETWORK POLICY & PROCEDURE****TITLE: Financial Assistance Program****1.6 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.

1.7 Staff Information:

All employees in patient registration, billing, collections, patient accounting, finance and Emergency Services areas will understand the fundamentals of the Financial Assistance Policy, have access to the application forms, and be able to direct questions to the appropriate staff member(s).

1.8 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.

1.9 Financial Assistance Representative:

Each corporation will designate an individual to approve Financial Assistance applications, coordinate outreach efforts and oversee Financial Assistance practices.

1.10 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.

1.11 Physician Participation:

We will encourage and support physicians not employed by Community Health Network who possess admitting privileges and others who provide services to our patients to establish and implement a Financial Assistance program for the patients they see in connection with services rendered by Community. We will provide qualification status for individual patients, upon request, to physicians who are making efforts to financially clear their patient. Such communication will reveal minimum necessary information. (See *Appendix C*—"Notification of Financial Assistance Program Qualification")

1.12 Notification/Duty to Inform:--Notwithstanding any other provision of any other policy at Community regarding billing and collection matters, Community will not engage in any extraordinary collection actions before it makes reasonable efforts to determine whether an individual who has an unpaid bill from Community is eligible for financial assistance under this policy.

1.12.1 For the purposes of this policy "Extraordinary efforts" include lawsuits, liens, garnishments, or other collection efforts that are deemed extraordinary by the U.S. Department of Treasury or the Internal Revenue Service.

1.12.2 "Reasonable Efforts" will be deemed significantly fulfilled via any combination of the following information delivery tools:

1.12.2.1 Posters and Brochures-- A notice (Attachment B) of the availability of Financial Assistance will be posted in each patient registration and waiting area. Brochures (Attachment C) 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.

1.12.2.2 Oral Notification -- All points of access will make every effort to inform each

Community Health Network

COMMUNITY HEALTH NETWORK NETWORK POLICY & PROCEDURE

TITLE: Financial Assistance Program

- Responsible Party about the existence of the network's Financial Assistance program in the appropriate language during any pre-admission, registration, admission or discharge Process. Additionally, the collection process post-service will integrate notification of the availability of assistance into the standard process when collection efforts fail.
- 1 12 2 3 Statement Notification- statements will provide information about the financial assistance program.
- 1 12 2 4 "About Your Bill- Frequently Asked Questions." Copies of these documents will be available in patient registration areas, through the Business Offices and Patient Financial Counselors, as well as available online at www.communitycnh.com. These documents will substantially meet the content and language set forth in Attachment D.
- 1 12 2 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.
- 1 13 **Uniformity across Network:** 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. The only exclusions to this are certain business units operating separate financial assistance programs due to regulations or statutory requirements. Such entities include:
- 1 13 1 Gallahue Mental Health Services
- 1 13 2 The Jane Pauley Center, a Federally Qualified Healthcare Center (FQHC)
- 1 14 **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 re-codified from time to time. Such report will be made available to the public upon request.
- 1 15 **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 16 **Accounting:** Accounting for Financial Assistance will be in accordance with the Community Benefits Accounting Policy.
- 1 17 **Internal Record Keeping:**
- 1 17 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 and available in the network's imaging system. 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 17 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 17 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.

Community Health Network

COMMUNITY HEALTH NETWORK NETWORK POLICY & PROCEDURE

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2. **Eligibility for Financial Assistance--** The financial clearance process will include investigation and collection of relevant documentation to verify available income (current and past), family size, assets, and other factors that may affect the network's decision to extend charity care or assistance to an individual. Any individual that follows the financial clearance process and ultimately meets the network's financial guidelines will receive free care or substantially discounted services according to the applicant's financial resources.
 - 2.1 **Generalized patient situation** The following are examples that can serve as guidelines for charity care consideration:
 - 2.1.1 Uninsured patients who lack the ability to pay
 - 2.1.2 Insured patients who lack the ability to pay for services not covered by their insurer
 - 2.1.3 Deceased patient without an estate
 - 2.1.4 Unsupported disabled patient with little or no income
 - 2.1.5 Patients involved in a medical catastrophe that results in financial hardship
 - 2.2 **Interested Party Requests-** 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 Community personnel. We will inform the Responsible Party of such a request and it will be processed as any other such request.
 - 2.3 **Conversion from Uninsured-**When an Uninsured patient has been given a discount on an account(s) under policy "Uninsured Discount 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 **Presumptive eligibility for financial assistance**
 - 2.4.1 There are instances when a patient is unable to complete the financial assistance application and/or supply the necessary supporting documentation. In such cases, the financial counselor shall complete the enrollment form on behalf of a patient and search for evidence of indigence. ***For non-Medicare Traditional enrolled applicants,*** Community staff will use all available resources to verify such information including public databases, credit reports, or other directories. Staff must find documentation of at least two of the following unless marked as automatic eligibility:
 - 2.4.1.1 Current enrollment in State assistance program (food stamps, welfare, certain pharmaceutical assistance programs, etc.): **AUTOMATIC Eligibility**
 - 2.4.1.2 Natural Disaster victim as designated by federally published zip codes: **AUTOMATIC Eligibility**
 - 2.4.1.3 Low-income housing resident, supported by a county appraisal district record: **AUTOMATIC Eligibility**
 - 2.4.1.4 Unfavorable credit history (delinquent accounts, charge-offs, bankruptcy filing within past year, no credit)
 - 2.4.1.5 Lack of family support for incapacitated patient
 - 2.4.1.6 Mental incompetence as declared by a licensed medical professional
 - 2.4.1.7 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
 - 2.4.1.8 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
 - 2.4.1.9 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

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- 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.
- 2.4.1.10 When a Medicaid patient is admitted for inpatient 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.
- 2.4.1.11 Upon verbal confirmation of family size and income by the applicant, outside financial information (e.g. credit scores) and/or "propensity to pay" scoring information provided by an outside vendor may be used as a screening tool for the manual verification of eligibility for the Community financial assistance program.
- 2.4.2 **Automated Presumptive Eligibility** - In an effort to screen 100% of patients for potential charity care eligibility, **Community Hospital East, Community Hospital North, Community Hospital South, Community Heart and Vascular, and other Community subsidiaries** utilize data from trusted third-party vendors to automatically estimate the financial condition of each *non-Medicare Traditional enrolled applicants*. This data is collected from multiple sources using multiple methodologies including predictive modeling to maximize the accuracy of these financial estimates.
- 2.4.2.1 To accomplish these tasks, the aforementioned hospitals and other network affiliates 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.
- 2.4.2.2 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.
- 2.4.2.3 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.

Community Health Network

COMMUNITY HEALTH NETWORK NETWORK POLICY & PROCEDURE

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- 2.4.2.4 A guarantor'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
- 2.4.2.5 Automated presumptive eligibility qualification will not provide prospective coverage for patients as prospective coverage is reserved for those who qualify through the manual qualification process
- 2.4.3. **Special Programs Affiliation-** As approved by the leadership of each network entity, a relationship may be established whereby patient referrals from specified outside sources may be deemed as presumptively qualified for the Community financial assistance program in order to facilitate expedited access to services. Such affiliations require
 - 2.4.3.1 significant initial due diligence before initiation to determine volume and resource constraints
 - 2.4.3.2 Scrutiny of the referring sources methodology for assessment of a patient's qualification of for assistance. Revenue cycle leadership must deem the qualification process as acceptable
 - 2.4.3.3 creation of a specific insurance/plan number within the patient accounting system
- 3. **Collection of data for the Manual Determination of Financial Need**
 - 3.1. Financial Assistance Application- upon request from Community the Financial Assistance Application must be completed by the patient or the financial counselor on their behalf and submitted to the network for review before financial assistance will be considered (See *Attachment a "Financial Assistance Program Information and Application"*). The following items may be requested to substantiate financial need of an individual patient
 - 3.1.1 Recent W-2s, recent payment stub to verify income level, and/or previous year's tax forms
 - 3.1.2 External public data that provide information on a patient's or guarantor's ability to pay (such as credit scoring or property searches). A credit report will be obtained to verify lack of assets to pay off any outstanding debt
 - 3.1.3 Non-qualification for any other State/Government financial assistance programs (i.e. Medicaid or other grant-based county or city programs). Substantial effort will be made by Community and its business associates to identify alternative sources of payment via patient qualification for other programs before financial assistance will be granted. This effort will require cooperation from the patient/guarantor. Lack of cooperation with this phase of the determination process will disqualify the patient from the Community Health Network financial assistance program
 - 3.2. Collection of Family Size and Income Data Family size and income are the key drivers of the calculation to determine qualification for financial assistance. Community's definitions of family size and income are located in the "Definitions" section of this policy. For purposes of determining the scope of documentation required with the application
 - 3.2.1 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)
 - 3.2.2 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

Community Health Network

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- signed plus the spouse and all dependents on that person(s) tax return(s)
- 3.2.3 As per section **2.4.1.11**, Family income, family size, FPL %, and other data may be obtained and used to corroborate provided details leading to eligibility for Community's financial assistance program

4. Calculation of Scope of Eligibility

4.1 Assistance Basis

The basis for the Community Health Network's financial assistance policy is the Federal Poverty Level (FPL) guidelines as published annually by the U.S. Department of Health and Human Services. The calculation of the financial assistance discount is a conversion of the patient's basic demographic information (monthly family income and family size) into a % of FPL.

4.2 Assistance Levels

A Sliding Scale assistance protocol will be applied to each patient account as follows:

- 4.2.1 Patients (applicants) with income levels less than 200% of the current year's federal poverty level (FPL) with no substantial assets will qualify for 100% financial assistance. Patients in this category are considered medically indigent.
- 4.2.2 Patients (applicants) with income levels ranging from 200% to 300% of the current year's federal poverty level (FPL) will qualify for partial assistance determined by a sliding scale detailed in table 1.1.
- 4.2.3 Patients (applicants) with income levels greater than 300% of federal poverty level (FPL) will not be eligible for the financial assistance program unless approved by the Director, Patient Financial Services. These patients may be eligible to receive discounted rates on a case-by-case basis based on their specific situation, such as catastrophic illness, at the discretion of the Community Health Network through an appeal process.

4.3 Liability Limitation- Responsible Parties who do not qualify for financial Assistance (>300% of the FPL) will have medical/dental debt per calendar year limited to twenty-five percent (25%) of their annual family income. In such cases the patient must present all medical bills for the 12 months immediately preceding the application date or must be evidenced in the Community's patient accounting system. At the point where the 25% threshold has been met during this 12 month period, Community will limit further liability for services provided within the network that are subject to the terms of the financial assistance policy.

4.4 Patients qualifying for partial assistance will be asked to pay the determined balance in full. If patient cannot pay the discounted balance in full then patients can be set up on payment arrangements within the payment arrangement guidelines. All others follow the chart below, but no patient will receive charity care if >300% of FPL without approval from the Director, Patient Financial Services. If a patient qualifies for <100% discount, he/she will be asked to pay a 50% deposit in advance of services and enter into an acceptable balance resolution plan.

4.5 Based on the totality of a patient's circumstances, further allowances may be made at the discretion of the Director, Patient Financial Services.

5. Financial Assistance Coverage Date Span

5.1 It is preferred, but not required, that a request for charity and a determination of financial need occur *prior* to the rendering of services. However, the determination may be completed at any point during the collection cycle. However, the following restrictions apply:

5.1.1 Financial Assistance eligibility is only partially retroactive. Only accounts with dates of service falling within the 6 months immediately prior to the application month will be considered for provision of financial assistance.

5.1.2 Accounts assigned to an outside collection agency can only be recalled if ≤60 days have passed since the date of assignment.

5.1.2.1 The account must not be in a legal status as evidenced by a new lawsuit, an upcoming court date, scheduled mediation or an outstanding judgment.

Community Health Network

COMMUNITY HEALTH NETWORK NETWORK POLICY & PROCEDURE

TITLE: Financial Assistance Program

- 5.1.3 Prospective Coverage through financial assistance program
 - 5.1.3.1 Patients will be granted extended prospective financial assistance eligibility for a period of 6 months from the date of qualification.
 - 5.1.3.2 Patients outside the immediate Community Health Network service area (Marion, Boone, Hamilton, Madison, Hendricks, Hancock, Morgan, Johnson, Shelby counties) may not be granted prospective coverage unless approved by Director, Patient Financial Services.
 - 5.1.3.3 Financial assistance Expiration date shall always be rounded up to the final day of the month in which the prospective coverage period ends.
Example:- If a patient is approved for a 3-month prospective coverage period on 5/15/2011, the expiration of the financial assistance approval will be 8/31/2011.

6 Processing of Applications for Financial Assistance

- 6.1 Application Process
 - 6.1.1 An application for financial assistance will be provided to any requesting party. This may be done in person or by mail (Attachments A). Assistance in completing the application will be available and provided to the Responsible Party as required.
 - 6.1.2 The patient will also be provided a list of additional documentation that will be required to substantiate their financial situation. The application and all required supplemental documentation must be received before a decision can be made regarding the provision of financial assistance.
 - 6.1.3 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.
 - 6.1.4 All patients submitting an application will have their respective accounts at issue logged in appropriate database for future use.
 - 6.1.5 Using the documentation provided, the Financial Counselor will use the current year's financial assistance program criteria to determine the "scope of eligibility" as detailed in **section 4** of this policy.
 - 6.1.6 Patient Approval/Denial Notification Requirements
 - 6.1.6.1 Upon receipt of a complete application, it will be approved or denied within thirty (30) days following the date of receipt.
 - 6.1.6.2 The applicant will be given or mailed a letter indicating approval or denial and, if approved, the amount of debt discharged, any balance due and the date due.

Calculated % of FPL	Discount %	CDM-Adjustment
≤ 200%	100%	0910
200%-225%	90%	0910
226%-250%	80%	0910
251%-275%	70%	0910
276%-300%	60%	0910

Community Health Network

**COMMUNITY HEALTH NETWORK
NETWORK POLICY & PROCEDURE**

TITLE: Financial Assistance Program

Written By Charles B. Meadows

Network Vice President Revenue Cycle

Approved By



Thomas P. Fischer, CFO

Date

5/10/12

Forms & Brouchures

ADDENDUM A-1

Community Health Network

APPLICATION FOR FINANCIAL ASSISTANCE

Your application for financial assistance is welcome. For your convenience we offer two ways to apply for financial assistance.

- Call Customer Service at 317-355-5555. This is the easiest way to apply. In most cases we can work with you to determine if you qualify for financial assistance with one phone call.
- Complete this short application and return it according to directions noted on the bottom of the application.

We will do everything possible to accurately and quickly evaluate your application. The information you provide will be held in strict confidence and will not be used for any purpose other than to assess your need for financial assistance. We will not share this information with any person or organization outside of Community Health Network. The person completing this application must be an adult 18 years of age or older who is financially responsible for the payment of unreimbursed medical care provided by Community Health Network.

Please provide the following information so we can better understand how many people are in your family. Dependents may live outside of your primary household residence if they are claimed on your (or your spouses) tax return.

APPLICANT NAME _____ TELEPHONE # _____ E-MAIL _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH ____/____/____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE/DEPENDENT FAMILY INFORMATION

	NAME	RELATIONSHIP	SSN	DOB
1			____-____-____	____/____/____
2			____-____-____	____/____/____
3			____-____-____	____/____/____
4			____-____-____	____/____/____
5			____-____-____	____/____/____
6			____-____-____	____/____/____

FAMILY FINANCIAL INFORMATION

What is your monthly household pre-tax spendable income from all sources such as, but not limited to wages, salaries, tips, commissions, pensions, Social Security interest, investments, rent, royalties, alimony, child support, disability benefits, unemployment compensation, etc.?

\$

ADDITIONAL QUALIFICATION INFORMATION

1. Did you apply for Medicaid through your home state? ☐ YES ☐ NO Was your application approved? ☐ YES ☐ NO

2. Did you or your spouse have active health insurance at the time of service or up to 75 days prior? ☐ YES ☐ NO

If yes, Insurance Carrier Name _____ Policy Number _____

I CERTIFY that the information I have provided is a true and accurate representation of my family size and household income. I understand that any misrepresentation of this information will result in a denial of financial assistance. I authorize Community to access additional sources of information to verify my qualification for assistance.

Applicant/Patient Signature _____ Date _____

Spouse Signature (if co-applicant) _____ Date _____

Thank you for your application and for the opportunity you have given us to serve your health care needs. Please return your completed application to: Fax Number (317) 355-7863, Email Address: financial@community.com or U.S. Mail Address: 1500 N. River Ave. Indianapolis, IN 46219. We will notify you of our decision in writing within 10 business days of the receipt of your application.

717 Financial Assistance App 11-12

ADDENDUM A-2

Community Health Network

APPLICATION FOR FINANCIAL ASSISTANCE

Thank you for giving us the opportunity to serve your health care needs and for contacting us to resolve your outstanding account balance.

Although you have met the initial screening qualifications for financial assistance we need additional information to complete the application process. The information you provide will be held in strict confidence and will not be used for any purpose other than to assess your need for financial assistance. We will not share this information with any person or organization outside of Community Health Network. It is very important that you return this application to us within the next three business days.

Please provide the following information so we can better understand how many people are in your family. Dependents may live outside of your primary household residence if they are claimed on your (or your spouses) tax return.

APPLICANT NAME _____ TELEPHONE # _____ EMAIL _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH ____/____/____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE/DEPENDENT FAMILY INFORMATION

	NAME	RELATIONSHIP	SSN	DOB
1			- - - - -	- / - / -
2			- - - - -	- / - / -
3			- - - - -	- / - / -

FAMILY FINANCIAL INFORMATION

What is your monthly household pre-tax, spendable income from all sources such as, but not limited to wages, salaries, tips, commissions, pensions, Social Security interest, investments, rent, royalties, alimony, child support, disability benefits, unemployment compensation, etc.?

\$


I CERTIFY that the information I have provided is a true and accurate representation of my family size and household income. I understand that any misrepresentation of this information will result in a denial of financial assistance. I authorize Community to access additional sources of information to verify my qualification for assistance.

Applicant/Patient Signature _____ Date _____

Spouse Signature (if co-applicant) _____ Date _____

Thank you for your application and for the opportunity you have given us to serve your health care needs. Please return your completed application to: Fax Number (317-351-7862) Email Address financialhelp@community.com or U.S. Mail Address: 11700 N. Ritter Ave. Indianapolis, IN 46219. We will notify you of our decision in writing within 10 business days of the receipt of your application.

10 Financial Assistance App 2



Community Health Network

ADDENDUM A-3

APPLICATION FOR FINANCIAL ASSISTANCE

Thank you for giving us the opportunity to serve your health care needs and for contacting us to resolve your outstanding account balance.

We need additional information to evaluate your application for financial assistance. Please complete this application and return it along with the supplemental documentation required. The information you provide will be held in strict confidence and will not be used for any purpose other than to assess your need for financial assistance. We will not share this information with any person or organization outside of Community Health Network.

Please provide the following information so we can better understand how many people are in your family. Dependents may live outside of your primary household residence if they are claimed on your (or your spouses) tax return.

APPLICANT NAME _____ TELEPHONE # _____ E-MAIL _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH ____/____/____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE/DEPENDENT FAMILY INFORMATION				
	NAME	RELATIONSHIP	SSN	DOB
1			____-____-____	____/____/____
2			____-____-____	____/____/____
3			____-____-____	____/____/____

FAMILY FINANCIAL INFORMATION

What is your monthly household, pre-tax, spendable income from all sources such as, but not limited to wages, salaries, tips, commissions, pensions, Social Security interest, investments, rent, royalties, alimony, child support, disability benefits, unemployment compensation, etc.?

\$

Please submit unaltered copies of the following documents

- The first page of your most recent federal tax return
- The first page of your spouse's federal tax return if you filed separately
- Bank statements for the past two months
- Your spouse's bank statements for the past two months if there is a separate account

ADDITIONAL QUALIFICATION INFORMATION

I CERTIFY that the information I have provided is a true and accurate representation of my family size and household income. I understand that any misrepresentation of this information will result in a denial of financial assistance. I authorize Community to access additional sources of information to verify my qualification for assistance.

Applicant/Patient Signature _____ Date _____

Spouse Signature (if co-applicant) _____ Date _____

Thank you for your application and for the opportunity you have given us to serve your health care needs. Please return your completed application to: Fax Number (317-351-7862); Email Address (online@chnc.community.com) or U.S. Mail Address (1500 N. Ritter Ave., Indianapolis, IN 46219). We will notify you of our decision in writing within 10 business days of the receipt of your application.

U-990 (990) H-100 (2010) OF PAGE 2

Poster

ATTACHMENT B

Poster

Table Top or Wall Mounted with Brochure Rack

To Our Patients:

Are you worried that you may not be able to pay for all or part of your care?

We may be able to help.

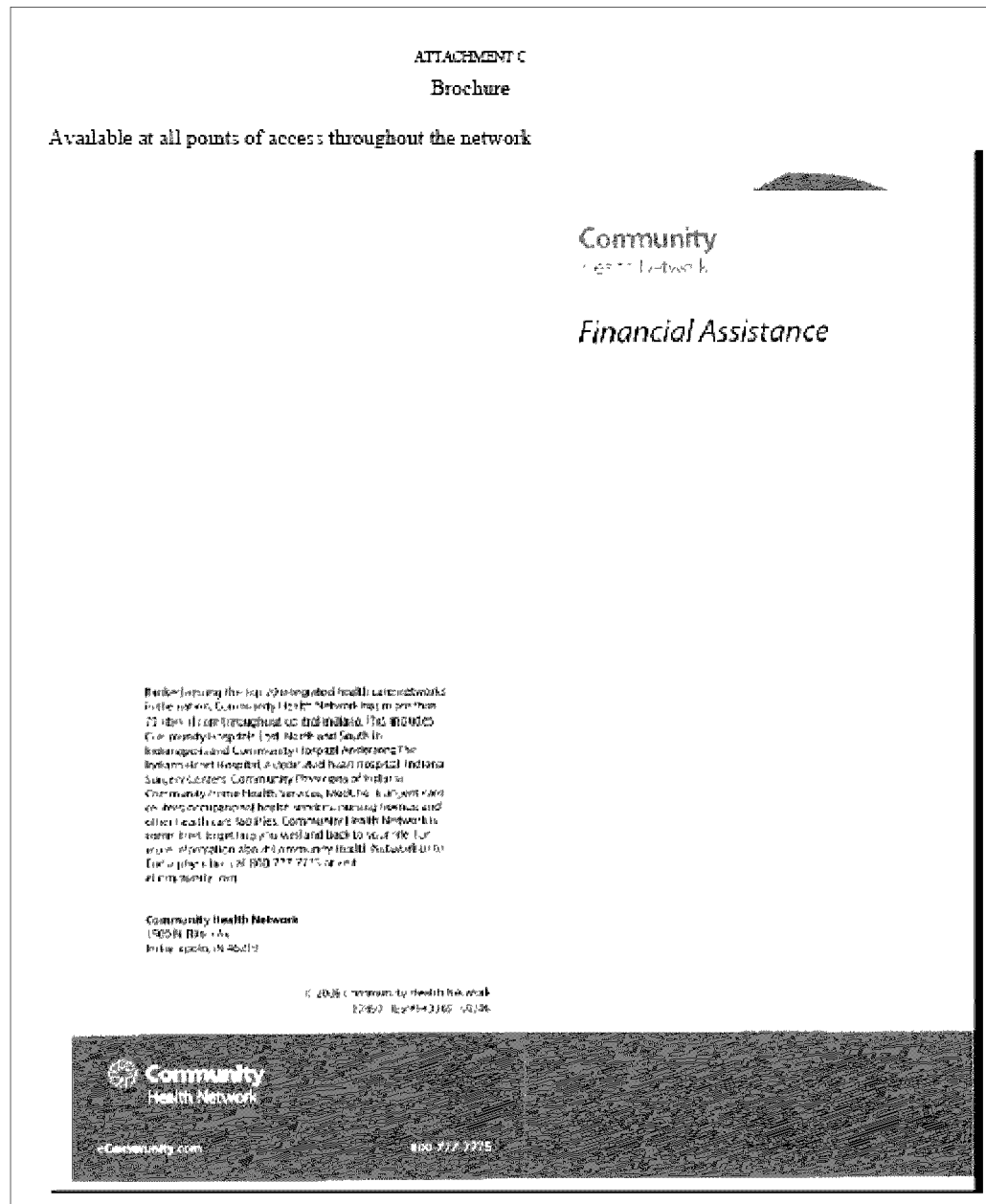
Please speak with one of our Financial Counselors who will provide you with more information about financial assistance and payment arrangements.

Thank you.



Community
Health Network

Brouchure Front and Back Page



Brouchure Center Fold

At Community Health Network, we're committed to keeping you healthy. As a result, concerns about your ability to pay should never stop you from seeking needed care.

If you are worried about your ability to pay for the services you need, we may be able to help. Medical bills are often unplanned, and it can be difficult to understand exactly

May we provide you with financial assistance?

- You may qualify for medically necessary services free of charge.
- You may qualify for our discount for 10% uninsured.
- You may qualify for a new birth, birth from your spouse, financial or other assistance.
- You may qualify for a payment plan.

If you believe that you may need assistance with your bill, please call 1-800-635-6776 for more information.

Community Health Network has financial counselors available who can explain your bill, answer billing or insurance questions, arrange payment options or provide applications for financial assistance with the bill.

Community Hospital Anderson

1515 N. Madison Ave., Anderson, IN 46001
765-298-3300 or 866-298-5633

Community Hospital East

1500 N. Ritter Ave., Indianapolis, IN 46219
317-621-5633

Community Hospital North

7150 Clearvista Dr., Indianapolis, IN 46256
317-621-5317

Community Hospital South

1401 E. County Circle Rd., South Indianapolis, IN 46225
317-621-7420

The Indiana Heart Hospital

8075 Shadeland Ave., Indianapolis, IN 46256
317-621-8000

Community Regional Cancer Care Center

7227 Clearvista Dr., Indianapolis, IN 46256
317-621-9100

Community Health Pavilion Saxony

15121 Elm Rd., Fishers, IN 46037
317-621-1419

Community North Imaging Center

6601 Clearvista Parkway, Indianapolis, IN 46256
317-621-1640

Carmel Imaging

1011 N. Madison St., Suite 375, Carmel, IN 46032
317-621-6718

Greenfield Imaging

7416 Green Meadows Dr., Suite 120
Greenfield, IN 45602
317-621-7410, 317-731-1144

Sample Spanish FAQ's

Community
Health Network

Addendum D

PROGRAMA DE ASISTENCIA FINANCIERA PREGUNTAS FRECUENTES

¿Por qué debo aplicar para Asistencia Financiera?

Si piensa que no podía pagar la factura completa o parte de ella, aun cuando tenga seguro médico, usted nos debe notificar. Si califica para recibir asistencia financiera, se reducirá su factura de acuerdo con su habilidad de pagar tomando en consideración su ingreso y su situación financiera. Si no califica para recibir asistencia financiera pero necesita más tiempo para pagar, con gusto prepararemos juntos un plan de pago.

¿Qué tipo de descuento puedo esperar si califico para recibir Asistencia Financiera?

Esta asistencia dependerá del porcentaje de Límite Federal de Pobreza (FPL por su siglas en inglés) de su familia. Si su ingreso familiar es menos de 200 por ciento del FPL su cubrimiento será del 100%. Para ingresos que estén sobre los 200 por ciento del FPL, el descuento será menor.

¿Qué necesito hacer para aplicar para Asistencia Financiera?

Completar la Solicitud de Asistencia Financiera y remitir los documentos solicitados.

¿Cuánto tiempo tengo para remitir mi Solicitud, Declaración y documentos?

Tiene quince (15) días a partir de la Fecha de Pención Inicial indicada en el margen superior derecho de la Solicitud.

¿Qué sucede si no puedo remitirlos en quince (15) días de calendario?

Con una razón justificada, puede solicitar una extensión de quince (15) días de calendario.

¿Los esfuerzos de colección continuarán por la cuenta?

Si, la persecución del pago completo continuará hasta la fecha en la cual su solicitud sea adjudicada. Es decir las cuentas no se pondrán en alto durante este periodo.

¿Cuándo recibire una decisión?

Le notificaremos sobre la decisión dentro de treinta (30) días laborables siguientes al recibo de su solicitud completa.

¿Tengo que hacer algo más para calificar para Asistencia Financiera?

Le pediremos que coopere con el proceso de la identificación de cualquier otra fuente financiera disponible para cubrir el cuidado médico anterior y futuro.

¿Qué sucede si rehúso cooperar con el proceso de evaluación de asistencia financiera o no aplico para estos recursos disponibles?

Usted no está obligada a cooperar con cualquier aspecto del proceso de aplicación de este programa; no tiene que hacerlo. Sin embargo, se le negará su aplicación para ayuda financiera. Se espera la cooperación con todos los aspectos de este programa.

¿Permaneceré como parte del programa de asistencia financiera para servicios futuros?

Este cubrimiento de servicio puede extenderse para fechas futuras relacionado a su situación. Hable con el consejero financiero para aclarar este periodo de cubrimiento.

¿Qué sucede si no estoy satisfecho con la decisión?

Puede apelar a nuestra decisión. Debe presentar su apelación por escrito e incluir la razón de su apelación. Esta apelación puede incluir información adicional y/o un cambio en las circunstancias.

¿Cuánto tiempo tengo para presentar la apelación?

Se debe recibir su apelación dentro de quince (15) días laborables a partir de la fecha que recibio nuestra decisión.

Envíe su apelación a

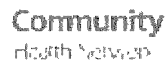
Financial Assistance Appeals Coordinator
CHN Patient Accounts
1500 N. River Avenue
Indianapolis, IN 46219

¿Cuándo me notificarán de su decisión en relación a mi apelación?

Será notificado sobre la decisión dentro de veinte (20) días laborables a partir de la fecha que recibamos su apelación.

¿Es final esta decisión?

Si, la decisión es final. Sin embargo, no le previene que solicite asistencia financiera para nuevas facturas no sujetas a esta solicitud.

Sample English FAQ's**FINANCIAL ASSISTANCE PROGRAM
FREQUENTLY ASKED QUESTIONS****Why should I apply for Financial Assistance?**

If you believe that you may not be able to pay all or part of your Bill, even if you have insurance, you should let us know. If you qualify for financial assistance, your Bill will be reduced in accordance with your ability to pay considering your income and financial situation. If you do not qualify for financial assistance but need extra time to pay, we will be happy to make payment arrangements with you.

What kind of discount can I expect if I qualify for assistance?

Your qualification for this program will be based on your family's percentage of the Federal Poverty Limit (FPL). If you are $\leq 200\%$ of the current year's FPL, your care will be covered 100%. For those falling above 200% FPL, the discount will be less.

What do I need to do to apply for Financial Assistance?

Complete the Financial Assistance Application and submit the requested documents.

How soon do I need to submit my Application, Statement and documents?

You have fifteen (15) calendar days from the Initial Date of Request indicated in the upper right hand corner of the Application.

What if I can't get it done in fifteen calendar (15) days?

You may request an extension of fifteen (15) calendar days for good cause.

Will collection efforts continue for the accounts?

Yes, pursuit of payment in full will continue until such time as your application is adjudicated. I.e., accounts will not be placed on hold during this time frame.

When will I get a decision?

We will notify you of the decision within thirty (30) business days following our receipt of your completed application.

Do I have to do anything else to qualify for Financial Assistance?

We may ask that you cooperate with the process to identify any other eligible payment sources to cover past or future medical care.

What if I refuse to cooperate with the financial assistance screening process or do not apply for these available resources?

If you choose not to cooperate with any aspect of this program's application process, you are not required to do so. However, your application for financial assistance will be denied. Cooperation with all aspects of this program is expected.

Will I remain a part of the financial assistance program for future services?

Your coverage by this program may extend into future dates of service relative to your situation. Speak to the financial counselor about this coverage period.

What if I am not satisfied with your decision?

You may appeal our decision. You must put your appeal in writing and include the basis for your appeal. This may include additional information and/or a change in circumstances.

How soon do I need to file the appeal?

Your appeal must be received within fifteen (15) business days following the date you received our decision. Mail your appeal to:

Financial Assistance Appeals Coordinator
CHN Patient Accounts
1500 N. Ratter Avenue
Indianapolis, IN 46219

When will I be notified of your decision regarding my appeal?

You will be notified of the decision within twenty (20) business days following our receipt of your appeal.

Is the decision regarding my application for financial assistance final?

Yes, the decision is final. However, it does not prevent you from applying for Financial Assistance for new Bills that were not subject to this application.

Community
 Health Network

APPENDIX C

NOTIFICATION OF FINANCIAL ASSISTANCE PROGRAM QUALIFICATION

Response Date	
---------------	--

Requestor		Fax #	
-----------	--	-------	--

Patient Name		Patient DOB	
Date of Service		FAP Discount %	

Dear Sir / Madam:

A financial screening was completed by an associate of Community Health Network and indicates that the above referenced patient meets the network's definition of a medically indigent patient or qualified for a discount in accordance with the network's financial assistance policy. Accordingly, the patient qualifies for the above FAP discount for services received on the referenced date of service. This letter is not an obligation; the requestor of this notification to provide the patient with reduced or no-cost care for the services they provide and this qualification shall be deemed expired on the last day of the FAP coverage period.

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.

Should you have any questions regarding CHN's provision of financial assistance please contact customer service at (317) 355-5555.

Patient Account Representative
 Patient Financial Services
 Community Health Network

The documents accompanying this fax transmission contain health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the content of these documents is strictly prohibited. If you have received this information in error, please notify the sender and the privacy officer immediately and arrange for the return or destruction of these documents.

**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.
► Information about Schedule H (Form 990) and its instructions is at www.irs.gov/form990

OMB No. 1545-0047

2013

**Open to Public
Inspection**

- 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	✓	

Questions 6a and b:



Community Benefit Report

2013

The Community Health Network Board of Directors approved the Community health needs assessment in 2012. Financial and Charity Care in December 2012 and the Implementation Strategy in May 2013

I. Introduction

Today, as the country remains confused and dismayed at the potential changes in the health care delivery system, the overall health of our nation consistently ranks low. On average, Americans die sooner and experience higher rates of disease and injury than people in other high-income countries. According to a 2013 report by the National Research Council and Institute of Medicine, the U.S. health disadvantage exists at all ages from birth to age 75 and that even advantaged Americans -- those who have health insurance, college educations, higher incomes, and healthy behaviors -- appear to be sicker than their peers in other rich nations. To add a local dimension to the story of poor health, "Americas Health Rankings" rank the State of Indiana at the bottom quartile of all states, Indiana comes in at 41st out of the 50 states. Marion County ranks at

the bottom quartile of the state, it comes in at 79th out of the 92 counties in Indiana. These rankings illustrated in our community health needs assessment, highlight the grim state of health in our local communities.

But there is hope. The Community Health Network organization only needs to look back at a hope instilled in our institution from its inception. In the 1950's it was the desire to improve the health of the community that led citizens on Indianapolis' east side to raise funds and build a hospital to serve the community. They named it appropriately, Community Hospital. These residents wanted health care services designed in their best interests. They wanted easy access to medical resources. They wanted health care providers 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 hospital has grown into the Community Health Network, the second largest not-for-profit health system in Indiana. What hasn't 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, well individuals within strong sustainable communities. In short we believe that any lasting cultural change in community health status will be driven by local communities initiating the change they want and need.

II. Philosophy

In 2009, for the first time in history, the Nobel Prize for Economics was given to a woman. A local Hoosier, Elinor Ostrom held the title of Distinguished Professor as a member of the faculty at Indiana University in Bloomington, Indiana and she won the award for her research and validation that a community can manage their own community resources successfully. Ostrom's Nobel Prize winning philosophy is illustrated in the story of how Community Health Network began and in the strategies of our Community Benefit Plan.

- Prior to her research, economics taught that resources held in common were at risk for exploitation, degradation or destroyed by overuse when managed by the community, like anglers over fishing a lake. The belief was that all community resources in order to be managed appropriately should be held as private property or managed by the government and government regulations in the form of taxes or limits on use. It was assumed that

individuals in a community had no incentives to protect the resources as a whole

- “Elinor Ostrom showed that it was possible to safeguard commonly owned resources like water and forests, writes former Medicare administrator Donald M. Berwick. ‘Her work should inspire us to look for ways to prevent health care costs from overwhelming another shared resource: the public coffers.’ In our community benefit plan, the “public coffer” Berwick refers to is referenced as “relieving or reducing the burden of government or other community efforts”
- Berwick reflecting on Ostroms’ philosophy argues that communities need to define their “healthcare commons”, the collective resources that can treat disease and promote health, and to develop community based strategies. These can include medical strategies but also healthy food environments, housing, livable jobs, parks. Berwick believes that communities themselves are going to have to take responsibility to define their health care commons, set goals, develop metrics, and establish a healthcare solution, which includes but is not limited to the traditional healthcare system.
- Health care does not happen exclusively in the institutions; it happens in the community. Our Community Benefit strategies reflect Berwick’s sentiment that communities need to define their health care commons. It is a place based, community driven approach, extending the health outside the hospital walls for the benefit of all. Just as local Hoosier Elinor Ostroms’ Nobel Prize winning research emphasizes collaboration and cooperation as essential, so does our Community Benefit Plan.

III. Community Leadership

All hospitals are tethered to their communities regardless of the prevailing economy, their mission, invested capital, and customer relationships. All of these issues and more bind them to their communities. It is one thing to be de facto the anchor in the community and quite another to be consciously recognize and adopt that role. Community Health Network began by a grass roots effort of the eastside community and has always had a hospital based strategy that utilizes our assets as a not for profit hospital, with long term stakes in the community and we have used our economic power to improve the long term welfare of the communities we serve. While many health systems have abandoned the inner city locations in favor of outlying suburban locations,

Community Health Network has improved the Community Hospital East city location to provide state of the art medicine. By doing this alone we have demonstrated our belief that we have a role in the community to support greater health equity and reinforce the foundational understanding that health is built in community.

IV. About Community Health Network

Community Health Network, Inc., along with its nonprofit affiliates (collectively the “Network”), comprises an integrated health care delivery system in central Indiana. The Network’s vision is to be an integrated health delivery system that is centered on patients and inspired by physicians and other clinicians. Through its mission, the Network is deeply committed to the communities it serves in order to enhance health and well-being. The Network’s values include putting the patients first along with the needs of their families and building relationships among patients, providers, physicians and other clinicians. The Network and its subsidiaries and affiliates operate the following hospitals:

- **Community Hospital East** is an acute care hospital located on a 27-acre campus on the east side of Indianapolis. Community Hospital East continues to serve as the principal provider of health care services to the east side of Indianapolis. Community Hospital East’s service complement includes medical/surgical services, neurosciences, orthopedics, cancer care and an emergency department to the residents of the east side of Indianapolis.
- **Community Hospital North** is an acute care hospital located in the northeast section of Marion County bordering Hamilton County. The Community Hospital North facility serves as the tertiary referral site for the Network. Community Hospital North offers expanded program services and unique centers of excellence through a full range of inpatient, outpatient and community-based services.
- **Community Hospital South** is an acute care hospital located on a 40-acre campus on the south side of Indianapolis. Community Hospital South offers primary and secondary services including medical/surgical services, women’s and children’s services, cardiac services (including catheterizations), and an emergency department.

- **Community Hospital of Anderson** and Madison County, Incorporated is a community hospital located on a 21-acre campus in Anderson, Indiana, approximately 45 miles northeast of Indianapolis. Anderson primarily serves the residents of Madison County. This hospital offers primary and secondary services including medical/surgical services, women's and children's services, cardiac services (including catheterizations), and an emergency department.
- **Community Heart and Vascular Hospital** was the nation's first all-digital heart hospital and is a three-time Thomson Reuters Top 100 Cardiovascular Hospital (2006-2008). CHVH provides a comprehensive array of services ranging from open heart surgery to non-invasive diagnostic testing to cardiac rehabilitation - all with a cardiologist on site 24/7.
- **Community Westview Hospital** is central Indiana's only osteopathic hospital. Located on the west side of Indianapolis, Westview is committed to promoting wellness and preventing illness. Osteopathic medicine is gaining nationwide attention as it focuses on a holistic approach to healthcare. In addition to its inpatient facilities and 24-hour emergency department, Westview provides the following services: intensive and acute care nursing services, inpatient and outpatient surgery, imaging, laboratory, cancer care, cardiology, cardiopulmonary, inpatient and outpatient rehabilitation, sleep disorders and geriatric behavioral health services.
- **Community Howard Regional Health, Inc.** is a community hospital located on an 18-acre campus in Kokomo, Indiana approximately 45 miles northwest of Indianapolis. CHRH primarily serves the residents of Howard County and surrounding communities. CHRH's primary services include inpatient and outpatient services, behavioral health, cancer care, emergency services, women's services and cardiology.

V. Commitment to Community

The board of our network plays an integral role in the community benefit plan and is involved in setting strategy, communicating the plan within the organization and the community at large. Our leadership team members, the network board, and physician leaders have developed a strategic plan and vision for our network. This plan will serve as our roadmap from 2013 through 2020 to fulfill our commitment to the community as embodied in the mission statement, values and vision.

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:

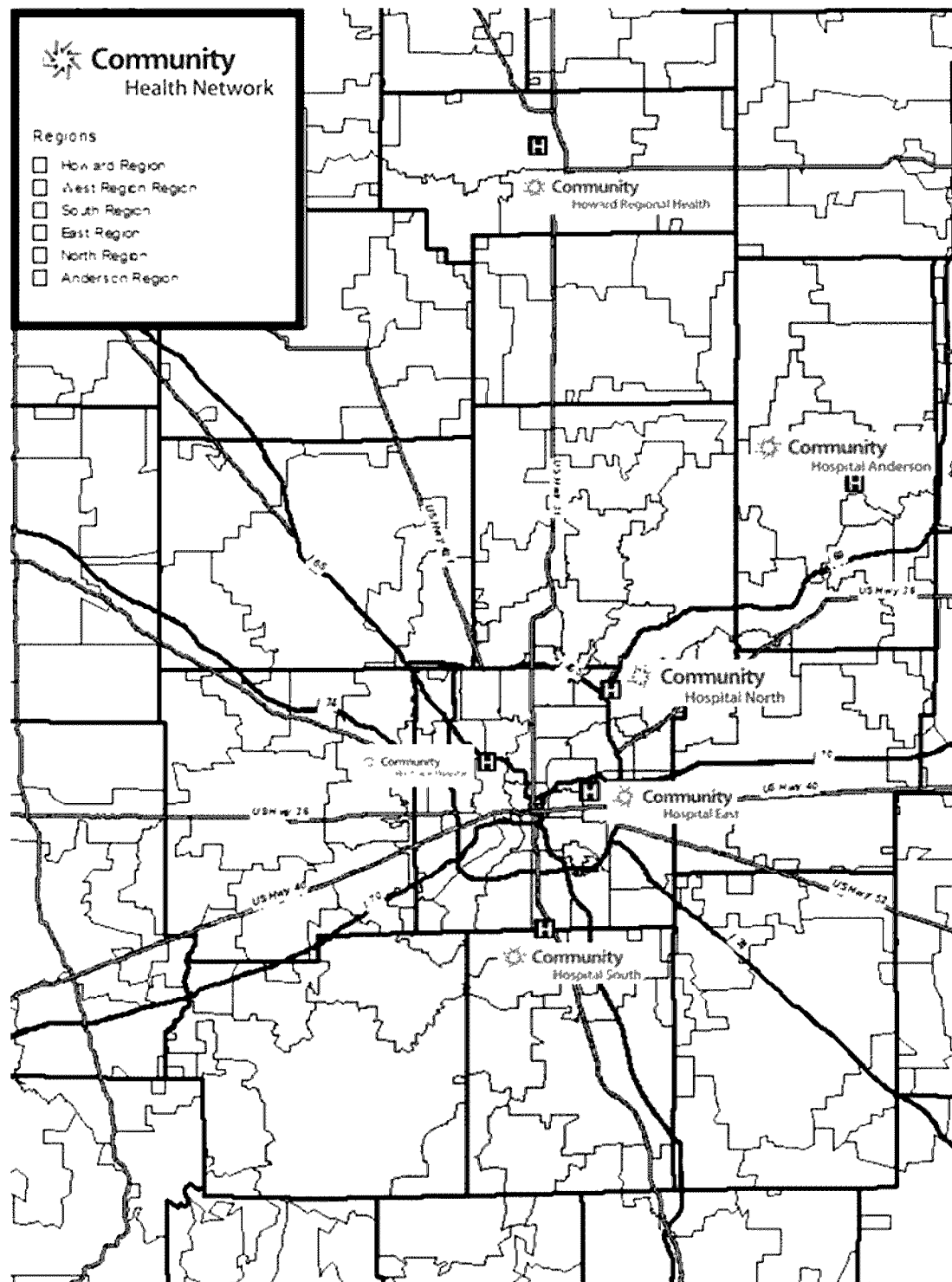
- *Advancing the health status of our communities through outreach, wellness and prevention.*

VI. Overview of Communities Served by Community Health Network

Community Health Network is ranked among the nation's most integrated healthcare systems. Community Health Network is central Indiana's leader in providing convenient access to exceptional healthcare services, where and when patients need them—in hospitals, health pavilions and doctor's offices, as well as workplaces, schools and homes. As a non-profit health system with over 200 sites of care and affiliates, including seven hospitals, Community's full continuum of care integrates hundreds of physicians, specialty and acute care hospitals, surgery centers, home care services, MedChecks, behavioral health and employer health services.

As a system we have one board of directors and strategy is centralized. Therefore the Community Health Needs Assessment and the Implementation Strategy have been done jointly. Although there is centralized strategy there is strong regional management and data to support regional variation in the CHNA and IS which has been considered into the overall priorities listed and gives adequate attention to the target Populations unique to each region.

Hospital Service Areas



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.*

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 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 its proactive measure taken to inform patients throughout the billing processes, 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 have been scrutinizing 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. The Community Health Network was one of the recipients of the award in 2009. We were one of five health networks in the United States to be recognized with this award. Community Health Network was one of three health organization in the United States to win the Healthy Communities achievement award for use of data.

Community Health Network used data to target community benefit resources strategically, and set out to find an innovative way to help children with asthma. The following community benefit highlights demonstrate the reasons we won the awards, 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 strategies employed to address the health needs identified in our Community Health Needs Assessment and needed to succeed in creating and sustaining a healthy community and viable organization as illustrated by the pillars in our overall corporate strategy. Many of the stories and illustration of Community Benefit are actual news articles and press releases used to highlight our role in the community and our responsibility to building a healthier community in the designated service areas.

Part II

Community Building Activities

Schedule H (Form 990) 2013 **COMMUNITY HEALTH NETWORK, INC.** **35-0983617** Page **2**

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development	1	900	81,271		81,271	0.01
3 Community support	5	1,075	4,062		4,062	
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building	2	183	1,992		1,992	
7 Community health improvement advocacy	12	92,403	5,197,239	111,408	5,085,831	0.72
8 Workforce development	2		810,969	79,436	731,533	0.10
9 Other						
10 Total	22	94,561	6,095,533	190,844	5,904,689	0.83

a) 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, the 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 2012 Habitat for Humanity build on the east side is a strong example of the network's commitment to encouraging employee volunteerism and supporting economic development for the past six 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 – had 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 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. Panel builds on the Community North campus preceded the onsite project. Some 310 onsite volunteers clocked over 700 volunteer hours during the six weeks of building. With the 2012 Habitat Home complete, the total number of homes that the network has built or rehabbed is eight.

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 have also 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 the trust is developed with the community.

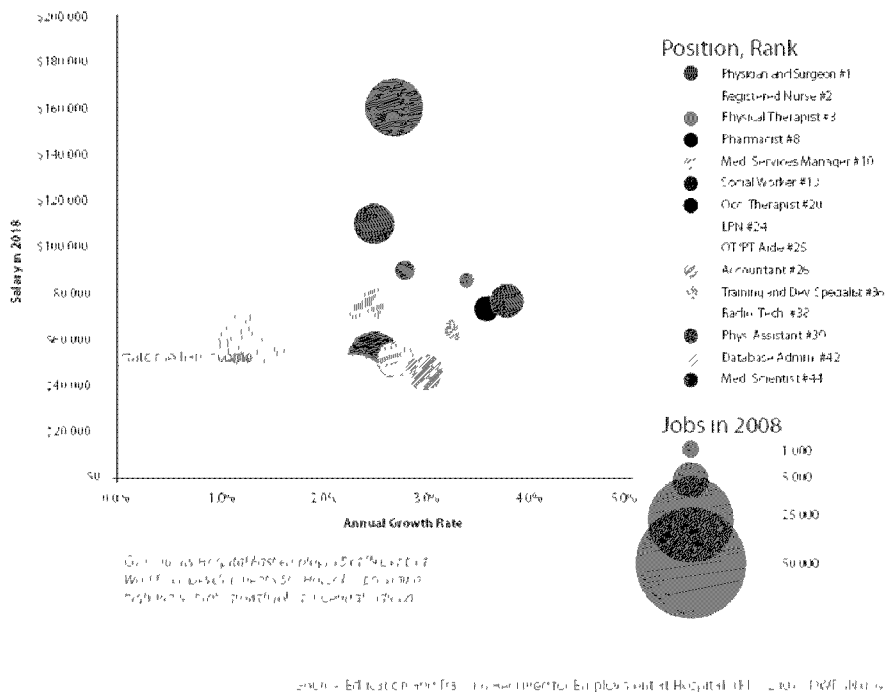
b) Economic Development
COMMUNITY'S INDIANA IMPACT

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 388,872 patients annually. With a mission to enhance the health and well-being of the communities we serve, in 2012 we provided \$41 million in community benefit dollars. With the additional growth of programs and construction we will add over 250 jobs in the community. 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.

The following illustration shows the impact that Community Health Network and specifically Community Hospital East on workforce development. Community Hospital East as noted in the diagram below, employs 15 of Indiana Department of Workforce Development's 50 "Hot Jobs" providing high-wage, high-growth jobs for central Indiana.

Workforce Developer

State of Indiana Job Growth and Salaries, 2008 - 2018



Community Health Network launches unique bold focus on innovation

Indianapolis, IN---Community Health Network announced an aggressive plan to foster innovation among its employees and external partners with the unveiling of Community Launchpad, an innovation incubator designed to develop healthcare advancements, improve healthcare delivery, and seed entrepreneurial opportunities to reinvest in future innovations.

Community Launchpad will invest in the most promising services, products and technologies that solve needs for patients, while creating a culture of entrepreneurship among its physicians, nurses, clinical and administrative staff.

"We studied conventional centers of innovation across the country, both in and out of the healthcare industry," said Kyle Fisher, chief strategic development officer for Community Health Network. "In the end, we developed our own two-way incubation portal connecting the talent of our employees with the expertise of outside

collaborators. This effort will improve services for our patients, while further distinguishing Community as an even more attractive place for healthcare entrepreneurs to partner with and succeed.”

Key principles for guiding the innovative activity of Community Launchpad include

- **Core business** a structured process for stakeholders to explore the feasibility of big, bold ideas aimed at improving patient experiences and outcomes
- **Alliances** a two-way innovation portal to catalyze value-added partnerships with outside industry, such as universities, corporate America, small entrepreneurs, vendors and consumers
- **Intellectual property** a platform to protect and commercialize intellectual capital
- **Ventures** an investment in promising healthcare solutions yielding attractive returns to reinvest in future innovations

“Community Launchpad goes beyond a traditional R&D lab or healthcare venture capital fund,” said Pete Turner, vice president of innovation for Community Health Network and leader of Community Launchpad. “We’ve created the engine to advance our core business by thinking boldly, harvesting promising ideas that improve the delivery and quality of care, and moving quickly to bring our solutions to market.” Community Launchpad is a division of Visionary Enterprises, Inc. (VEI), the wholly-owned, for-profit subsidiary of Community Health Network. Community Launchpad management will receive strategic guidance and direction from the VEI Board of Directors and an innovation advisory board, bringing deep physician, healthcare and corporate experience.

For more information on Community Launchpad, visit

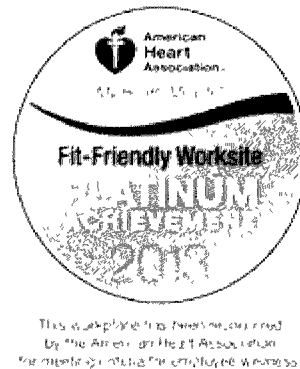
About Community Launchpad

Community Launchpad is the innovation incubator of Community Health Network. Designed as an entrepreneurial epicenter, Community Launchpad fosters a creative work environment for Community Health Network employees, as well as external collaborators such as universities, corporate America and entrepreneurs, to improve the delivery of healthcare for patients. The goal is to develop breakthrough healthcare products and services that will be utilized at Community Health Network and commercialized throughout the healthcare industry. For more information about Community Launchpad, visit eCommunity.com/Launchpad.

As an integral part of the Indianapolis Community and a driver of economic growth, Community Health Network has received several Awards in 2013.

The Indianapolis Star “Top Workplaces”

Top 15 ranking among large employers for the last six years



Platinum-Level Fit-Friendly Worksite

Fit-Friendly Worksites are recognized by the American Heart Association as employers who make their employees' health and wellness a priority.



2013 Healthy Communities Achievement Award

Community Health Network used resources strategically,
and set out to find an innovative way to help children with asthma.

Indianapolis Star "Top Workplaces"

Top 10 ranking among large employers, multiple years

For the fourth year in a row, Community Health Network has been named one of Central Indiana's "Top Workplaces" by The Indianapolis Star. Our employees have confidence in the future of the organization, and consistently consider us a leader in

- Work/Life Flexibility

- Strong Values & Ethics
- Supportive Management
- Employee Appreciation
- Learning & Professional Development Opportunities

c) 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% 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.

“Records show that 741 injuries occurred as a result of falls,” said Steve Davison, Division Chief, Emergency Medical Services for Fishers Fire Department. “Many of those injured were senior citizens, so we decided to develop a comprehensive plan to help seniors avoid hospitalization and live comfortably and safely in their own homes.” Since the implementation of the program we have seen a reduction in falls from 741 to 558 or 24%.”

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:

- 1 Heart disease, stroke, Parkinson's and low blood pressure can cause dizziness, balance problems and fatigue
- 2 Diabetes can cause a loss of sensation in the feet, leading to a reduced “sense of place”
- 3 Arthritis results in loss of flexibility and increased difficulty maintaining balance
- 4 Chronic obstructive pulmonary disease and heart failure result in breathing difficulties, weakness and fatigue, even with slight exertion

- 5 Vision problems, such as glaucoma and cataracts, decreased visual function
- 6 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 , the campaign to reduce falls in the Fishers area has several components including education, awareness and EMS trainings 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 includes

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

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

d) Environmental Improvement

Community Health network continues to support several economic and environmental activities that would change the use and look of specific spaces The most dramatic of these initiatives will be the Emerson Street Gateway project which has been delayed by the city constraints and politics We remain supportive and willing to provide match dollars to initiate the project Other ongoing projects include INSTEPP, Binford Redevelopment and Growth (BRAG) CAFÉ and several others Below is just one example of our efforts

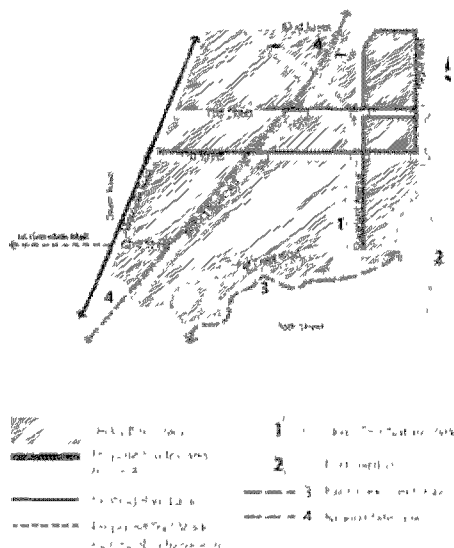
INSTEPP - Indy Northside Sidewalks and Trails Engaging People with Places

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. Having spent the last twelve months developing relationships with community and residents, government agencies, elected officials, community organizations and key businesses,

e) Leadership Development/Training for Community Members

No training were conducted in 2013

f) Coalition Building

Binford Redevelopment and Growth (BRAG)

In the Fall of 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 to be a proud sponsor of this successful community organization.

g) 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.

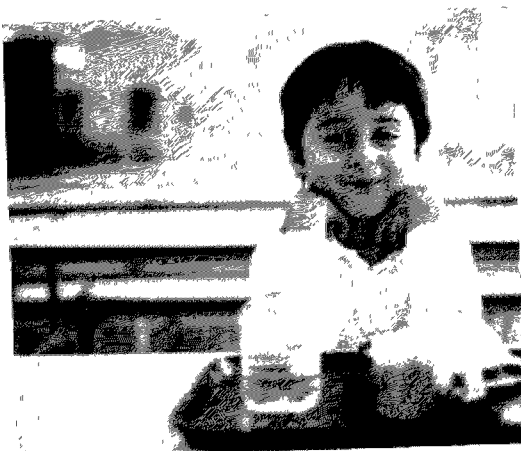


As a response to federal, state and local initiatives that address the needs for families to receive basic primary healthcare, Community Health Network (CHN) has successfully partnered with schools, churches, community associations, local businesses and funding sources to bring health education and health 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 a partnership with school systems. These partnerships lead 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 professionals 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 clinic's 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, begun 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

Community Hospital'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.

New Jane Pauley Community Health Center Dental Clinic results from grant, partnership to help underserved students and adults

Indianapolis, IN---A federal grant awarded to Community Health Network Foundation has resulted in a new eastside dental clinic, providing affordable, integrated oral and primary health care to underserved students and adults in Warren Township and surrounding areas. Warren Central High School alumnus Jane Pauley led today's ribbon-cutting ceremony for Jane Pauley Community Health Center Dental Clinic, which was funded in part by a nearly \$500,000 U.S. Department of Health and Human Services grant.

More than 100 people attended the ceremony and toured the new dental clinic, located inside the Metropolitan School District of Warren Township's Walker Career Center, at 9651 East 21st Street, on the campus of Warren Central High School. The 1,976 square-foot clinic features four private treatment rooms and one consultation room, new dental equipment, a lab, sterilization area and reception space. The clinic will be open year-round with daytime and evening appointments, to accommodate patient needs and schedules.

A dentist and dental hygienist from the Indiana University School of Dentistry (IUSD) will staff the clinic, supervising IUSD dental residents, students and high school seniors enrolled in the Walker Career Center's dental assistant teaching program. Dental services at the clinic will be affordable and accessible to all, regardless of income or insurance coverage. Most major insurance plans, as well as Medicaid and Medicare, will be accepted. Financial assistance programs will be available for uninsured patients, based on income and family size.

Jane Pauley Community Health Center, located inside MSDWT's Renaissance School at 30th and Post Road, will serve as a partner, directing patients with dental needs to the clinic and accepting primary health care referrals from the dental providers. Nurses from local school districts may refer students to the dental clinic, as well.

According to Dan Hodgkins, vice president of community benefit and economic development at Community Health Network, this collaborative project leverages the success of Community Health Network's school-based health care delivery system, which annually offers free primary care to more than 40,000 underserved students in Indianapolis.

Community Health Network to provide sports medicine program for Metropolitan School District of Lawrence Township; New services expand healthcare relationship with school system

For release: 2/7/2012

Indianapolis, IN---Students in the Metropolitan School District of Lawrence Township will have access to a wide range of sports medicine programs and services provided by Community Health Network, beginning in the 2012-2013 school year. The school board recently voted to extend the current partnership between the MSD of Lawrence Township and Community to include the sports medicine program and services. The comprehensive range of medical services now available in the school district is unique to Central Indiana.

The sports medicine program is part of a broader relationship between Community Health Network and the school system. Community launched an employee health and wellness center for the MSD of Lawrence Township employees and their covered dependents in April of 2011. The center, located at 8501 East 56th Street, is housed in remodeled space at Community Health Pavilion-Fort Ben, and has a strong focus on wellness and disease prevention. Last July, Community Health Network hired the MSD of Lawrence Township school nurses to continue providing exceptional medical care for students, as well as enhancing the continuity of care with clinical education resources and support from the network.

The sports medicine program component calls for Community Health Network to provide athletic trainers to cover the school system's middle and high schools, beginning in the 2012-2013 school year. A team physician will be available at each high school. Community will provide sports physicals to the middle and high schools. Other services will include a certified strength and conditioning coach at the high schools during the academic school year, as well as physical and occupational therapy available through Community's outpatient Rehab & Sports Medicine Centers. "It is thrilling to expand our long-standing partnership with Lawrence Township schools to the venue of sports medicine," said Jon Fohrer, CEO of ambulatory services at Community Health Network. "The township has a long and storied history of athletic success and we look forward to working with its student athletes, as they continue on their path to excellence. Not only are these students shining stars within their sport,

they can also be tremendous ambassadors in the community for healthy lifestyle choices ”

Community Health Network-employed nurses staff 20 school nurse clinics throughout Lawrence Township Schools. Community is providing additional nursing staff to support vacancies left by vacations and time off. The network also provides durable medical equipment to all the MSD of Lawrence Township school clinics, in-service educational seminars and support materials for nurses, and ensures proper state certification for all staff nurses.

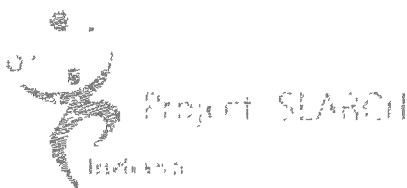
"Lawrence Township is very pleased with the expansion of our Community Health Network partnership to include unprecedented nursing services for our children, said Joanie Emhardt, coordinator of health services for Lawrence Township schools. "Our nurses have become part of a larger team of professionals with access to resources that will ultimately improve the health and well-being of our students."

h) 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



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 healthcare 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 students 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 participate 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. Students 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% 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

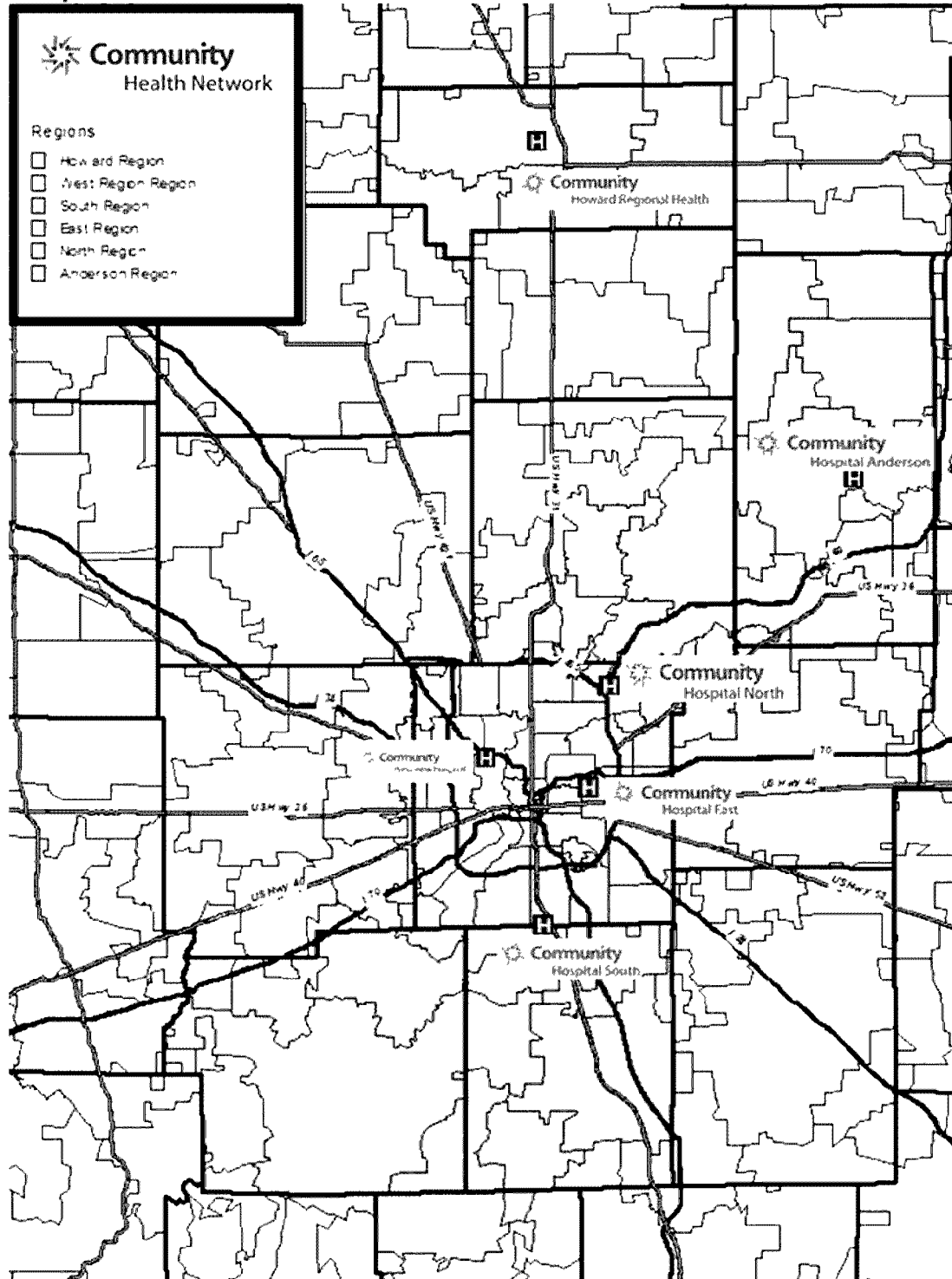
i) Other
N/A

Part V.

		Yes	No
Community Health Needs Assessment (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)			
1	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9. If "Yes," indicate what the CHNA report describes (check all that apply)	1	✓
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 Section C)		
2	Indicate the tax year the hospital facility last conducted a CHNA 20 <u>1</u> <u>2</u>		
3	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3	✓
4	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	4	✓
5	Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply):	5	✓
a	<input type="checkbox"/> Hospital facility's website (list url) <u>ecomunity.com</u>		
b	<input type="checkbox"/> Other website (list url) _____		
c	<input checked="" type="checkbox"/> Available upon request from the hospital facility		
d	<input type="checkbox"/> Other (describe in Section C)		
6	If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply as of the end of the tax year):		
a	<input checked="" type="checkbox"/> Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA		
b	<input checked="" type="checkbox"/> Execution of the implementation strategy		
c	<input checked="" type="checkbox"/> Participation in the development of a community-wide plan		
d	<input checked="" type="checkbox"/> Participation in the execution of a community-wide 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 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 type="checkbox"/> Other (describe in Section C)		
7	Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Section C which needs it has not addressed and the reasons why it has not addressed such needs	7	✓
8a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	8a	✓
b	If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?	8b	
c	If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

a) A definition of the community served by the hospital facility.

Hospital Service Areas.



Community Health Needs Assessment

Community Health Network is pleased to present the 2013 tax year community health needs assessment (CHNA). This CHNA report provides an overview of the health needs and priorities in all the counties served by Community Health Network. The goal of this report is to provide readers a stronger and deeper understanding of the health needs in the communities in which we serve. This data serves as an expansion of our earlier assessment in 2012. It will help guide the hospital in the community benefit planning efforts and assist us in the monitoring of our implementation strategy that will address the prioritized needs. The CHNA and implementation plan was approved by the Board of Directors in May of 2013.

b) Demographics of the community

Demographics by County

County: Marion

	Marion	Indiana
<u>2013 Base Counts</u>		
<u>2013 Population</u>	929,601	6,567,159
<u>2013 Households</u>	375,549	2,537,304
<u>2013 Housing Units</u>	428,634	2,847,494
<u>2013 Families</u>	223,652	1,697,646
<u>Percent Population Growth 2010 to 2013</u>	2.90%	1.29%
<u>Percent Household Growth 2010 to 2013</u>	2.56%	1.40%
<u>Percent Housing Unit Growth 2010 to 2013</u>	2.58%	1.86%
<u>Percent Family Growth 2010 to 2013</u>	2.43%	1.40%
<u>2013 Population by Sex and Ethnicity</u>		
<u>2013 Population by Sex</u>	929,601	6,567,159
<u>2013 Population by Ethnicity</u>	929,601	6,567,159

Marion

Indiana

2013 Population by Single Race and Sex

<u>White</u>	581,137 (62.51%)	5,482,760 (83.49%)
<u>Black/Af Amer</u>	242,611 (26.10%)	608,472 (9.27%)
<u>Am Ind/AK Native</u>	2,839 (0.31%)	19,770 (0.30%)
<u>Asian</u>	19,997 (2.15%)	115,844 (1.76%)
<u>Native HI/PI</u>	475 (0.05%)	2,705 (0.04%)
<u>Some Other Race</u>	54,848 (5.90%)	195,570 (2.98%)
<u>2+ Races</u>	27,694 (2.98%)	142,038 (2.16%)

2013 Population by Ethnicity and Single Race

<u>Hisp/Lat</u>	96,136 (10.34%)	443,564 (6.75%)
<u>Not Hisp/Lat</u>	833,465 (89.66%)	6,123,595 (93.25%)

2013 Population by Age

<u>2013 Population by Age</u>	929,601	6,567,159
<u>2013 Population, Age <18</u>	234,813 (25.26%)	1,584,889 (24.13%)
<u>2013 Population, Age 18+</u>	694,788 (74.74%)	4,982,270 (75.87%)
<u>2013 Population, Age 25+</u>	605,380 (65.12%)	4,297,886 (65.45%)
<u>2013 Population, Age 65+</u>	106,952 (11.51%)	926,902 (14.11%)
<u>2013 Median Age</u>	34.70	37.40

2013 Population by Sex and Age

<u>2013 Male Population by Age</u>	449,180	3,234,243
<u>2013 Population, Male Age <18</u>	120,062 (26.73%)	810,071 (25.05%)
<u>2013 Population, Male: Age 18+</u>	329,118 (73.27%)	2,424,172 (74.95%)
<u>2013 Population, Male Age 65+</u>	44,159 (9.83%)	400,975 (12.40%)
<u>2013 Median Age Male</u>	33.60	36.10
<u>2013 Female Population by Age</u>	480,421	3,332,916
<u>2013 Population, Female: Age <18</u>	114,751 (23.89%)	774,818 (23.25%)
<u>2013 Population, Female Age 18+</u>	365,670 (76.11%)	2,558,098 (76.75%)

	Marion	Indiana
<u>2013 Population, Female: Age 65+</u>	62,793 (13.07%)	525,927 (15.78%)
<u>2013 Median Age Female</u>	35.80	38.70

2013 Population 5+ by Language Spoken at Home

<u>Speak Only English at Home</u>	754,974 (87.80%)	5,637,772 (91.84%)
<u>Speak Spanish at Home</u>	71,948 (8.37%)	280,446 (4.57%)
<u>Speak Asian/PI Lang at Home</u>	9,813 (1.14%)	61,690 (1.00%)
<u>Speak Indo-European Lang at Home</u>	14,440 (1.68%)	136,306 (2.22%)
<u>Speak Other Lang at Home</u>	8,662 (1.01%)	22,189 (0.36%)

2013 Population 15+ by Sex, Marital Status

<u>Never Married</u>	281,055 (38.41%)	1,579,191 (30.03%)
<u>Married, Spouse present</u>	274,150 (37.47%)	2,538,688 (48.27%)
<u>Married, Spouse absent</u>	35,620 (4.87%)	176,235 (3.35%)
<u>Divorced</u>	99,923 (13.66%)	648,607 (12.33%)
<u>Widowed</u>	40,947 (5.60%)	316,491 (6.02%)

2013 Owner-Occ Housing Units by Value

<u>2013 Own Occ HUs Median Value</u>	\$126,658	\$129,943
<u>2013 Own Occ HUs Avg Value</u>	\$156,422	\$160,383

2013 Households by Number of People in Household

<u>2013 Households</u>	375,549	2,537,304
<u>2013 Average Household Size</u>	2.43	2.51

2013 Households by Presence of People Under 18

<u>2013 Households, People < 18</u>	121,412 (32.33%)	846,429 (33.36%)
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2013 Occupied Housing Units by Year Householder Moved In

<u>2013 Median Length of Residence</u>	8.10	10.40
<u>2013 Renter Occ Housing Units Median Length of Residence</u>	5.20	5.50

	Marion	Indiana
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<u>2013 Owner Occ Housing Units: Median Length of Residence</u>	13.50	14.10
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2013 Occupied Housing Units by Vehicles Available

<u>2013 Avg Number Vehicles Available</u>	1.60	1.80
<u>No Vehicle</u>	34,465 (9.18%)	173,610 (6.84%)
<u>1 Vehicle</u>	153,634 (40.91%)	841,253 (33.16%)
<u>2 Vehicles</u>	136,344 (36.31%)	994,081 (39.18%)
<u>3 Vehicles</u>	39,208 (10.44%)	372,825 (14.69%)
<u>4 Vehicles</u>	9,152 (2.44%)	113,390 (4.47%)
<u>5+ Vehicles</u>	2,746 (0.73%)	42,145 (1.66%)

2013 Households by Household Income

<u>2013 Households by Income</u>	375,549	2,537,304
<u>2013 Median Household Income</u>	\$39,060	\$47,121
<u>2013 Average Household Income</u>	\$53,002	\$61,175

2013 Households by Race and Household Income

<u>2013 Median HH Inc, White</u>	\$45,203	\$49,584
<u>2013 Avg HH Inc, White</u>	\$58,219	\$61,980
<u>2013 Median HH Inc, Black/Af Amer</u>	\$28,430	\$29,027
<u>2013 Avg HH Inc, Black/Af Amer</u>	\$38,444	\$40,280
<u>2013 Median HH Inc, Am Ind/AK Native</u>	\$33,211	\$39,188
<u>2013 Avg HH Inc, Am Ind/AK Native</u>	\$46,022	\$53,778
<u>2013 Median HH Inc, Asian</u>	\$44,246	\$52,265
<u>2013 Avg HH Inc, Asian</u>	\$56,429	\$71,027
<u>2013 Median HH Inc, Native HI/PI</u>	\$20,462	\$32,730
<u>2013 Avg HH Inc, Native HI/PI</u>	\$29,641	\$54,324
<u>2013 Median HH Inc, Some Other Race</u>	\$28,872	\$34,787
<u>2013 Avg HH Inc, Some Other Race</u>	\$32,657	\$42,982
<u>2013 Median HH Inc, 2+ Races</u>	\$32,447	\$37,608

	Marion	Indiana
<u>2013 Avg HH Inc, 2+ Races</u>	\$44,193	\$49,819

2013 Households by Ethnicity and Household Income

<u>2013 Median HH Inc, Hisp/Lat</u>	\$27,935	\$36,166
<u>2013 Avg HH Inc, Hisp/Lat</u>	\$37,495	\$49,820
<u>2013 Median HH Inc, Not Hisp/Lat</u>	\$40,300	\$47,679
<u>2013 Avg HH Inc, Not Hisp/Lat</u>	\$54,140	\$61,718

2013 Families by Poverty Status

<u>2013 Families Below Poverty</u>	37,052 (16.57%)	192,959 (11.37%)
<u>2013 Families Below Poverty with Children</u>	31,497 (14.08%)	154,999 (9.13%)

2013 Population by Sex and Educational Attainment

<u>2013 Population 25+ with Less Than High School Graduation</u>	94,321 (15.58%)	552,982 (12.87%)
<u>2013 Population 25+, Male, with Less Than High School Graduation</u>	46,599 (16.35%)	278,974 (13.46%)
<u>2013 Population 25+, Female, with Less Than High School Graduation</u>	47,722 (14.89%)	274,008 (12.32%)
<u>Population 25+ by Educational Attainment</u>	605,380	4,297,886
<u>Male Population 25+ by Educational Attainment</u>	284,968	2,073,100
<u>Female Population 25+ by Educational Attainment</u>	320,412	2,224,786

County: Hamilton

	Hamilton	Indiana
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2013 Base Counts

<u>2013 Population</u>	299,027	6,567,159
<u>2013 Households</u>	108,909	2,537,304
<u>2013 Housing Units</u>	115,892	2,847,494
<u>2013 Families</u>	81,600	1,697,646
<u>Percent Population Growth 2010 to 2013</u>	8.91%	1.29%

	Hamilton	Indiana
<u>Percent Household Growth 2010 to 2013</u>	9.09%	1.40%
<u>Percent Housing Unit Growth 2010 to 2013</u>	8.54%	1.86%
<u>Percent Family Growth 2010 to 2013</u>	9.16%	1.40%

2013 Population by Sex and Ethnicity

<u>2013 Population by Sex</u>	299,027	6,567,159
<u>2013 Population by Ethnicity</u>	299,027	6,567,159

2013 Population by Single Race and Sex

<u>White</u>	260,571 (87.14%)	5,482,760 (83.49%)
<u>Black/Af Amer</u>	12,606 (4.22%)	608,472 (9.27%)
<u>Am Ind/AK Native</u>	611 (0.20%)	19,770 (0.30%)
<u>Asian</u>	14,964 (5.00%)	115,844 (1.76%)
<u>Native HI/PI</u>	135 (0.05%)	2,705 (0.04%)
<u>Some Other Race</u>	4,091 (1.37%)	195,570 (2.98%)
<u>2+ Races</u>	6,049 (2.02%)	142,038 (2.16%)

2013 Population by Ethnicity and Single Race

<u>Hisp/Lat</u>	12,140 (4.06%)	443,564 (6.75%)
<u>Not Hisp/Lat</u>	286,887 (95.94%)	6,123,595 (93.25%)

2013 Population by Age

<u>2013 Population by Age</u>	299,027	6,567,159
<u>2013 Population, Age <18</u>	85,634 (28.64%)	1,584,889 (24.13%)
<u>2013 Population, Age 18+</u>	213,393 (71.36%)	4,982,270 (75.87%)
<u>2013 Population, Age 25+</u>	189,397 (63.34%)	4,297,886 (65.45%)
<u>2013 Population, Age 65+</u>	29,610 (9.90%)	926,902 (14.11%)
<u>2013 Median Age</u>	36.40	37.40

2013 Population by Sex and Age

<u>2013 Male Population by Age</u>	145,841	3,234,243
<u>2013 Population, Male Age <18</u>	43,549 (29.86%)	810,071 (25.05%)

	Hamilton	Indiana
<u>2013 Population, Male: Age 18+</u>	102,292 (70.14%)	2,424,172 (74.95%)
<u>2013 Population, Male: Age 65+</u>	13,077 (8.97%)	400,975 (12.40%)
<u>2013 Median Age Male</u>	35.60	36.10
<u>2013 Female Population by Age</u>	153,186	3,332,916
<u>2013 Population, Female: Age <18</u>	42,085 (27.47%)	774,818 (23.25%)
<u>2013 Population, Female: Age 18+</u>	111,101 (72.53%)	2,558,098 (76.75%)
<u>2013 Population, Female: Age 65+</u>	16,533 (10.79%)	525,927 (15.78%)
<u>2013 Median Age Female</u>	37.20	38.70

2013 Population 5+ by Language Spoken at Home

<u>Speak Only English at Home</u>	249,321 (89.95%)	5,637,772 (91.84%)
<u>Speak Spanish at Home</u>	8,239 (2.97%)	280,446 (4.57%)
<u>Speak Asian/PI Lang at Home</u>	8,200 (2.96%)	61,690 (1.00%)
<u>Speak Indo-European Lang at Home</u>	9,130 (3.29%)	136,306 (2.22%)
<u>Speak Other Lang at Home</u>	2,286 (0.82%)	22,189 (0.36%)

2013 Population 15+ by Sex, Marital Status

<u>Never Married</u>	52,964 (23.30%)	1,579,191 (30.03%)
<u>Married, Spouse present</u>	139,237 (61.25%)	2,538,688 (48.27%)
<u>Married, Spouse absent</u>	6,333 (2.79%)	176,235 (3.35%)
<u>Divorced</u>	21,573 (9.49%)	648,607 (12.33%)
<u>Widowed</u>	7,230 (3.18%)	316,491 (6.02%)

2013 Owner-Occ Housing Units by Value

<u>2013 Own Occ HUs Median Value</u>	\$228,181	\$129,943
<u>2013 Own Occ HUs Avg Value</u>	\$279,816	\$160,383

2013 Households by Number of People in Household

<u>2013 Households</u>	108,909	2,537,304
<u>2013 Average Household Size</u>	2.73	2.51

2013 Households by Presence of People Under 18

	Hamilton	Indiana
<u>2013 Households, People < 18</u>	47,334 (43.46%)	846,429 (33.36%)

2013 Occupied Housing Units by Year Householder Moved In

<u>2013 Median Length of Residence</u>	8.70	10.40
<u>2013 Renter Occ Housing Units: Median Length of Residence</u>	5.20	5.50
<u>2013 Owner Occ Housing Units: Median Length of Residence</u>	10.30	14.10

2013 Occupied Housing Units by Vehicles Available

<u>2013 Avg Number Vehicles Available</u>	2.00	1.80
<u>No Vehicle</u>	3,804 (3.49%)	173,610 (6.84%)
<u>1 Vehicle</u>	26,759 (24.57%)	841,253 (33.16%)
<u>2 Vehicles</u>	55,928 (51.35%)	994,081 (39.18%)
<u>3 Vehicles</u>	16,847 (15.47%)	372,825 (14.69%)
<u>4 Vehicles</u>	4,171 (3.83%)	113,390 (4.47%)
<u>5+ Vehicles</u>	1,400 (1.29%)	42,145 (1.66%)

2013 Households by Household Income

<u>2013 Households by Income</u>	108,909	2,537,304
<u>2013 Median Household Income</u>	\$82,590	\$47,121
<u>2013 Average Household Income</u>	\$109,623	\$61,175

2013 Households by Race and Household Income

<u>2013 Median HH Inc, White</u>	\$82,717	\$49,584
<u>2013 Avg HH Inc, White</u>	\$100,117	\$61,980
<u>2013 Median HH Inc, Black/Af Amer</u>	\$70,074	\$29,027
<u>2013 Avg HH Inc, Black/Af Amer</u>	\$85,814	\$40,280
<u>2013 Median HH Inc, Am Ind/AK Native</u>	\$62,281	\$39,188
<u>2013 Avg HH Inc, Am Ind/AK Native</u>	\$69,252	\$53,778
<u>2013 Median HH Inc, Asian</u>	\$108,870	\$52,265
<u>2013 Avg HH Inc, Asian</u>	\$122,374	\$71,027

	Hamilton	Indiana
<u>2013 Median HH Inc, Native HI/PI</u>	\$30,795	\$32,730
<u>2013 Avg HH Inc, Native HI/PI</u>	\$35,196	\$54,324
<u>2013 Median HH Inc, Some Other Race</u>	\$53,373	\$34,787
<u>2013 Avg HH Inc, Some Other Race</u>	\$69,008	\$42,982
<u>2013 Median HH Inc, 2+ Races</u>	\$85,376	\$37,608
<u>2013 Avg HH Inc, 2+ Races</u>	\$109,371	\$49,819

2013 Households by Ethnicity and Household Income

<u>2013 Median HH Inc, Hisp/Lat</u>	\$67,545	\$36,166
<u>2013 Avg HH Inc, Hisp/Lat</u>	\$87,860	\$49,820
<u>2013 Median HH Inc, Not Hisp/Lat</u>	\$83,076	\$47,679
<u>2013 Avg HH Inc, Not Hisp/Lat</u>	\$110,263	\$61,718

2013 Families by Poverty Status

<u>2013 Families Below Poverty</u>	2,969 (3.64%)	192,959 (11.37%)
<u>2013 Families Below Poverty with Children</u>	2,353 (2.88%)	154,999 (9.13%)

2013 Population by Sex and Educational Attainment

<u>2013 Population 25+ with Less Than High School Graduation</u>	6,913 (3.65%)	552,982 (12.87%)
<u>2013 Population 25+, Male, with Less Than High School Graduation</u>	2,911 (3.24%)	278,974 (13.46%)
<u>2013 Population 25+, Female, with Less Than High School Graduation</u>	4,002 (4.03%)	274,008 (12.32%)
<u>Population 25+ by Educational Attainment</u>	189,397	4,297,886
<u>Male Population 25+ by Educational Attainment</u>	89,977	2,073,100
<u>Female Population 25+ by Educational Attainment</u>	99,420	2,224,786

County: Hancock

	Hancock	Indiana
<u>2013 Base Counts</u>		
<u>2013 Population</u>	71,545	6,567,159
<u>2013 Households</u>	26,926	2,537,304
<u>2013 Housing Units</u>	28,851	2,847,494
<u>2013 Families</u>	20,273	1,697,646
<u>Percent Population Growth 2010 to 2013</u>	2.20%	1.29%
<u>Percent Household Growth 2010 to 2013</u>	2.36%	1.40%
<u>Percent Housing Unit Growth 2010 to 2013</u>	2.58%	1.86%
<u>Percent Family Growth 2010 to 2013</u>	2.43%	1.40%
<u>2013 Population by Sex and Ethnicity</u>		
<u>2013 Population by Sex</u>	71,545	6,567,159
<u>2013 Population by Ethnicity</u>	71,545	6,567,159
<u>2013 Population by Single Race and Sex</u>		
<u>White</u>	67,463 (94.29%)	5,482,760 (83.49%)
<u>Black/Af Amer</u>	1,851 (2.59%)	608,472 (9.27%)
<u>Am Ind/AK Native</u>	161 (0.23%)	19,770 (0.30%)
<u>Asian</u>	624 (0.87%)	115,844 (1.76%)
<u>Native HI/PI</u>	27 (0.04%)	2,705 (0.04%)
<u>Some Other Race</u>	369 (0.52%)	195,570 (2.98%)
<u>2+ Races</u>	1,050 (1.47%)	142,038 (2.16%)
<u>2013 Population by Ethnicity and Single Race</u>		
<u>Hisp/Lat</u>	1,537 (2.15%)	443,564 (6.75%)
<u>Not Hisp/Lat</u>	70,008 (97.85%)	6,123,595 (93.25%)
<u>2013 Population by Age</u>		
<u>2013 Population by Age</u>	71,545	6,567,159

	Hancock	Indiana
<u>2013 Population, Age <18</u>	17,502 (24.46%)	1,584,889 (24.13%)
<u>2013 Population, Age 18+</u>	54,043 (75.54%)	4,982,270 (75.87%)
<u>2013 Population, Age 25+</u>	47,847 (66.88%)	4,297,886 (65.45%)
<u>2013 Population, Age 65+</u>	10,334 (14.44%)	926,902 (14.11%)
<u>2013 Median Age</u>	39.90	37.40

2013 Population by Sex and Age

<u>2013 Male Population by Age</u>	35,145	3,234,243
<u>2013 Population, Male Age <18</u>	8,968 (25.52%)	810,071 (25.05%)
<u>2013 Population, Male: Age 18+</u>	26,177 (74.48%)	2,424,172 (74.95%)
<u>2013 Population, Male Age 65+</u>	4,700 (13.37%)	400,975 (12.40%)
<u>2013 Median Age Male</u>	38.80	36.10
<u>2013 Female Population by Age</u>	36,400	3,332,916
<u>2013 Population, Female: Age <18</u>	8,534 (23.45%)	774,818 (23.25%)
<u>2013 Population, Female Age 18+</u>	27,866 (76.55%)	2,558,098 (76.75%)
<u>2013 Population, Female: Age 65+</u>	5,634 (15.48%)	525,927 (15.78%)
<u>2013 Median Age Female</u>	40.90	38.70

2013 Population 5+ by Language Spoken at Home

<u>Speak Only English at Home</u>	65,580 (97.46%)	5,637,772 (91.84%)
<u>Speak Spanish at Home</u>	984 (1.46%)	280,446 (4.57%)
<u>Speak Asian/PI Lang at Home</u>	286 (0.43%)	61,690 (1.00%)
<u>Speak Indo-European Lang at Home</u>	399 (0.59%)	136,306 (2.22%)
<u>Speak Other Lang at Home</u>	39 (0.06%)	22,189 (0.36%)

2013 Population 15+ by Sex, Marital Status

<u>Never Married</u>	14,204 (24.76%)	1,579,191 (30.03%)
<u>Married, Spouse present</u>	30,440 (53.06%)	2,538,688 (48.27%)
<u>Married, Spouse absent</u>	1,534 (2.67%)	176,235 (3.35%)
<u>Divorced</u>	7,970 (13.89%)	648,607 (12.33%)
<u>Widowed</u>	3,222 (5.62%)	316,491 (6.02%)

	Hancock	Indiana
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2013 Owner-Occ Housing Units by Value

<u>2013 Own Occ HUs Median Value</u>	\$158,969	\$129,943
<u>2013 Own Occ HUs Avg Value</u>	\$186,930	\$160,383

2013 Households by Number of People in Household

<u>2013 Households</u>	26,926	2,537,304
<u>2013 Average Household Size</u>	2.63	2.51

2013 Households by Presence of People Under 18

<u>2013 Households, People < 18</u>	10,051 (37.33%)	846,429 (33.36%)
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2013 Occupied Housing Units by Year Householder Moved In

<u>2013 Median Length of Residence</u>	11.10	10.40
<u>2013 Renter Occ Housing Units Median Length of Residence</u>	5.80	5.50
<u>2013 Owner Occ Housing Units: Median Length of Residence</u>	13.00	14.10

2013 Occupied Housing Units by Vehicles Available

<u>2013 Avg Number Vehicles Available</u>	2.10	1.80
<u>No Vehicle</u>	465 (1.73%)	173,610 (6.84%)
<u>1 Vehicle</u>	7,495 (27.84%)	841,253 (33.16%)
<u>2 Vehicles</u>	11,445 (42.51%)	994,081 (39.18%)
<u>3 Vehicles</u>	5,640 (20.95%)	372,825 (14.69%)
<u>4 Vehicles</u>	1,447 (5.37%)	113,390 (4.47%)
<u>5+ Vehicles</u>	434 (1.61%)	42,145 (1.66%)

2013 Households by Household Income

<u>2013 Households by Income</u>	26,926	2,537,304
<u>2013 Median Household Income</u>	\$58,094	\$47,121
<u>2013 Average Household Income</u>	\$67,978	\$61,175

	Hancock	Indiana
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2013 Households by Race and Household Income

<u>2013 Median HH Inc, White</u>	\$59,054	\$49,584
<u>2013 Avg HH Inc, White</u>	\$68,058	\$61,980
<u>2013 Median HH Inc, Black/Af Amer</u>	\$34,568	\$29,027
<u>2013 Avg HH Inc, Black/Af Amer</u>	\$46,596	\$40,280
<u>2013 Median HH Inc, Am Ind/AK Native</u>	\$35,441	\$39,188
<u>2013 Avg HH Inc, Am Ind/AK Native</u>	\$50,654	\$53,778
<u>2013 Median HH Inc, Asian</u>	\$59,211	\$52,265
<u>2013 Avg HH Inc, Asian</u>	\$66,403	\$71,027
<u>2013 Median HH Inc, Native HI/PI</u>	\$62,500	\$32,730
<u>2013 Avg HH Inc, Native HI/PI</u>	\$66,250	\$54,324
<u>2013 Median HH Inc, Some Other Race</u>	\$61,895	\$34,787
<u>2013 Avg HH Inc, Some Other Race</u>	\$65,891	\$42,982
<u>2013 Median HH Inc, 2+ Races</u>	\$39,185	\$37,608
<u>2013 Avg HH Inc, 2+ Races</u>	\$37,098	\$49,819

2013 Households by Ethnicity and Household Income

<u>2013 Median HH Inc, Hisp/Lat</u>	\$57,826	\$36,166
<u>2013 Avg HH Inc, Hisp/Lat</u>	\$68,136	\$49,820
<u>2013 Median HH Inc, Not Hisp/Lat</u>	\$58,099	\$47,679
<u>2013 Avg HH Inc, Not Hisp/Lat</u>	\$67,976	\$61,718

2013 Families by Poverty Status

<u>2013 Families Below Poverty</u>	1,272 (6.27%)	192,959 (11.37%)
<u>2013 Families Below Poverty with Children</u>	954 (4.71%)	154,999 (9.13%)

2013 Population by Sex and Educational Attainment

<u>2013 Population 25+ with Less Than High School Graduation</u>	3,541 (7.40%)	552,982 (12.87%)
<u>2013 Population 25+, Male, with Less Than High School Graduation</u>	1,601 (6.96%)	278,974 (13.46%)

	Hancock	Indiana
<u>2013 Population 25+, Female, with Less Than High School Graduation</u>	1,940 (7.81%)	274,008 (12.32%)
<u>Population 25+ by Educational Attainment</u>	47,847	4,297,886
<u>Male Population 25+ by Educational Attainment</u>	22,997	2,073,100
<u>Female Population 25+ by Educational Attainment</u>	24,850	2,224,786

County: Hendricks

	Hendricks	Indiana
<u>2013 Base Counts</u>		
<u>2013 Population</u>	153,515	6,567,159
<u>2013 Households</u>	55,007	2,537,304
<u>2013 Housing Units</u>	58,156	2,847,494
<u>2013 Families</u>	41,749	1,697,646
<u>Percent Population Growth 2010 to 2013</u>	5.55%	1.29%
<u>Percent Household Growth 2010 to 2013</u>	5.04%	1.40%
<u>Percent Housing Unit Growth 2010 to 2013</u>	4.87%	1.86%
<u>Percent Family Growth 2010 to 2013</u>	5.17%	1.40%

2013 Population by Sex and Ethnicity

<u>2013 Population by Sex</u>	153,515	6,567,159
<u>2013 Population by Ethnicity</u>	153,515	6,567,159

2013 Population by Single Race and Sex

<u>White</u>	136,004 (88.59%)	5,482,760 (83.49%)
<u>Black/Af Amer</u>	9,002 (5.86%)	608,472 (9.27%)
<u>Am Ind/AK Native</u>	378 (0.25%)	19,770 (0.30%)
<u>Asian</u>	3,404 (2.22%)	115,844 (1.76%)
<u>Native HI/PI</u>	77 (0.05%)	2,705 (0.04%)
<u>Some Other Race</u>	1,848 (1.20%)	195,570 (2.98%)

	Hendricks	Indiana
<u>2+ Races</u>	2,802 (1.83%)	142,038 (2.16%)

2013 Population by Ethnicity and Single Race

<u>Hisp/Lat</u>	5,335 (3.48%)	443,564 (6.75%)
<u>Not Hisp/Lat</u>	148,180 (96.52%)	6,123,595 (93.25%)

2013 Population by Age

<u>2013 Population by Age</u>	153,515	6,567,159
<u>2013 Population, Age <18</u>	39,656 (25.83%)	1,584,889 (24.13%)
<u>2013 Population, Age 18+</u>	113,859 (74.17%)	4,982,270 (75.87%)
<u>2013 Population, Age 25+</u>	100,500 (65.47%)	4,297,886 (65.45%)
<u>2013 Population, Age 65+</u>	18,610 (12.12%)	926,902 (14.11%)
<u>2013 Median Age</u>	37.50	37.40

2013 Population by Sex and Age

<u>2013 Male Population by Age</u>	76,739	3,234,243
<u>2013 Population, Male Age <18</u>	20,395 (26.58%)	810,071 (25.05%)
<u>2013 Population, Male: Age 18+</u>	56,344 (73.42%)	2,424,172 (74.95%)
<u>2013 Population, Male Age 65+</u>	8,163 (10.64%)	400,975 (12.40%)
<u>2013 Median Age Male</u>	36.50	36.10
<u>2013 Female Population by Age</u>	76,776	3,332,916
<u>2013 Population, Female: Age <18</u>	19,261 (25.09%)	774,818 (23.25%)
<u>2013 Population, Female Age 18+</u>	57,515 (74.91%)	2,558,098 (76.75%)
<u>2013 Population, Female: Age 65+</u>	10,447 (13.61%)	525,927 (15.78%)
<u>2013 Median Age Female</u>	38.60	38.70

2013 Population 5+ by Language Spoken at Home

<u>Speak Only English at Home</u>	135,642 (94.55%)	5,637,772 (91.84%)
<u>Speak Spanish at Home</u>	3,344 (2.33%)	280,446 (4.57%)
<u>Speak Asian/PI Lang at Home</u>	783 (0.55%)	61,690 (1.00%)
<u>Speak Indo-European Lang at Home</u>	3,015 (2.10%)	136,306 (2.22%)

	Hendricks	Indiana
<u>Speak Other Lang at Home</u>	683 (0.48%)	22,189 (0.36%)
<u>2013 Population 15+ by Sex, Marital Status</u>		
<u>Never Married</u>	29,408 (24.32%)	1,579,191 (30.03%)
<u>Married, Spouse present</u>	67,956 (56.21%)	2,538,688 (48.27%)
<u>Married, Spouse absent</u>	3,443 (2.85%)	176,235 (3.35%)
<u>Divorced</u>	13,921 (11.51%)	648,607 (12.33%)
<u>Widowed</u>	6,170 (5.10%)	316,491 (6.02%)
<u>2013 Owner-Occ Housing Units by Value</u>		
<u>2013 Own Occ HUs Median Value</u>	\$173,404	\$129,943
<u>2013 Own Occ HUs Avg Value</u>	\$200,724	\$160,383
<u>2013 Households by Number of People in Household</u>		
<u>2013 Households</u>	55,007	2,537,304
<u>2013 Average Household Size</u>	2.72	2.51
<u>2013 Households by Presence of People Under 18</u>		
<u>2013 Households, People < 18</u>	22,281 (40.51%)	846,429 (33.36%)
<u>2013 Occupied Housing Units by Year Householder Moved In</u>		
<u>2013 Median Length of Residence</u>	10.10	10.40
<u>2013 Renter Occ Housing Units Median Length of Residence</u>	5.20	5.50
<u>2013 Owner Occ Housing Units: Median Length of Residence</u>	11.70	14.10
<u>2013 Occupied Housing Units by Vehicles Available</u>		
<u>2013 Avg Number Vehicles Available</u>	2.00	1.80
<u>No Vehicle</u>	1,819 (3.31%)	173,610 (6.84%)
<u>1 Vehicle</u>	14,227 (25.86%)	841,253 (33.16%)
<u>2 Vehicles</u>	26,203 (47.64%)	994,081 (39.18%)
<u>3 Vehicles</u>	9,024 (16.41%)	372,825 (14.69%)

	Hendricks	Indiana
<u>4 Vehicles</u>	2,706 (4.92%)	113,390 (4.47%)
<u>5+ Vehicles</u>	1,028 (1.87%)	42,145 (1.66%)

2013 Households by Household Income

<u>2013 Households by Income</u>	55,007	2,537,304
<u>2013 Median Household Income</u>	\$66,098	\$47,121
<u>2013 Average Household Income</u>	\$77,144	\$61,175

2013 Households by Race and Household Income

<u>2013 Median HH Inc, White</u>	\$66,284	\$49,584
<u>2013 Avg HH Inc, White</u>	\$76,012	\$61,980
<u>2013 Median HH Inc, Black/Af Amer</u>	\$61,879	\$29,027
<u>2013 Avg HH Inc, Black/Af Amer</u>	\$75,078	\$40,280
<u>2013 Median HH Inc, Am Ind/AK Native</u>	\$94,718	\$39,188
<u>2013 Avg HH Inc, Am Ind/AK Native</u>	\$116,849	\$53,778
<u>2013 Median HH Inc, Asian</u>	\$64,037	\$52,265
<u>2013 Avg HH Inc, Asian</u>	\$77,412	\$71,027
<u>2013 Median HH Inc, Native HI/PI</u>	\$62,500	\$32,730
<u>2013 Avg HH Inc, Native HI/PI</u>	\$68,106	\$54,324
<u>2013 Median HH Inc, Some Other Race</u>	\$73,302	\$34,787
<u>2013 Avg HH Inc, Some Other Race</u>	\$70,289	\$42,982
<u>2013 Median HH Inc, 2+ Races</u>	\$52,059	\$37,608
<u>2013 Avg HH Inc, 2+ Races</u>	\$64,302	\$49,819

2013 Households by Ethnicity and Household Income

<u>2013 Median HH Inc, Hisp/Lat</u>	\$61,930	\$36,166
<u>2013 Avg HH Inc, Hisp/Lat</u>	\$69,337	\$49,820
<u>2013 Median HH Inc, Not Hisp/Lat</u>	\$66,203	\$47,679
<u>2013 Avg HH Inc, Not Hisp/Lat</u>	\$77,325	\$61,718

2013 Families by Poverty Status

	Hendricks	Indiana
<u>2013 Families Below Poverty</u>	1,516 (3.63%)	192,959 (11.37%)
<u>2013 Families Below Poverty with Children</u>	1,138 (2.73%)	154,999 (9.13%)
<u>2013 Population by Sex and Educational Attainment</u>		
<u>2013 Population 25+ with Less Than High School Graduation</u>	6,373 (6.34%)	552,982 (12.87%)
<u>2013 Population 25+, Male, with Less Than High School Graduation</u>	3,282 (6.66%)	278,974 (13.46%)
<u>2013 Population 25+, Female, with Less Than High School Graduation</u>	3,091 (6.04%)	274,008 (12.32%)
<u>Population 25+ by Educational Attainment</u>	100,500	4,297,886
<u>Male Population 25+ by Educational Attainment</u>	49,311	2,073,100
<u>Female Population 25+ by Educational Attainment</u>	51,189	2,224,786

County: Howard

	Howard	Indiana
<u>2013 Base Counts</u>		
<u>2013 Population</u>	82,857	6,567,159
<u>2013 Households</u>	34,465	2,537,304
<u>2013 Housing Units</u>	39,047	2,847,494
<u>2013 Families</u>	22,690	1,697,646
<u>Percent Population Growth 2010 to 2013</u>	0.13%	1.29%
<u>Percent Household Growth 2010 to 2013</u>	0.48%	1.40%
<u>Percent Housing Unit Growth 2010 to 2013</u>	0.95%	1.86%
<u>Percent Family Growth 2010 to 2013</u>	0.38%	1.40%
<u>2013 Population by Sex and Ethnicity</u>		
<u>2013 Population by Sex</u>	82,857	6,567,159
<u>2013 Population by Ethnicity</u>	82,857	6,567,159
<u>2013 Population by Single Race and Sex</u>		

	Howard	Indiana
<u>White</u>	72,838 (87.91%)	5,482,760 (83.49%)
<u>Black/Af Amer</u>	5,976 (7.21%)	608,472 (9.27%)
<u>Am Ind/AK Native</u>	293 (0.35%)	19,770 (0.30%)
<u>Asian</u>	900 (1.09%)	115,844 (1.76%)
<u>Native HI/PI</u>	27 (0.03%)	2,705 (0.04%)
<u>Some Other Race</u>	769 (0.93%)	195,570 (2.98%)
<u>2+ Races</u>	2,054 (2.48%)	142,038 (2.16%)

2013 Population by Ethnicity and Single Race

<u>Hisp/Lat</u>	2,474 (2.99%)	443,564 (6.75%)
<u>Not Hisp/Lat</u>	80,383 (97.01%)	6,123,595 (93.25%)

2013 Population by Age

<u>2013 Population by Age</u>	82,857	6,567,159
<u>2013 Population, Age <18</u>	18,927 (22.84%)	1,584,889 (24.13%)
<u>2013 Population, Age 18+</u>	63,930 (77.16%)	4,982,270 (75.87%)
<u>2013 Population, Age 25+</u>	56,902 (68.67%)	4,297,886 (65.45%)
<u>2013 Population, Age 65+</u>	14,756 (17.81%)	926,902 (14.11%)
<u>2013 Median Age</u>	41.30	37.40

2013 Population by Sex and Age

<u>2013 Male Population by Age</u>	39,942	3,234,243
<u>2013 Population, Male Age <18</u>	9,649 (24.16%)	810,071 (25.05%)
<u>2013 Population, Male: Age 18+</u>	30,293 (75.84%)	2,424,172 (74.95%)
<u>2013 Population, Male Age 65+</u>	6,353 (15.91%)	400,975 (12.40%)
<u>2013 Median Age Male</u>	39.80	36.10
<u>2013 Female Population by Age</u>	42,915	3,332,916
<u>2013 Population, Female: Age <18</u>	9,278 (21.62%)	774,818 (23.25%)
<u>2013 Population, Female Age 18+</u>	33,637 (78.38%)	2,558,098 (76.75%)
<u>2013 Population, Female: Age 65+</u>	8,403 (19.58%)	525,927 (15.78%)
<u>2013 Median Age Female</u>	42.70	38.70

	Howard	Indiana
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2013 Population 5+ by Language Spoken at Home

<u>Speak Only English at Home</u>	74,410 (95.70%)	5,637,772 (91.84%)
<u>Speak Spanish at Home</u>	1,750 (2.25%)	280,446 (4.57%)
<u>Speak Asian/PI Lang at Home</u>	561 (0.72%)	61,690 (1.00%)
<u>Speak Indo-European Lang at Home</u>	957 (1.23%)	136,306 (2.22%)
<u>Speak Other Lang at Home</u>	79 (0.10%)	22,189 (0.36%)

2013 Population 15+ by Sex, Marital Status

<u>Never Married</u>	17,329 (25.75%)	1,579,191 (30.03%)
<u>Married, Spouse present</u>	34,250 (50.89%)	2,538,688 (48.27%)
<u>Married, Spouse absent</u>	1,960 (2.91%)	176,235 (3.35%)
<u>Divorced</u>	9,267 (13.77%)	648,607 (12.33%)
<u>Widowed</u>	4,502 (6.69%)	316,491 (6.02%)

2013 Owner-Occ Housing Units by Value

<u>2013 Own Occ HUs Median Value</u>	\$96,601	\$129,943
<u>2013 Own Occ HUs Avg Value</u>	\$119,750	\$160,383

2013 Households by Number of People in Household

<u>2013 Households</u>	34,465	2,537,304
<u>2013 Average Household Size</u>	2.37	2.51

2013 Households by Presence of People Under 18

<u>2013 Households, People < 18</u>	10,563 (30.65%)	846,429 (33.36%)
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2013 Occupied Housing Units by Year Householder Moved In

<u>2013 Median Length of Residence</u>	10.40	10.40
<u>2013 Renter Occ Housing Units Median Length of Residence</u>	5.30	5.50
<u>2013 Owner Occ Housing Units: Median Length of Residence</u>	14.60	14.10

2013 Occupied Housing Units by Vehicles Available

	Howard	Indiana
<u>2013 Avg Number Vehicles Available</u>	1.70	1.80
<u>No Vehicle</u>	3,166 (9.19%)	173,610 (6.84%)
<u>1 Vehicle</u>	11,607 (33.68%)	841,253 (33.16%)
<u>2 Vehicles</u>	14,161 (41.09%)	994,081 (39.18%)
<u>3 Vehicles</u>	3,984 (11.56%)	372,825 (14.69%)
<u>4 Vehicles</u>	1,209 (3.51%)	113,390 (4.47%)
<u>5+ Vehicles</u>	338 (0.98%)	42,145 (1.66%)

2013 Households by Household Income

<u>2013 Households by Income</u>	34,465	2,537,304
<u>2013 Median Household Income</u>	\$38,370	\$47,121
<u>2013 Average Household Income</u>	\$50,159	\$61,175

2013 Households by Race and Household Income

<u>2013 Median HH Inc, White</u>	\$39,849	\$49,584
<u>2013 Avg HH Inc, White</u>	\$50,995	\$61,980
<u>2013 Median HH Inc, Black/Af Amer</u>	\$25,155	\$29,027
<u>2013 Avg HH Inc, Black/Af Amer</u>	\$36,631	\$40,280
<u>2013 Median HH Inc, Am Ind/AK Native</u>	\$14,999	\$39,188
<u>2013 Avg HH Inc, Am Ind/AK Native</u>	\$29,205	\$53,778
<u>2013 Median HH Inc, Asian</u>	\$66,102	\$52,265
<u>2013 Avg HH Inc, Asian</u>	\$59,309	\$71,027
<u>2013 Median HH Inc, Native HI/PI</u>	\$165,625	\$32,730
<u>2013 Avg HH Inc, Native HI/PI</u>	\$142,955	\$54,324
<u>2013 Median HH Inc, Some Other Race</u>	\$28,475	\$34,787
<u>2013 Avg HH Inc, Some Other Race</u>	\$33,491	\$42,982
<u>2013 Median HH Inc, 2+ Races</u>	\$26,849	\$37,608
<u>2013 Avg HH Inc, 2+ Races</u>	\$39,988	\$49,819

2013 Households by Ethnicity and Household Income

<u>2013 Median HH Inc, Hisp/Lat</u>	\$32,063	\$36,166
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	Howard	Indiana
<u>2013 Avg HH Inc, Hisp/Lat</u>	\$45,104	\$49,820
<u>2013 Median HH Inc, Not Hisp/Lat</u>	\$38,609	\$47,679
<u>2013 Avg HH Inc, Not Hisp/Lat</u>	\$50,265	\$61,718

2013 Families by Poverty Status

<u>2013 Families Below Poverty</u>	3,012 (13.27%)	192,959 (11.37%)
<u>2013 Families Below Poverty with Children</u>	2,354 (10.37%)	154,999 (9.13%)

2013 Population by Sex and Educational Attainment

<u>2013 Population 25+ with Less Than High School Graduation</u>	6,337 (11.14%)	552,982 (12.87%)
<u>2013 Population 25+, Male, with Less Than High School Graduation</u>	2,923 (10.94%)	278,974 (13.46%)
<u>2013 Population 25+, Female, with Less Than High School Graduation</u>	3,414 (11.31%)	274,008 (12.32%)
<u>Population 25+ by Educational Attainment</u>	56,902	4,297,886
<u>Male Population 25+ by Educational Attainment</u>	26,729	2,073,100
<u>Female Population 25+ by Educational Attainment</u>	30,173	2,224,786

County: Johnson

	Johnson	Indiana
<u>2013 Base Counts</u>		
<u>2013 Population</u>	145,607	6,567,159
<u>2013 Households</u>	54,555	2,537,304
<u>2013 Housing Units</u>	59,179	2,847,494
<u>2013 Families</u>	39,400	1,697,646
<u>Percent Population Growth 2010 to 2013</u>	4.26%	1.29%
<u>Percent Household Growth 2010 to 2013</u>	4.43%	1.40%
<u>Percent Housing Unit Growth 2010 to 2013</u>	4.47%	1.86%
<u>Percent Family Growth 2010 to 2013</u>	4.48%	1.40%

	Johnson	Indiana
<u>2013 Population by Sex and Ethnicity</u>		
<u>2013 Population by Sex</u>	145,607	6,567,159
<u>2013 Population by Ethnicity</u>	145,607	6,567,159
<u>2013 Population by Single Race and Sex</u>		
<u>White</u>	134,441 (92.33%)	5,482,760 (83.49%)
<u>Black/Af Amer</u>	2,869 (1.97%)	608,472 (9.27%)
<u>Am Ind/AK Native</u>	361 (0.25%)	19,770 (0.30%)
<u>Asian</u>	3,224 (2.21%)	115,844 (1.76%)
<u>Native HI/PI</u>	43 (0.03%)	2,705 (0.04%)
<u>Some Other Race</u>	2,139 (1.47%)	195,570 (2.98%)
<u>2+ Races</u>	2,530 (1.74%)	142,038 (2.16%)
<u>2013 Population by Ethnicity and Single Race</u>		
<u>Hisp/Lat</u>	5,495 (3.77%)	443,564 (6.75%)
<u>Not Hisp/Lat</u>	140,112 (96.23%)	6,123,595 (93.25%)
<u>2013 Population by Age</u>		
<u>2013 Population by Age</u>	145,607	6,567,159
<u>2013 Population, Age <18</u>	36,890 (25.34%)	1,584,889 (24.13%)
<u>2013 Population, Age 18+</u>	108,717 (74.66%)	4,982,270 (75.87%)
<u>2013 Population, Age 25+</u>	95,399 (65.52%)	4,297,886 (65.45%)
<u>2013 Population, Age 65+</u>	19,691 (13.52%)	926,902 (14.11%)
<u>2013 Median Age</u>	37.50	37.40
<u>2013 Population by Sex and Age</u>		
<u>2013 Male Population by Age</u>	71,629	3,234,243
<u>2013 Population, Male Age <18</u>	18,907 (26.40%)	810,071 (25.05%)
<u>2013 Population, Male: Age 18+</u>	52,722 (73.60%)	2,424,172 (74.95%)
<u>2013 Population, Male Age 65+</u>	8,582 (11.98%)	400,975 (12.40%)
<u>2013 Median Age Male</u>	36.40	36.10

	Johnson	Indiana
<u>2013 Female Population by Age</u>	73,978	3,332,916
<u>2013 Population, Female: Age <18</u>	17,983 (24.31%)	774,818 (23.25%)
<u>2013 Population, Female Age 18+</u>	55,995 (75.69%)	2,558,098 (76.75%)
<u>2013 Population, Female: Age 65+</u>	11,109 (15.02%)	525,927 (15.78%)
<u>2013 Median Age Female</u>	38.60	38.70

2013 Population 5+ by Language Spoken at Home

<u>Speak Only English at Home</u>	128,860 (94.81%)	5,637,772 (91.84%)
<u>Speak Spanish at Home</u>	2,823 (2.08%)	280,446 (4.57%)
<u>Speak Asian/PI Lang at Home</u>	775 (0.57%)	61,690 (1.00%)
<u>Speak Indo-European Lang at Home</u>	3,007 (2.21%)	136,306 (2.22%)
<u>Speak Other Lang at Home</u>	455 (0.33%)	22,189 (0.36%)

2013 Population 15+ by Sex, Marital Status

<u>Never Married</u>	27,294 (23.68%)	1,579,191 (30.03%)
<u>Married, Spouse present</u>	65,007 (56.41%)	2,538,688 (48.27%)
<u>Married, Spouse absent</u>	3,776 (3.28%)	176,235 (3.35%)
<u>Divorced</u>	12,923 (11.21%)	648,607 (12.33%)
<u>Widowed</u>	6,238 (5.41%)	316,491 (6.02%)

2013 Owner-Occ Housing Units by Value

<u>2013 Own Occ HUs Median Value</u>	\$154,634	\$129,943
<u>2013 Own Occ HUs Avg Value</u>	\$184,070	\$160,383

2013 Households by Number of People in Household

<u>2013 Households</u>	54,555	2,537,304
<u>2013 Average Household Size</u>	2.63	2.51

2013 Households by Presence of People Under 18

<u>2013 Households, People < 18</u>	20,335 (37.27%)	846,429 (33.36%)
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2013 Occupied Housing Units by Year Householder Moved In

<u>2013 Median Length of Residence</u>	9.30	10.40
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	Johnson	Indiana
<u>2013 Renter Occ Housing Units Median Length of Residence</u>	5.10	5.50
<u>2013 Owner Occ Housing Units: Median Length of Residence</u>	12.20	14.10
<u>2013 Occupied Housing Units by Vehicles Available</u>		
<u>2013 Avg Number Vehicles Available</u>	2.00	1.80
<u>No Vehicle</u>	1,975 (3.62%)	173,610 (6.84%)
<u>1 Vehicle</u>	14,670 (26.89%)	841,253 (33.16%)
<u>2 Vehicles</u>	24,862 (45.57%)	994,081 (39.18%)
<u>3 Vehicles</u>	9,595 (17.59%)	372,825 (14.69%)
<u>4 Vehicles</u>	2,631 (4.82%)	113,390 (4.47%)
<u>5+ Vehicles</u>	822 (1.51%)	42,145 (1.66%)
<u>2013 Households by Household Income</u>		
<u>2013 Households by Income</u>	54,555	2,537,304
<u>2013 Median Household Income</u>	\$62,510	\$47,121
<u>2013 Average Household Income</u>	\$75,644	\$61,175
<u>2013 Households by Race and Household Income</u>		
<u>2013 Median HH Inc, White</u>	\$62,834	\$49,584
<u>2013 Avg HH Inc, White</u>	\$74,148	\$61,980
<u>2013 Median HH Inc, Black/Af Amer</u>	\$43,385	\$29,027
<u>2013 Avg HH Inc, Black/Af Amer</u>	\$63,182	\$40,280
<u>2013 Median HH Inc, Am Ind/AK Native</u>	\$42,500	\$39,188
<u>2013 Avg HH Inc, Am Ind/AK Native</u>	\$55,254	\$53,778
<u>2013 Median HH Inc, Asian</u>	\$88,358	\$52,265
<u>2013 Avg HH Inc, Asian</u>	\$104,131	\$71,027
<u>2013 Median HH Inc, Native HI/PI</u>	\$42,500	\$32,730
<u>2013 Avg HH Inc, Native HI/PI</u>	\$62,833	\$54,324
<u>2013 Median HH Inc, Some Other Race</u>	\$58,435	\$34,787

	Johnson	Indiana
<u>2013 Avg HH Inc, Some Other Race</u>	\$73,223	\$42,982
<u>2013 Median HH Inc, 2+ Races</u>	\$42,541	\$37,608
<u>2013 Avg HH Inc, 2+ Races</u>	\$49,645	\$49,819

2013 Households by Ethnicity and Household Income

<u>2013 Median HH Inc, Hisp/Lat</u>	\$45,467	\$36,166
<u>2013 Avg HH Inc, Hisp/Lat</u>	\$68,646	\$49,820
<u>2013 Median HH Inc, Not Hisp/Lat</u>	\$62,975	\$47,679
<u>2013 Avg HH Inc, Not Hisp/Lat</u>	\$75,832	\$61,718

2013 Families by Poverty Status

<u>2013 Families Below Poverty</u>	3,043 (7.72%)	192,959 (11.37%)
<u>2013 Families Below Poverty with Children</u>	2,335 (5.93%)	154,999 (9.13%)

2013 Population by Sex and Educational Attainment

<u>2013 Population 25+ with Less Than High School Graduation</u>	7,688 (8.06%)	552,982 (12.87%)
<u>2013 Population 25+, Male, with Less Than High School Graduation</u>	3,931 (8.56%)	278,974 (13.46%)
<u>2013 Population 25+, Female, with Less Than High School Graduation</u>	3,757 (7.59%)	274,008 (12.32%)
<u>Population 25+ by Educational Attainment</u>	95,399	4,297,886
<u>Male Population 25+ by Educational Attainment</u>	45,932	2,073,100
<u>Female Population 25+ by Educational Attainment</u>	49,467	2,224,786

County: Morgan

	Morgan	Indiana
<u>2013 Base Counts</u>		
<u>2013 Population</u>	69,604	6,567,159
<u>2013 Households</u>	26,159	2,537,304
<u>2013 Housing Units</u>	28,243	2,847,494

	Morgan	Indiana
<u>2013 Families</u>	19,653	1,697,646
<u>Percent Population Growth 2010 to 2013</u>	1.03%	1.29%
<u>Percent Household Growth 2010 to 2013</u>	1.53%	1.40%
<u>Percent Housing Unit Growth 2010 to 2013</u>	1.76%	1.86%
<u>Percent Family Growth 2010 to 2013</u>	1.54%	1.40%

2013 Population by Sex and Ethnicity

<u>2013 Population by Sex</u>	69,604	6,567,159
<u>2013 Population by Ethnicity</u>	69,604	6,567,159

2013 Population by Single Race and Sex

<u>White</u>	67,321 (96.72%)	5,482,760 (83.49%)
<u>Black/Af Amer</u>	570 (0.82%)	608,472 (9.27%)
<u>Am Ind/AK Native</u>	243 (0.35%)	19,770 (0.30%)
<u>Asian</u>	385 (0.55%)	115,844 (1.76%)
<u>Native HI/PI</u>	19 (0.03%)	2,705 (0.04%)
<u>Some Other Race</u>	324 (0.47%)	195,570 (2.98%)
<u>2+ Races</u>	742 (1.07%)	142,038 (2.16%)

2013 Population by Ethnicity and Single Race

<u>Hisp/Lat</u>	1,194 (1.72%)	443,564 (6.75%)
<u>Not Hisp/Lat</u>	68,410 (98.28%)	6,123,595 (93.25%)

2013 Population by Age

<u>2013 Population by Age</u>	69,604	6,567,159
<u>2013 Population, Age <18</u>	16,432 (23.61%)	1,584,889 (24.13%)
<u>2013 Population, Age 18+</u>	53,172 (76.39%)	4,982,270 (75.87%)
<u>2013 Population, Age 25+</u>	47,084 (67.65%)	4,297,886 (65.45%)
<u>2013 Population, Age 65+</u>	10,382 (14.92%)	926,902 (14.11%)
<u>2013 Median Age</u>	40.60	37.40

2013 Population by Sex and Age

	Morgan	Indiana
<u>2013 Male Population by Age</u>	34,442	3,234,243
<u>2013 Population, Male Age <18</u>	8,436 (24.49%)	810,071 (25.05%)
<u>2013 Population, Male: Age 18+</u>	26,006 (75.51%)	2,424,172 (74.95%)
<u>2013 Population, Male Age 65+</u>	4,724 (13.72%)	400,975 (12.40%)
<u>2013 Median Age Male</u>	39.70	36.10
<u>2013 Female Population by Age</u>	35,162	3,332,916
<u>2013 Population, Female: Age <18</u>	7,996 (22.74%)	774,818 (23.25%)
<u>2013 Population, Female Age 18+</u>	27,166 (77.26%)	2,558,098 (76.75%)
<u>2013 Population, Female: Age 65+</u>	5,658 (16.09%)	525,927 (15.78%)
<u>2013 Median Age Female</u>	41.50	38.70

2013 Population 5+ by Language Spoken at Home

<u>Speak Only English at Home</u>	64,064 (97.92%)	5,637,772 (91.84%)
<u>Speak Spanish at Home</u>	756 (1.16%)	280,446 (4.57%)
<u>Speak Asian/PI Lang at Home</u>	225 (0.34%)	61,690 (1.00%)
<u>Speak Indo-European Lang at Home</u>	356 (0.54%)	136,306 (2.22%)
<u>Speak Other Lang at Home</u>	27 (0.04%)	22,189 (0.36%)

2013 Population 15+ by Sex, Marital Status

<u>Never Married</u>	12,130 (21.56%)	1,579,191 (30.03%)
<u>Married, Spouse present</u>	33,101 (58.83%)	2,538,688 (48.27%)
<u>Married, Spouse absent</u>	1,300 (2.31%)	176,235 (3.35%)
<u>Divorced</u>	6,546 (11.63%)	648,607 (12.33%)
<u>Widowed</u>	3,190 (5.67%)	316,491 (6.02%)

2013 Owner-Occ Housing Units by Value

<u>2013 Own Occ HUs Median Value</u>	\$151,460	\$129,943
<u>2013 Own Occ HUs Avg Value</u>	\$183,826	\$160,383

2013 Households by Number of People in Household

<u>2013 Households</u>	26,159	2,537,304
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	Morgan	Indiana
<u>2013 Average Household Size</u>	2.64	2.51
<u>2013 Households by Presence of People Under 18</u>		
<u>2013 Households, People < 18</u>	9,372 (35.83%)	846,429 (33.36%)
<u>2013 Occupied Housing Units by Year Householder Moved In</u>		
<u>2013 Median Length of Residence</u>	10.60	10.40
<u>2013 Renter Occ Housing Units: Median Length of Residence</u>	5.40	5.50
<u>2013 Owner Occ Housing Units: Median Length of Residence</u>	13.40	14.10
<u>2013 Occupied Housing Units by Vehicles Available</u>		
<u>2013 Avg Number Vehicles Available</u>	2.10	1.80
<u>No Vehicle</u>	822 (3.14%)	173,610 (6.84%)
<u>1 Vehicle</u>	6,583 (25.17%)	841,253 (33.16%)
<u>2 Vehicles</u>	11,376 (43.49%)	994,081 (39.18%)
<u>3 Vehicles</u>	4,562 (17.44%)	372,825 (14.69%)
<u>4 Vehicles</u>	2,250 (8.60%)	113,390 (4.47%)
<u>5+ Vehicles</u>	566 (2.16%)	42,145 (1.66%)
<u>2013 Households by Household Income</u>		
<u>2013 Households by Income</u>	26,159	2,537,304
<u>2013 Median Household Income</u>	\$56,214	\$47,121
<u>2013 Average Household Income</u>	\$70,846	\$61,175
<u>2013 Households by Race and Household Income</u>		
<u>2013 Median HH Inc, White</u>	\$56,602	\$49,584
<u>2013 Avg HH Inc, White</u>	\$69,292	\$61,980
<u>2013 Median HH Inc, Black/Af Amer</u>	\$45,135	\$29,027
<u>2013 Avg HH Inc, Black/Af Amer</u>	\$70,422	\$40,280
<u>2013 Median HH Inc, Am Ind/AK Native</u>	\$103,198	\$39,188
<u>2013 Avg HH Inc, Am Ind/AK Native</u>	\$79,848	\$53,778

	Morgan	Indiana
<u>2013 Median HH Inc, Asian</u>	\$20,298	\$52,265
<u>2013 Avg HH Inc, Asian</u>	\$23,790	\$71,027
<u>2013 Median HH Inc, Native HI/PI</u>	\$20,000	\$32,730
<u>2013 Avg HH Inc, Native HI/PI</u>	\$23,333	\$54,324
<u>2013 Median HH Inc, Some Other Race</u>	\$48,421	\$34,787
<u>2013 Avg HH Inc, Some Other Race</u>	\$61,635	\$42,982
<u>2013 Median HH Inc, 2+ Races</u>	\$44,911	\$37,608
<u>2013 Avg HH Inc, 2+ Races</u>	\$57,667	\$49,819
<u>2013 Households by Ethnicity and Household Income</u>		
<u>2013 Median HH Inc, Hisp/Lat</u>	\$46,389	\$36,166
<u>2013 Avg HH Inc, Hisp/Lat</u>	\$66,886	\$49,820
<u>2013 Median HH Inc, Not Hisp/Lat</u>	\$56,404	\$47,679
<u>2013 Avg HH Inc, Not Hisp/Lat</u>	\$70,891	\$61,718
<u>2013 Families by Poverty Status</u>		
<u>2013 Families Below Poverty</u>	1,361 (6.93%)	192,959 (11.37%)
<u>2013 Families Below Poverty with Children</u>	1,060 (5.39%)	154,999 (9.13%)
<u>2013 Population by Sex and Educational Attainment</u>		
<u>2013 Population 25+ with Less Than High School Graduation</u>	5,883 (12.49%)	552,982 (12.87%)
<u>2013 Population 25+, Male, with Less Than High School Graduation</u>	3,195 (13.97%)	278,974 (13.46%)
<u>2013 Population 25+, Female, with Less Than High School Graduation</u>	2,688 (11.10%)	274,008 (12.32%)
<u>Population 25+ by Educational Attainment</u>	47,084	4,297,886
<u>Male Population 25+ by Educational Attainment</u>	22,868	2,073,100
<u>Female Population 25+ by Educational Attainment</u>	24,216	2,224,786

County: Shelby

	Shelby	Indiana
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2013 Base Counts

<u>2013 Population</u>	44,494	6,567,159
<u>2013 Households</u>	17,420	2,537,304
<u>2013 Housing Units</u>	19,326	2,847,494
<u>2013 Families</u>	12,283	1,697,646
<u>Percent Population Growth 2010 to 2013</u>	0.13%	1.29%
<u>Percent Household Growth 2010 to 2013</u>	0.68%	1.40%
<u>Percent Housing Unit Growth 2010 to 2013</u>	1.29%	1.86%
<u>Percent Family Growth 2010 to 2013</u>	0.51%	1.40%

2013 Population by Sex and Ethnicity

<u>2013 Population by Sex</u>	44,494	6,567,159
<u>2013 Population by Ethnicity</u>	44,494	6,567,159

2013 Population by Single Race and Sex

<u>White</u>	42,062 (94.53%)	5,482,760 (83.49%)
<u>Black/Af Amer</u>	698 (1.57%)	608,472 (9.27%)
<u>Am Ind/AK Native</u>	132 (0.30%)	19,770 (0.30%)
<u>Asian</u>	240 (0.54%)	115,844 (1.76%)
<u>Native HI/PI</u>	13 (0.03%)	2,705 (0.04%)
<u>Some Other Race</u>	775 (1.74%)	195,570 (2.98%)
<u>2+ Races</u>	574 (1.29%)	142,038 (2.16%)

2013 Population by Ethnicity and Single Race

<u>Hisp/Lat</u>	1,791 (4.03%)	443,564 (6.75%)
<u>Not Hisp/Lat</u>	42,703 (95.97%)	6,123,595 (93.25%)

2013 Population by Age

<u>2013 Population by Age</u>	44,494	6,567,159
<u>2013 Population, Age <18</u>	10,361 (23.29%)	1,584,889 (24.13%)

	Shelby	Indiana
<u>2013 Population, Age 18+</u>	34,133 (76.71%)	4,982,270 (75.87%)
<u>2013 Population, Age 25+</u>	30,247 (67.98%)	4,297,886 (65.45%)
<u>2013 Population, Age 65+</u>	6,798 (15.28%)	926,902 (14.11%)
<u>2013 Median Age</u>	40.50	37.40

2013 Population by Sex and Age

<u>2013 Male Population by Age</u>	22,065	3,234,243
<u>2013 Population, Male Age <18</u>	5,339 (24.20%)	810,071 (25.05%)
<u>2013 Population, Male: Age 18+</u>	16,726 (75.80%)	2,424,172 (74.95%)
<u>2013 Population, Male Age 65+</u>	2,968 (13.45%)	400,975 (12.40%)
<u>2013 Median Age Male</u>	39.30	36.10
<u>2013 Female Population by Age</u>	22,429	3,332,916
<u>2013 Population, Female: Age <18</u>	5,022 (22.39%)	774,818 (23.25%)
<u>2013 Population, Female Age 18+</u>	17,407 (77.61%)	2,558,098 (76.75%)
<u>2013 Population, Female: Age 65+</u>	3,830 (17.08%)	525,927 (15.78%)
<u>2013 Median Age Female</u>	41.80	38.70

2013 Population 5+ by Language Spoken at Home

<u>Speak Only English at Home</u>	39,982 (95.53%)	5,637,772 (91.84%)
<u>Speak Spanish at Home</u>	1,335 (3.19%)	280,446 (4.57%)
<u>Speak Asian/PI Lang at Home</u>	209 (0.50%)	61,690 (1.00%)
<u>Speak Indo-European Lang at Home</u>	312 (0.75%)	136,306 (2.22%)
<u>Speak Other Lang at Home</u>	15 (0.04%)	22,189 (0.36%)

2013 Population 15+ by Sex, Marital Status

<u>Never Married</u>	8,614 (23.91%)	1,579,191 (30.03%)
<u>Married, Spouse present</u>	18,827 (52.25%)	2,538,688 (48.27%)
<u>Married, Spouse absent</u>	1,214 (3.37%)	176,235 (3.35%)
<u>Divorced</u>	4,781 (13.27%)	648,607 (12.33%)
<u>Widowed</u>	2,595 (7.20%)	316,491 (6.02%)

	Shelby	Indiana
<u>2013 Owner-Occ Housing Units by Value</u>		
<u>2013 Own Occ HUs Median Value</u>	\$133,390	\$129,943
<u>2013 Own Occ HUs Avg Value</u>	\$158,012	\$160,383
<u>2013 Households by Number of People in Household</u>		
<u>2013 Households</u>	17,420	2,537,304
<u>2013 Average Household Size</u>	2.51	2.51
<u>2013 Households by Presence of People Under 18</u>		
<u>2013 Households, People < 18</u>	5,887 (33.79%)	846,429 (33.36%)
<u>2013 Occupied Housing Units by Year Householder Moved In</u>		
<u>2013 Median Length of Residence</u>	11.50	10.40
<u>2013 Renter Occ Housing Units Median Length of Residence</u>	6.00	5.50
<u>2013 Owner Occ Housing Units: Median Length of Residence</u>	15.10	14.10
<u>2013 Occupied Housing Units by Vehicles Available</u>		
<u>2013 Avg Number Vehicles Available</u>	2.00	1.80
<u>No Vehicle</u>	898 (5.15%)	173,610 (6.84%)
<u>1 Vehicle</u>	5,091 (29.23%)	841,253 (33.16%)
<u>2 Vehicles</u>	6,820 (39.15%)	994,081 (39.18%)
<u>3 Vehicles</u>	2,957 (16.97%)	372,825 (14.69%)
<u>4 Vehicles</u>	1,171 (6.72%)	113,390 (4.47%)
<u>5+ Vehicles</u>	483 (2.77%)	42,145 (1.66%)
<u>2013 Households by Household Income</u>		
<u>2013 Households by Income</u>	17,420	2,537,304
<u>2013 Median Household Income</u>	\$49,088	\$47,121
<u>2013 Average Household Income</u>	\$61,357	\$61,175
<u>2013 Households by Race and Household Income</u>		

	Shelby	Indiana
<u>2013 Median HH Inc, White</u>	\$49,235	\$49,584
<u>2013 Avg HH Inc, White</u>	\$60,202	\$61,980
<u>2013 Median HH Inc, Black/Af Amer</u>	\$21,754	\$29,027
<u>2013 Avg HH Inc, Black/Af Amer</u>	\$37,013	\$40,280
<u>2013 Median HH Inc, Am Ind/AK Native</u>	\$83,967	\$39,188
<u>2013 Avg HH Inc, Am Ind/AK Native</u>	\$80,615	\$53,778
<u>2013 Median HH Inc, Asian</u>	\$71,429	\$52,265
<u>2013 Avg HH Inc, Asian</u>	\$91,250	\$71,027
<u>2013 Median HH Inc, Native HI/PI</u>	\$37,500	\$32,730
<u>2013 Avg HH Inc, Native HI/PI</u>	\$48,750	\$54,324
<u>2013 Median HH Inc, Some Other Race</u>	\$29,844	\$34,787
<u>2013 Avg HH Inc, Some Other Race</u>	\$42,251	\$42,982
<u>2013 Median HH Inc, 2+ Races</u>	\$83,631	\$37,608
<u>2013 Avg HH Inc, 2+ Races</u>	\$86,151	\$49,819

2013 Households by Ethnicity and Household Income

<u>2013 Median HH Inc, Hisp/Lat</u>	\$39,364	\$36,166
<u>2013 Avg HH Inc, Hisp/Lat</u>	\$54,040	\$49,820
<u>2013 Median HH Inc, Not Hisp/Lat</u>	\$49,292	\$47,679
<u>2013 Avg HH Inc, Not Hisp/Lat</u>	\$61,543	\$61,718

2013 Families by Poverty Status

<u>2013 Families Below Poverty</u>	1,184 (9.64%)	192,959 (11.37%)
<u>2013 Families Below Poverty with Children</u>	918 (7.47%)	154,999 (9.13%)

2013 Population by Sex and Educational Attainment

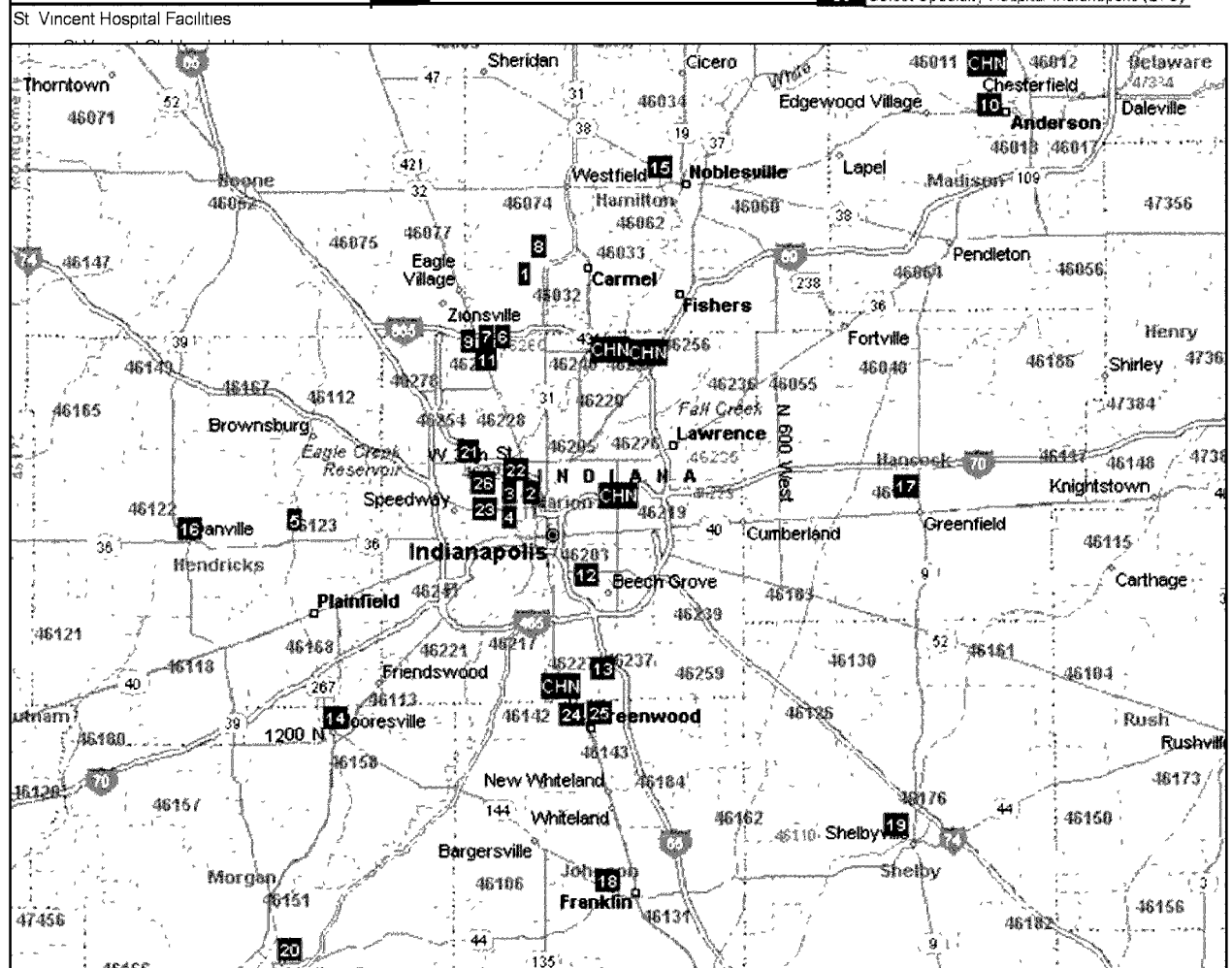
<u>2013 Population 25+ with Less Than High School Graduation</u>	4,418 (14.61%)	552,982 (12.87%)
<u>2013 Population 25+, Male, with Less Than High School Graduation</u>	2,293 (15.61%)	278,974 (13.46%)
<u>2013 Population 25+, Female, with Less Than High School Graduation</u>	2,125 (13.66%)	274,008 (12.32%)

	Shelby	Indiana
<u>Population 25+ by Educational Attainment</u>	30,247	4,297,886
<u>Male Population 25+ by Educational Attainment</u>	14,693	2,073,100
<u>Female Population 25+ by Educational Attainment</u>	15,554	2,224,786

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

Map & List of Hospital Facilities Serving the Health Needs of the Community

Community Health Network Hospital Facilities		St Vincent Hospital Facilities		Suburban Hospital Facilities	
CHN	Community Hospital Anderson	6	St Vincent Children's Hospital	15	Riverview Hospital
CHN	Community Hospital East	7	St Vincent - 86th Street	16	Hendricks Community
CHN	Community Hospital North	8	St Vincent - Carmel	17	Hancock 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	Major
Clarian Health Partners Hospital Facilities		11	St Vincent Seton Specialty Hospital (LTC)	Other Hospital Facilities	
1	Clarian North Medical Center	St Francis Hospital Facilities		21	Westview
2	Indiana University Medical Center			22	Wishard
3	Methodist	12	St Francis Beech Grove	23	Kindred Hospital Indianapolis
4	Riley Hospital for Children	13	St Francis Indianapolis	24	Kindred Hospital South
5	Clarian West Medical Center	14	St Francis Mooresville	25	Valle Vista Health System
				26	Select Specialty Hospital-Indianapolis (LTC)



d) How data was obtained**Secondary Data**

The zip code you live is a better determinant of your health expectancy than your genetic code. Since 1996, we 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 CB Implementation Strategy—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. The results are summarized and clearly defined how successful we have been in living up to the IRS requirements for assessment.

Beginning in 2009, we began using an advanced mapping tool, Health Landscape, so that we can truly delve into areas of need. Once we received information from our needs assessment, we could plot geographic data in our service areas in order to actually “see” on a map where our highest-need areas were located. This also allowed 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. This tool included a mapping feature that Health Landscapes had offered but more importantly the most up to date secondary data available in the community. 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 community health needs assessments by the end of 2011.

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 – 2013 Healthy Communities Institute –Community Health Needs Assessments
– All Counties in Community Health Network Service Areas

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 has been made available through our website and the Health Communities Institute. We believe that the breadth of the data and ease of obtaining this data from our website can enable an eighth grade student to access our information for a school project on health as well as support a professional in a not for profit agency with critical data for writing grants to serve the most vulnerable people in our communities.

To capture the broad interest of the community in our CHNA, everyone visiting our website was asked to participate in an online survey. Over 249 individuals responded to the request and participated in our survey. We reached out to the many community groups in which we are involved to obtain their input. In addition, we conducted interviews with patients receiving services from federal qualified health centers (FQHCs) and used screening results from the minority health fairs, in which the Network participates. Further, we partnered with the local health department sharing data and by participating in their citywide assessment. We used this information in our CHNA.

e) The health needs of the community.

Analysing over 125 community indicators on health and quality of life revealed community needs in the following areas:

	North	South	East	Westview	Anderson	Howard	TOTAL
Age-Adjusted Hospitalization Rate due to Pediatric Asthma	7 out of 16 zip codes 44%	4 out of 9 zip codes 44%	9 out of 11 zip codes 82%	12 out of 12 zip codes 100%	4 out of 9 zip codes 44%	2 out of 2 zip codes 100%	38 out of 59 zip codes 64%
Age-Adjusted Hospitalization Rate due to Asthma	3 out of 18 zip codes 17%	4 out of 12 zip codes 33%	10 out of 15 zip codes 67%	11 out of 12 zip codes 92%	9 out of 12 zip codes 75%	2 out of 4 zip codes 50%	39 out of 73 zip codes 53%
Age-Adjusted Hospitalization Rate due to Long-Term Complications of Diabetes	11 out of 17 zip codes 65%	10 out of 12 zip codes 83%	12 out of 13 zip codes 92%	12 out of 12 zip codes 100%	10 out of 11 zip codes 91%	3 out of 3 zip codes 100%	58 out of 68 zip codes 85%
Gap in Critical Incidence Percentage Impact in Zip Code of Service Areas for Hospitalization Data							
Age-Adjusted Hospitalization Rate due to Congestive Heart Failure	3 out of 19 zip codes 16%	4 out of 17 zip codes 24%	9 out of 16 zip codes 56%	10 out of 12 zip codes 83%	6 out of 13 zip codes 46%	0 out of 4 zip codes 0%	32 out of 81 zip codes 40%
Age-Adjusted Hospitalization Rate due to Alcohol Abuse	2 out of 17 zip codes 12%	3 out of 11 zip codes 27%	7 out of 14 zip codes 50%	5 out of 12 zip codes 42%	7 out of 11 zip codes 64%	3 out of 4 zip codes 75%	27 out of 69 zip codes 39%
Age-Adjusted Hospitalization Rate due to COPD	1 out of 19 zip codes 5%	2 out of 16 zip codes 13%	7 out of 16 zip codes 44%	4 out of 12 zip codes 33%	4 out of 13 zip codes 31%	0 out of 4 zip codes 0%	18 out of 80 zip codes 23%
Age-Adjusted Hospitalization Rate due to Bacterial Pneumonia	0 out of 18 zip codes 0%	4 out of 17 zip codes 24%	1 out of 16 zip codes 6%	2 out of 12 zip codes 17%	7 out of 13 zip codes 54%	0 out of 4 zip codes 0%	14 out of 80 zip codes 18%
Age-Adjusted Hospitalization Rate due to Dehydration	0 out of 17 zip codes 0%	2 out of 12 zip codes 17%	1 out of 14 zip codes 7%	1 out of 12 zip codes 8%	6 out of 11 zip codes 55%	0 out of 3 zip codes 0%	10 out of 69 zip codes 10%

Primary data

We captured the broad interest of the community by asking those visiting our website to participate in an online survey. We used input from the many community groups that we participate in and which have membership from the communities we serve. Some included interviews with FQHC patient Population and at the screening results from minority health fair.

The prioritization of issues was simple in that access has been a network strategy for over three years and impacts all identified health issues. Diabetes and asthma are clearly out ahead of any other chronic disease in the community by at least 15%. Finally by developing market specific strategies it is best to let the community drive the priorities and communicate to the network through organizations in which we participate. There has been little past success in having the hospital drive the priorities rather than the community.

The full CHNA report is available on our website (<http://www.ecommunity.com/aboutus/care.aspx#>) and displays over 125 health and quality of life indicators updated in real time and offers hundreds of evidence-based community interventions in the “Promising Practices” section. Anyone in the network and the community can quickly access the website and know the health needs of their communities. When they reach the CHNA section as a first time user, they are asked to take a survey of what they believe are the health issues of their community, which is then used as primary data in our own CHNA. The website displays national, state, county data, including our own institutional medical and data by county, zip code and census tract. Internally we analyze financial data and incorporate other sensitive data like crime statistics, valuable in setting strategies for the network.

We analyzed the data and started our community assessments with a list of the top community health issues for each of our hospital regions. The diagram below illustrates the process parameters we used in interpreting our community health needs assessment data and transforming the data into a viable and measurable implementation strategy. Through surveys and interviews from both key community informants and general public the secondary data supported the primary findings. While there were a few outliers from the different counties across the spectrum, they were generally the same: obesity, mental health, access to health services, asthma, community involvement and diabetes.

- f) Primary and chronic diseases needs and other issues of uninsured persons, low income persons and minority groups.**

Areas of need –Implementation Strategy

#1 Access to Care

The first significant health need to be addressed is Access to Care. Evidence suggests that access to effective and timely primary care has the potential to improve the overall quality of care and help reduce costs. Some Populations experience additional barriers in access to preventive health services due to lack of transportation to providers' offices, lack of knowledge about preventive care, long waits to get an appointment, low health literacy, and inability to pay the high-deductible of many insurance plans and/or co-pays for receiving treatment. Our first priority therefore is access to quality health services and expanding the capacity needed to address the health issues in the areas we serve.

2 Asthma and #3 Diabetes

There were several factors that helped us select asthma and diabetes as the two priority health issues to be addressed. Although access can help address many critical health issues both asthma and diabetes rank high in the preventable hospital stays for ambulatory-care sensitive conditions, can usually be addressed in an outpatient setting, and do not normally require hospitalization if the condition is well-managed. The most striking difference between these two diseases is that a diagnosis of asthma has immediate short and long-term consequences of hospitalizations while diabetic hospitalizations are the result of longer term complications.

#4 Community-Driven Initiatives that Address the Social Determinants of Health

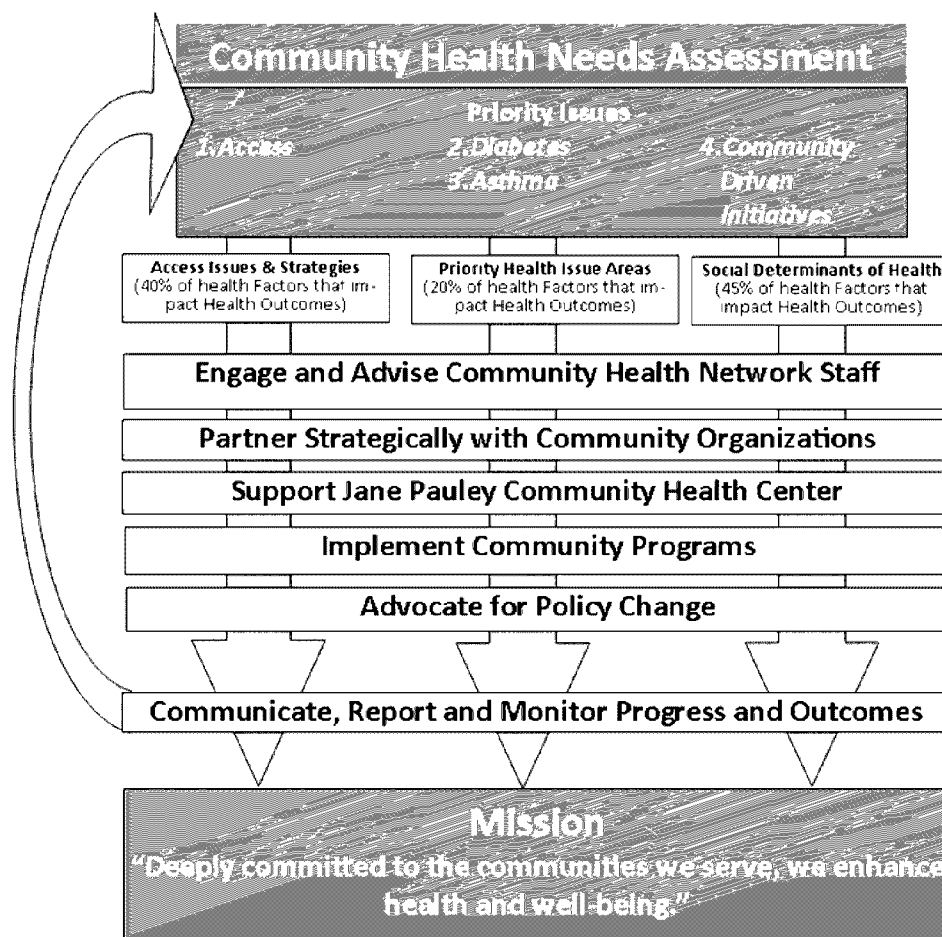
According to the Centers for Disease Control and the World Health Organization, the social determinants of health are the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics. In our model the social determinants of health impact 45% of all health outcomes. This is the highest impact area with access accounting for 40% of all health outcomes and priority health issues only accounting for 20% of all outcomes. To have the most positive outcomes we need to have activities in all three areas. The ability to successfully work in the areas of the social determinants of health requires working with the community as they "own" the areas that have the greater impact and we'd have little effect working on our own to change the culture of the community. Consequently each market area has their own culture and their own community driven initiatives that focus around the social determinants of health and we will only be successful if we engage with the communities around their top health issues – not

ours Each initiative in each of the market areas is in communities that are adjacent to each hospital and incorporates the leadership, businesses and citizens of that adjacent community

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

Throughout the counties additional needs were identified from both secondary and primary data however they were not priorities as chosen from the community and key informants By chosing the four areas above a consistent basic theme can be seen and we can track and show progress with these chosen areas

We analyzed the data and started our community assessments with a list of the top community health issues for each of our hospital regions The diagram below illustrates the process parameters we used in interpreting our community health needs assessment data and transforming the data into a viable and measurable implementation strategy



Asthma service areas

Age-Adjusted Hospitalization Rate due to Pediatric Asthma

Location	Status	Hospitalizations/ 10,000 Population under 18 years	Source	Measurement Period
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Comparison: IN Counties Period 2010-2012

<u>County</u> Hamilton		6.0	Indiana Hospital Association	2010-2012
<u>County</u> Hancock		8.4	Indiana Hospital Association	2010-2012
<u>County</u> Hendricks		9.1	Indiana Hospital Association	2010-2012
<u>County</u> Howard		11.9	Indiana Hospital Association	2010-2012
<u>County</u> Johnson		8.5	Indiana Hospital Association	2010-2012
<u>County</u> Marion		32.5	Indiana Hospital Association	2010-2012
<u>County</u> Morgan		10.0	Indiana Hospital Association	2010-2012
<u>County</u> Shelby		13.3	Indiana Hospital Association	2010-2012

Single-Parent Households

Location	Status	Percent	Source	Measurement Period
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Comparison: U S Counties
Period 2008-2012

<u>County</u> <u>Hamilton</u>		16.9	American Community Survey	2008-2012
<u>County</u> <u>Hancock</u>		24.8	American Community Survey	2008-2012
<u>County</u> <u>Hendricks</u>		20.8	American Community Survey	2008-2012
<u>County</u> Howard		32.2	American Community Survey	2008-2012
<u>County</u> Johnson		24.3	American Community Survey	2008-2012
<u>County</u> Marion		46.1	American Community Survey	2008-2012
<u>County</u> Morgan		28.1	American Community Survey	2008-2012
<u>County</u> Shelby		37.0	American Community Survey	2008-2012

Houses Built Prior to 1950

Location	Status	Percent	Source	Measurement Period
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Comparison: U S Counties
Period 2008-2012

<u>County</u> <u>Hamilton</u>		5.6	American Community Survey	2008-2012
<u>County</u> <u>Hancock</u>		15.0	American Community Survey	2008-2012
<u>County</u> <u>Hendricks</u>		9.0	American Community Survey	2008-2012

<u>County Howard</u>		28.7	American Community Survey	2008-2012
<u>County Johnson</u>		8.9	American Community Survey	2008-2012
<u>County Marion</u>		23.0	American Community Survey	2008-2012
<u>County Morgan</u>		18.4	American Community Survey	2008-2012
<u>County Shelby</u>		32.6	American Community Survey	2008-2012

Children Living Below Poverty Level

Location	Status	Percent	Source	Measurement Period
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Comparison: U S Counties
Period 2008-2012

<u>County Hamilton</u>		6.0	American Community Survey	2008-2012
<u>County Hancock</u>		10.1	American Community Survey	2008-2012
<u>County Hendricks</u>		6.2	American Community Survey	2008-2012
<u>County Howard</u>		24.7	American Community Survey	2008-2012
<u>County Johnson</u>		13.0	American Community Survey	2008-2012
<u>County Marion</u>		29.1	American Community Survey	2008-2012
<u>County Morgan</u>		16.3	American Community Survey	2008-2012
<u>County Shelby</u>		17.1	American Community Survey	2008-2012

Asthma Madison

Children Living Below Poverty Level

Location	Status	Percent	Source	Measurement Period
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Comparison: U S Counties

Period 2008-2012


<u>County</u> <u>Madison</u>		25.4	American Community Survey	2008-2012
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Age-Adjusted Hospitalization Rate due to Pediatric Asthma

Location	Status	Hospitalizations/ 10,000 Population under 18 years	Source	Measurement Period
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Comparison: IN Counties

Period 2010-2012

<u>County</u> <u>Madison</u>		15.9	Indiana Hospital Association	2010-2012
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Houses Built Prior to 1950

Location	Status	Percent	Source	Measurement Period
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Comparison: U S Counties

Period 2008-2012

<u>County</u> <u>Madison</u>		30.4	American Community Survey	2008-2012
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Single-Parent Households

Location	Status	Percent	Source	Measurement Period
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Comparison: U S Counties









Period 2008-2012

<u>County</u> <u>Madison</u>		37.6	American Community Survey	2008-2012
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Diabetes service areas
Age-Adjusted Death Rate due to Diabetes

Location	Status	Deaths/ 100,000 Population	Source	Measurement Period
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Comparison: U S Counties
Period 2009-2011






County Hamilton		13.8	Centers for Disease Control and Prevention	2009-2011
County Hancock		17.6	Centers for Disease Control and Prevention	2009-2011
County Hendricks		12.1	Centers for Disease Control and Prevention	2009-2011
County Howard		30.6	Centers for Disease Control and Prevention	2009-2011
County Johnson		23.1	Centers for Disease Control and Prevention	2009-2011
County Marion		20.0	Centers for Disease Control and Prevention	2009-2011
County Morgan		18.3	Centers for Disease Control and Prevention	2009-2011
County Shelby		22.2	Centers for Disease Control and Prevention	2009-2011

Age-Adjusted Hospitalization Rate due to Uncontrolled Diabetes

Location	Status	Hospitalizations/ 10,000 Population 18+ years	Source	Measurement Period
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Comparison: IN Counties
Period 2010-2012

County Hamilton		0.6	Indiana Hospital Association	2010-2012
County		0.8	Indiana Hospital	2010-2012

Hancock			Association	
County Hendricks		0.7	Indiana Hospital Association	2010-2012
County Howard		2.5	Indiana Hospital Association	2010-2012
County Johnson		1.0	Indiana Hospital Association	2010-2012
County Marion		2.5	Indiana Hospital Association	2010-2012
County Morgan		1.3	Indiana Hospital Association	2010-2012

Access to Exercise Opportunities

Location	Status	Percent	Source	Measurement Period
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Comparison: U.S. Counties Period: 2013

County Hamilton		64.4	County Health Rankings	2013
County Hancock		46.9	County Health Rankings	2013
County Hendricks		53.0	County Health Rankings	2013
County Howard		77.4	County Health Rankings	2013
County Johnson		66.9	County Health Rankings	2013
County Marion		78.5	County Health Rankings	2013
County Morgan		45.0	County Health Rankings	2013
County Shelby		43.2	County Health Rankings	2013

Age-Adjusted Hospitalization Rate due to Short-Term Complications of Diabetes

Location	Status	Hospitalizations/ 10,000 Population 18+ years	Source	Measurement Period
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Comparison: IN Counties
Period 2010-2012

County Hamilton		3 2	Indiana Hospital Association	2010-2012
County Hancock		4 6	Indiana Hospital Association	2010-2012
County Hendricks		3 1	Indiana Hospital Association	2010-2012
County Howard		10 8	Indiana Hospital Association	2010-2012
County Johnson		6 1	Indiana Hospital Association	2010-2012
County Marion		9 7	Indiana Hospital Association	2010-2012
County Morgan		11 2	Indiana Hospital Association	2010-2012
County Shelby		6 4	Indiana Hospital Association	2010-2012

Adults who are Sedentary

Location	Status	Percent	Source	Measurement Period
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Comparison: IN Counties
Period 2010






County Hamilton		19 5	County Health Rankings	2010
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County Hancock		25.7	County Health Rankings	2010
County Hendricks		25.9	County Health Rankings	2010
County Howard		30.7	County Health Rankings	2010
County Johnson		24.7	County Health Rankings	2010
County Marion		27.2	County Health Rankings	2010
County Morgan		29.5	County Health Rankings	2010
County Shelby		30.6	County Health Rankings	2010

Households with No Car and Low Access to a Grocery Store

Location	Status	Percent	Source	Measurement Period
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Comparison: U S Counties
Period 2010

County Hamilton		0.8	U S Department of Agriculture - Food Environment Atlas	2010
County Hancock		1.4	U S Department of Agriculture - Food Environment Atlas	2010
County Hendricks		1.4	U S Department of Agriculture - Food Environment Atlas	2010
County Howard		2.2	U S Department of Agriculture - Food Environment Atlas	2010
County Johnson		1.5	U S Department of Agriculture - Food Environment Atlas	2010
County Marion		1.5	U S Department of Agriculture - Food Environment Atlas	2010
County Morgan		1.2	U S Department of Agriculture - Food Environment Atlas	2010

County
Shelby



14

U S Department of Agriculture
- Food Environment Atlas

2010

Age-Adjusted Death Rate due to Kidney Disease

	Status	Deaths/ 100,000 Population	Source	Measurement Period
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Comparison: U S Counties
Period 2009-2011

County Hamilton		15.2	Centers for Disease Control and Prevention	2009-2011
County Hancock		15.6	Centers for Disease Control and Prevention	2009-2011
County Hendricks		18.1	Centers for Disease Control and Prevention	2009-2011
County Howard		20.9	Centers for Disease Control and Prevention	2009-2011
County Johnson		18.3	Centers for Disease Control and Prevention	2009-2011
County Marion		21.1	Centers for Disease Control and Prevention	2009-2011
County Morgan		19.8	Centers for Disease Control and Prevention	2009-2011
County Shelby		22.7	Centers for Disease Control and Prevention	2009-2011

Diabetic Screening: Medicare Population

Location	Status	Percent	Source	Measurement Period
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Comparison: U S Counties
Period 2011






County Hamilton		88.2	County Health Rankings	2011
County Hancock		86.1	County Health Rankings	2011
County Hendricks		86.5	County Health Rankings	2011
County Howard		83.5	County Health Rankings	2011
County Johnson		81.6	County Health Rankings	2011
County Marion		83.7	County Health Rankings	2011
County Morgan		83.3	County Health Rankings	2011
County Shelby		81.7	County Health Rankings	2011

Diabetes: Medicare Population

Location	Status	Percent	Source	Measurement Period
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Comparison: U S Counties
Period 2012






County Hamilton		23.5	Centers for Medicare & Medicaid Services	2012
County Hancock		25.9	Centers for Medicare & Medicaid Services	2012

County Hendricks		26.7	Centers for Medicare & Medicaid Services	2012
County Howard		30.2	Centers for Medicare & Medicaid Services	2012
County Johnson		27.3	Centers for Medicare & Medicaid Services	2012
County Marion		28.1	Centers for Medicare & Medicaid Services	2012
County Morgan		26.5	Centers for Medicare & Medicaid Services	2012
County Shelby		29.4	Centers for Medicare & Medicaid Services	2012

Age-Adjusted Hospitalization Rate due to Long-Term Complications of Diabetes

Location	Status	Hospitalizations/ 10,000 Population 18+ years	Source	Measurement Period
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Comparison: IN Counties
Period 2010-2012









County Hamilton		4.4	Indiana Hospital Association	2010-2012
County Hancock		3.5	Indiana Hospital Association	2010-2012
County Hendricks		6.3	Indiana Hospital Association	2010-2012
County Howard		7.0	Indiana Hospital Association	2010-2012
County Johnson		7.0	Indiana Hospital Association	2010-2012
County Marion		13.3	Indiana Hospital Association	2010-2012
County Morgan		7.7	Indiana Hospital Association	2010-2012

County Shelby		8 3	Indiana Hospital Association	2010-2012
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Age-Adjusted Hospitalization Rate due to Diabetes

Location	Status	Hospitalizations/ 10,000 Population 18+ years	Source	Measurement Period
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Comparison: IN Counties
Period 2010-2012

County Hamilton		8 4	Indiana Hospital Association	2010-2012
County Hancock		9 2	Indiana Hospital Association	2010-2012
County Hendricks		10 3	Indiana Hospital Association	2010-2012
County Howard		20 9	Indiana Hospital Association	2010-2012
County Johnson		14 4	Indiana Hospital Association	2010-2012
County Marion		26 3	Indiana Hospital Association	2010-2012
County Morgan		20 8	Indiana Hospital Association	2010-2012
County Shelby		16 0	Indiana Hospital Association	2010-2012

Adults who are Obese

Location	Status	Percent	Source	Measurement Period
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Comparison: IN Counties
Period 2010

County Hamilton		22 0	County Health Rankings	2010
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County Hancock		28.8	County Health Rankings	2010
County Hendricks		31.8	County Health Rankings	2010
County Howard		37.8	County Health Rankings	2010
County Johnson		29.1	County Health Rankings	2010
County Marion		31.9	County Health Rankings	2010
County Morgan		33.2	County Health Rankings	2010
County Shelby		33.8	County Health Rankings	2010

Diabetes Madison

Age-Adjusted Hospitalization Rate due to Uncontrolled Diabetes

Location	Status	Hospitalizations/ 10,000 Population 18+ years	Source	Measurement Period
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Comparison: IN Counties

Period 2010-2012


<u>County</u> <u>Madison</u>		2.6	Indiana Hospital Association	2010-2012
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Age-Adjusted Death Rate due to Kidney Disease

Location	Status	Deaths/ 100,000 Population	Source	Measurement Period
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Comparison: U S Counties

Period 2009-2011

<u>County</u> <u>Madison</u>		19.3	Centers for Disease Control and Prevention	2009-2011
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Adults who are Sedentary

Location	Status	Percent	Source	Measurement Period
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Comparison: IN Counties
Period 2010

<u>County</u> Madison		34.1	County Health Rankings	2010
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Diabetic Screening: Medicare Population

Location	Status	Percent	Source	Measurement Period
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Comparison: U S Counties
Period 2011

<u>County</u> Madison		87.6	County Health Rankings	2011
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Adults who are Obese

Location	Status	Percent	Source	Measurement Period
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Comparison: IN Counties
Period 2010

<u>County</u> Madison		37.3	County Health Rankings	2010
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Age-Adjusted Hospitalization Rate due to Diabetes

Location	Status	Hospitalizations/ 10,000 Population 18+ years	Source	Measurement Period
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Comparison: IN Counties
Period 2010-2012

<u>County</u> Madison		23.7	Indiana Hospital Association	2010-2012
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Age-Adjusted Hospitalization Rate due to Short-Term Complications of Diabetes

Location	Status	Hospitalizations/ 10,000 Population 18+ years	Source	Measurement Period
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Comparison: IN Counties

Period 2010-2012

County
Madison



8.8

Indiana Hospital
Association

2010-2012

Age-Adjusted Hospitalization Rate due to Long-Term Complications of Diabetes

Location	Status	Hospitalizations/ 10,000 Population 18+ years	Source	Measurement Period
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Comparison: IN Counties

Period 2010-2012

County
Madison



11.7

Indiana Hospital
Association

2010-2012

Age-Adjusted Death Rate due to Diabetes

Location	Status	Deaths/ 100,000 Population	Source	Measurement Period
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Comparison: U S Counties

Period 2009-2011

County
Madison



30.5

Centers for Disease
Control and Prevention

2009-2011

Diabetes: Medicare Population

Location	Status	Percent	Source	Measurement Period
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Comparison: U S Counties

Period 2012

County
Madison



28.6

Centers for Medicare &
Medicaid Services

2012

Access service areas
Mammography Screening: Medicare Population

Location	Status	Percent	Source	Measurement Period
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Comparison: U S Counties
Period 2011






County Hamilton		69.0	County Health Rankings	2011
County Hancock		67.8	County Health Rankings	2011
County Hendricks		68.0	County Health Rankings	2011
County Howard		66.3	County Health Rankings	2011
County Johnson		64.0	County Health Rankings	2011
County Marion		60.9	County Health Rankings	2011
County Morgan		61.3	County Health Rankings	2011
County Shelby		62.7	County Health Rankings	2011

Preventable Hospital Stays

Location	Status	Discharges/ 1,000 Medicare enrollees	Source	Measurement Period
----------	--------	--	--------	-----------------------

Comparison: U S Counties
Period 2011









County Hamilton		52	County Health Rankings	2011
County Hancock		58	County Health Rankings	2011
County Hendricks		66	County Health Rankings	2011

County Howard		57	County Health Rankings	2011
County Johnson		61	County Health Rankings	2011
County Marion		67	County Health Rankings	2011
County Morgan		85	County Health Rankings	2011
County Shelby		85	County Health Rankings	2011









Primary Care Provider Rate

Location	Status	Providers/ 100,000 Population	Source	Measurement Period
----------	--------	-------------------------------------	--------	-----------------------







**Comparison: U S Counties
Period 2011**



County Hamilton		137	County Health Rankings	2011
County Hancock		71	County Health Rankings	2011
County Hendricks		55	County Health Rankings	2011
County Howard		59	County Health Rankings	2011
County Johnson		77	County Health Rankings	2011
County Marion		81	County Health Rankings	2011
County Morgan		45	County Health Rankings	2011
County Shelby		25	County Health Rankings	2011

Health Behaviors Ranking

Location	Status	Value	Source	Measurement Period
Comparison: IN Counties				
Period 2013				
County Hamilton		1	County Health Rankings	2013
County Hancock		13	County Health Rankings	2013
County Hendricks		9	County Health Rankings	2013
County Howard		80	County Health Rankings	2013
County Johnson		21	County Health Rankings	2013
County Marion		87	County Health Rankings	2013
County Morgan		52	County Health Rankings	2013
County Shelby		67	County Health Rankings	2013

Clinical Care Ranking

Location	Status	Value	Source	Measurement Period
Comparison: IN Counties				
Period 2013				
County Hamilton		1	County Health Rankings	2013
County Hancock		6	County Health Rankings	2013
County Hendricks		4	County Health Rankings	2013
County Howard		7	County Health Rankings	2013
County Johnson		8	County Health Rankings	2013
County Marion		18	County Health Rankings	2013

County Morgan		42	County Health Rankings	2013
County Shelby		56	County Health Rankings	2013

People 65+ Living Alone

Location	Status	Percent	Source	Measurement Period
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Comparison: U S Counties
Period 2008-2012

County Hamilton		21.9	American Community Survey	2008-2012
County Hancock		23.6	American Community Survey	2008-2012
County Hendricks		25.6	American Community Survey	2008-2012
County Howard		26.7	American Community Survey	2008-2012
County Johnson		29.0	American Community Survey	2008-2012
County Marion		32.7	American Community Survey	2008-2012
County Morgan		21.8	American Community Survey	2008-2012
County Shelby		29.3	American Community Survey	2008-2012

Adults with Health Insurance

Location	Status	Percent	Source	Measurement Period
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Comparison: U S Counties
Period 2013

County Hamilton		89.3	American Community Survey	2013
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County Hancock		85.1	American Community Survey	2013
County Hendricks		88.8	American Community Survey	2013
County Howard		80.6	American Community Survey	2013
County Johnson		86.1	American Community Survey	2013
County Marion		75.8	American Community Survey	2013
County Morgan		85.7	American Community Survey	2013








Children with Health Insurance

Location	Status	Percent	Source	Measurement Period
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Comparison: U.S. Counties
Period: 2013


County Hamilton		94.1	American Community Survey	2013
County Hancock		98.3	American Community Survey	2013
County Hendricks		94.7	American Community Survey	2013
County Howard		93.8	American Community Survey	2013
County Johnson		94.0	American Community Survey	2013
County Marion		93.1	American Community Survey	2013
County Morgan		94.9	American Community Survey	2013

Households without a Vehicle

Location	Status	Percent	Source	Measurement Period
Comparison: U S Counties				
Period 2008-2012				
County Hamilton		2 4	American Community Survey	2008-2012
County Hancock		2 8	American Community Survey	2008-2012
County Hendricks		2 5	American Community Survey	2008-2012
County Howard		8 0	American Community Survey	2008-2012
County Johnson		3 7	American Community Survey	2008-2012
County Marion		8 8	American Community Survey	2008-2012
County Morgan		3 2	American Community Survey	2008-2012
County Shelby		5 9	American Community Survey	2008-2012

Access Madison


Children with Health Insurance

Location	Status	Percent	Source	Measurement Period
Comparison: U S Counties				
Period 2013				
<u>County Madison</u>		92 4	American Community Survey	2013

Adults with Health Insurance

Location	Status	Percent	Source	Measurement Period
----------	--------	---------	--------	--------------------

Comparison: U S Counties
Period 2013

<u>County</u> Madison		78.1	American Community Survey	2013
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Mammography Screening: Medicare Population

Location	Status	Percent	Source	Measurement Period
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Comparison: U S Counties
Period 2011

<u>County</u> Madison		70.8	County Health Rankings	2011
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Preventable Hospital Stays

Location	Status	Discharges/ 1,000 Medicare enrollees	Source	Measurement Period
----------	--------	--	--------	--------------------

Comparison: U S Counties
Period 2011

<u>County</u> Madison		85	County Health Rankings	2011
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Primary Care Provider Rate

Location	Status	Providers/ 100,000 Population	Source	Measurement Period
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Comparison: U S Counties
Period 2011

<u>County</u> Madison		53	County Health Rankings	2011
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Clinical Care Ranking

Location	Status	Value	Source	Measurement Period
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Comparison: IN Counties
Period 2013

<u>County</u> Madison		22	County Health Rankings	2013
-----------------------	---	----	------------------------	------

People 65+ Living Alone

Location	Status	Percent	Source	Measurement Period
Comparison: U S Counties				
Period 2008-2012				
<u>County</u> Madison		32.6	American Community Survey	2008-2012

h) Process for consulting with persons representing the community's interests.

In 2011 the network began 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. In 2013 we continue to conduct online surveys, focus groups and soliciting comments for the communities, their consultants and agents. We currently have active committees in the health network to gain community knowledge.

They include organizations such as

- Partnership for a Healthier Johnson County
- Healthy Hamilton County
- Top 10 in 2020 (Marion and surrounding counties)
- JumpIn
- United Ways

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

In 2011 it became apparent that there are many gaps in the data required to access and address the community health needs. Specifically the data was too broad and lacks the ability to drive "actionable" activities. County level data does not illustrate the unique features, assets and liabilities of neighborhoods. In 2012 we can now drill the data to zip code and census tract level to give more detail and to illustrate some of the more subtle states of health in the neighborhoods and cultures of the community. The lessons learned in this years approach is that the communities may not want the specific data public (crime data, rate of smoking to name a couple). This kind of data paints their community in a negative light rather than their reality of "this is home". Consequently our philosophy and approach has adapted to their approach which is very much driven by the wants of the community we serve not the "need" to extol the community health needs assessment information and stories. This awareness has also been the impetus for delving into Elinor Ostrom's belief that a community can manage the "commons" without the intervention of business and government.

j) Other (describe in Section C)

N/A

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

2012

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 Section C how the hospital facility took into account input from persons who represent the community, and identify the person the hospital facility consulted.

(3 Cont.) Alphabetical List of People & Organizations Consulted for CHNA:

1	Alice McCray - CAFE	35	Helen Machal Marion County Prosecutor's Office	68	Maria Tischner-Indiana Latino Institute
2	Allison King John H. Boner Community Center	36	Jake Readon-McSoley-Fishers YMCA	69	Mary McBeth Windsor Village
3	Amandula Anderson United North East Community Development Corporation	37	James Jackson-Pastor Fervent Prayer Church	70	Mary McKee-Associate Director
4	Ann Yeakle Community Health Network	38	James Taylor John H. Boner Community Center	71	Mary Moriarity Adams City-County Council Office
5	Anne Majewski Lutherwood	39	Jan Diggins Citizens Gas	72	Matt Hedrix-GIPC
6	Anne-Marrie Taylor-INRC	40	Jane Beers-St. Thomas Clinic	73	Melissa Drew CAFE
7	Bea Northcott-Marriage Investors	41	Janette Helm-St. Vincent	74	Michael Halstead-Halstead Architects
8	Beverly Brown Community relations senator Breaux	42	JennySkeehan Irvington Development	75	Mike Kolenda-CEO Windrose health Network
9	Beverly Mukes-Gaither Fifth Third Bank	43	Jim Ginder-Hamilton county Health Department	76	Mike Lindbloom-Fishers YMCA
10	Bill Oakes-Director of Business Development	44	Jim McGuinness Seccina Memorial High School	77	Millicent-Fleming-Moran-Epidemiologist researcher
11	Bill Taft Local Initiatives Support Corporation	45	Joe Gibson-Director epidemiology	78	Miriam Aceveda Davis-LaPlaza
12	Book Thomas-HealthNet health Centers	46	Joe Sagsky-Indiana heart Physicians St Francis	79	Nancy Chance-Executive Director Good Samaritan Network
13	Brenda Horn-Attorney	47	Joe Thurber Seccina Memorial High School	80	Orin Bell, President CICOA
14	Carla Slauter-Center Grove Schools	48	John Ault-Franklin Insurance	81	Paula Mandel-Johnson County Health Department
15	Cathy Burton-Marion c Alliance of Neighborhood Associations	49	John Kunzer-Wishard Primary Care Services	82	Phyllis Price-Eastside resident
16	Chris Gilmore RN-Grace United Methodist Church	50	Johnny Washington-MDwise	83	Re Angelique Walker-Smith-The Church Federation of Greater Indianapolis
17	Chris Weaver-CMO Wishard Health Services	51	Joy Davis- IU Saxony	84	Rebecca Rominger-Counselor
18	Christine Green-Hayes-Eastside resident	52	Judy Ferguson-Meridian Management Corp	85	Rebecca Seifert-Executive Director
19	Chuck Brandenburg-United Way	53	Judy Jacobson-Windrose Health network	86	Rev Alice Goshorn-St. Thomas Episcopal church
20	Cleven McBeth Windsor Village	54	Juli Pains-Office of Disability Affairs, Mayor's office	87	Rita Steinberg Indianapolis Symphony
21	David Forsell Keep Indianapolis Beautiful	55	Karen Lightbourne Mayor's Office of Neighborhood Services	88	Rob Riewoldt-Certified mortgage banker
22	David Minor_hunger Alliance	56	Karen Luehmann-Gateway Services	89	Sara VanSlambrook Local Initiatives Support Corporation
23	Dawn Underwood-Franklin College	57	Kate Hill-Johnson-St. Francis	90	Sarah Ketterer-IU Health
24	Deb Johnson-Whiteland Community High School	58	Kelly Peisker-St. Vincent	91	Schefcik Morris Little Flower Neighborhood Association
25	Diane Hannel Marion County Prosecutor's Office	59	Kelly Wensing NESCO (near eastside neighborhood Association)	92	Shaheen Yvonne CHNW Board member
26	Dick Hammon American Senior Communities	60	Kevin Robinson-Olympic Products	93	Spalding Irvington Development
27	Donna Vaughan-Aspire	61	Larry Heydon-President/CEO Johnson Memorial Hospital	94	Sue Burow-Indiana Public Policy Institute
28	Doreen St. Clair-Health Educator	62	Linda Ruskowski-RT Community Health Network	95	Suzanne Miller-Juvenile Probation
29	Duncan Brown-Aspire	63	Lori Hazlett Indianapolis Parks Foundation	96	Tamara Moore-Education Services Director
30	Ellen Quigley-Grants officer	64	Lori Meyers-Johnson County Community Corrections	97	Tammy Hughes East 10th Street Civic Association
31	Frank Hancock Sports Graphic, Inc	65	Margaret Lawrence Banning Irvington Development Organization	98	Terri Nigh-Director of Health Services
32	Gloria Nordemyer Rosewalk at Lutherwood	66	Marganta Hart-Executive Director Esperanza Ministries	99	Terry West-Financial Consultant Riverview Hospital
33	Greg Ernest 38th & Shadeland Business Group	67	Maria Rusomarov-City of Indianapolis, DMD	100	Virginia Caine-Director, Public Health MCPHD
34	Gregory Steele-Associate Professor				

4. Was the hospital facility's CHNA conducted with one or more other hospital facilities? If 'yes,' list the other hospital facilities in Section C.

No

5. Did the hospital facility make its CHNA report widely available to the public? If yes indicate how the CHNA report was made widely available (check all that apply):

- a) ☒ Hospital facility website (list url): ecommunity.com
- b) ☐ Other Website (list url): NA
- c) ☒ Available upon request from hospital facility (yes)
- d) ☐ Other (describe in Section C) NA

6. If the hospital facility addressed needs identified in its most recent conducted CHNA, indicate how (check all that apply as of the end of the tax year):

- a) ☒ Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA.
- b) ☒ Execution of the implementation strategy
- c) ☒ Participation in the development of a community wide plan
- d) ☒ Participation in the execution of a community wide plan
- e) ☒ Inclusion of a community benefit section in operational plans
- f) ☒ Adoption of a budget for provisions of services that address the needs identified in the CHNA
- 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 Section C)

NOTE:

The Community Health Network Board of Directors approved the Community health needs assessment in 2012. Financial and Charity Care in December 2012 and the Implementation Strategy in May 2013. Although redundant, the following is the full text of the Implementation Strategy. It represents the full text of the document that was reviewed and approved. Every region was required to incorporate the Implementation Strategy into their strategic plans and operational objectives.



Community Benefit Plan 2013

Community Health Needs Assessment 2013 – 2015 Implementation Strategy

Daniel E Hodgkins, M.Ed.

10/28/2013

The Community Health Network's, Community Benefit Plan is driven by the practices of our founding organization, the neighborhoods and businesses surrounding Community Hospital East. These principles and practices are echoed in the teachings of the Nobel Prize winner in Economics, Elinor Ostrum PhD and the "Triple Aim" of Don Berwick, MD and the Institute for Healthcare Improvement. These community development and data driven approaches are applied and amplified in the CHNw Community Benefit Plan.

Introduction

Today, as the country remains confused at the potential changes in the health care delivery system, the Community Health Network organization only needs to look back at a hope instilled in our institution from its inception. In the 1950's it was the desire to improve the health of the community that led citizens on Indianapolis' east side to raise funds and build a hospital to serve the community. Today, the original hospital has grown into the Community Health Network, the second largest not-for-profit health system in Indiana. What hasn't 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, well individuals within strong sustainable communities. In short we believe that any lasting cultural change in community health status will be driven by local communities initiating the change they want and need.

The 2013 Community Health Needs Assessment (CHNA) and this Implementation Strategy (IS) were undertaken by the health network to understand and address community health needs, and in accordance with proposed Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

This implementation strategy addresses the significant community health needs described in the CHNA that the hospital plans to address in whole or in part. The hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and merit enhancements to the described strategic initiatives. Alternately, other organizations in the community may decide to address certain community health needs, and the hospital may amend its strategies and refocus on other identified significant health needs. Beyond the initiatives and programs described herein, the hospital is addressing some of these needs simply by providing health care to the community, regardless of ability to pay.

About Community Health Network**Community Benefit Plan / Implementation Strategy**

The board of our network plays an integral role in the community benefit plan and is involved in setting strategy, communicating the plan within the organization and the community at large. Our leadership team members, the network board, and physician leaders have developed a strategic plan and vision for our network. This plan will serve as our roadmap from 2013 through 2020. We established a 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

History

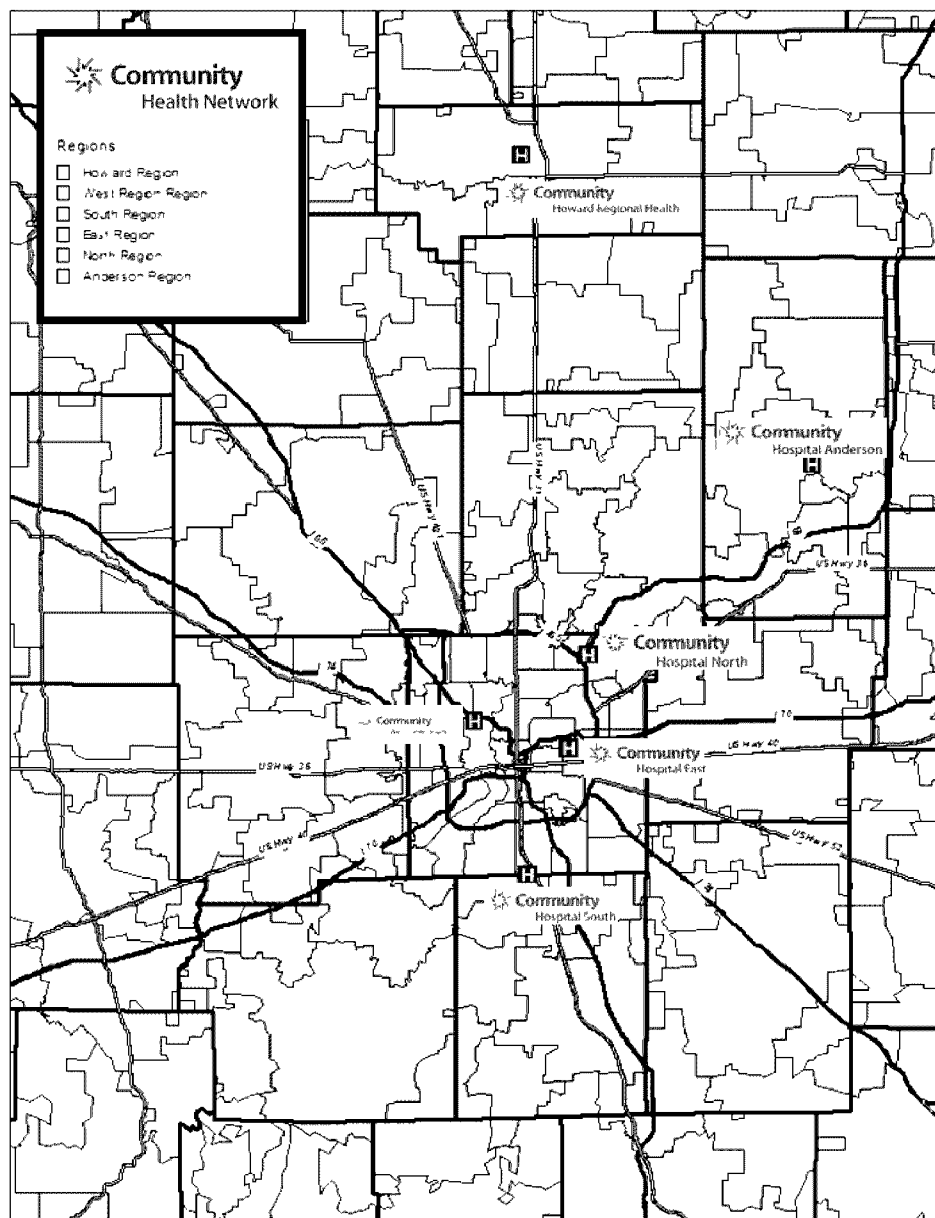
In 1954 the citizens on Indianapolis' east side decided to raise funds and build a hospital to serve the community. They did not have a name for the collective trust, action, cooperation and stewardship necessary in dealing with such a complex health and social dilemma. Nor did they understand that their transformation in 1954 would inform the leadership of the organization that they developed in the transformation of health care on the eastside into a better and more sustainable form in 2013. It wasn't until 2009, that the term for this collective care for the community resources was coined “care for the commons” by Indiana University Professor Elinor Ostrom. Her research led to the validation for what we have known and experienced since 1954, that a community can manage their own community resources successfully. Her theory was considered so significant she won the Nobel Prize in Economics.

Today Community Health Network is ranked among the nation's most integrated healthcare systems, Community Health Network is Central Indiana's leader in

providing convenient access to exceptional healthcare services, where and when patients need them—in hospitals, health pavilions and doctor's offices, as well as workplaces, schools and homes. As a non-profit health system with over 200 sites of care and affiliates throughout Central Indiana, Community's full continuum of care integrates hundreds of physicians, specialty and acute care hospitals, surgery centers, home care services, MedChecks, behavioral health and employer health services.

Overview of Communities Served by Community Health Network

Figure 1: Map of Service Regions:



The above map illustrates our service areas reach into 11 Indiana Counties

Demographics of the community:

Each hospital facility has a defined services area as illustrated in the map above. What follows is an example of the demographics for an individual service area in this case the North Market. Each market has its own set of data that is reviewed. Included is a comprehensive analysis of the top demographic issues targeted at the North service area of the network.

North

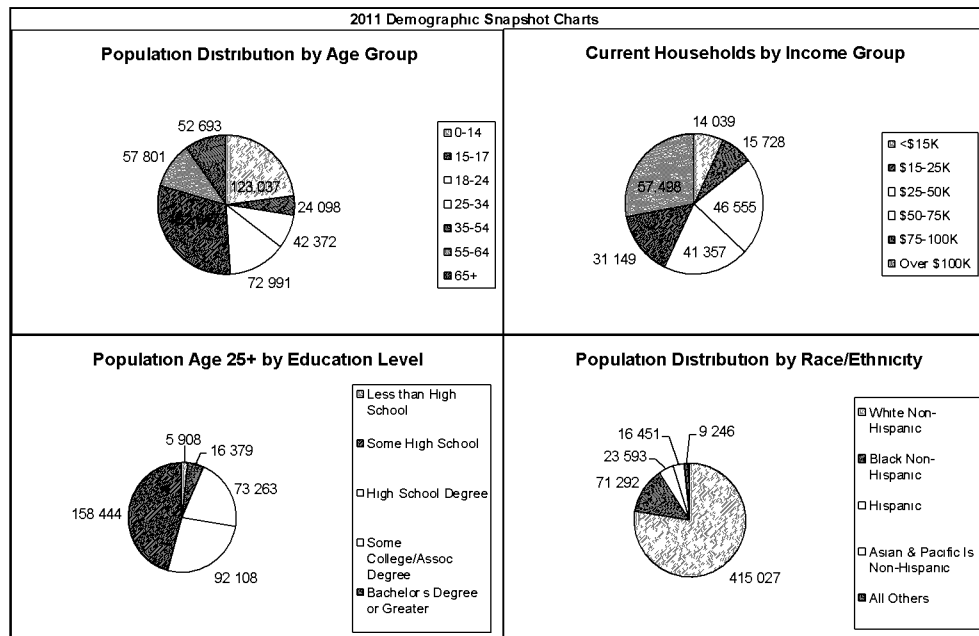
Demographics Expert 2.7
2011 Demographic Snapshot
Area: North Market
Level of Geography: ZIP Code

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

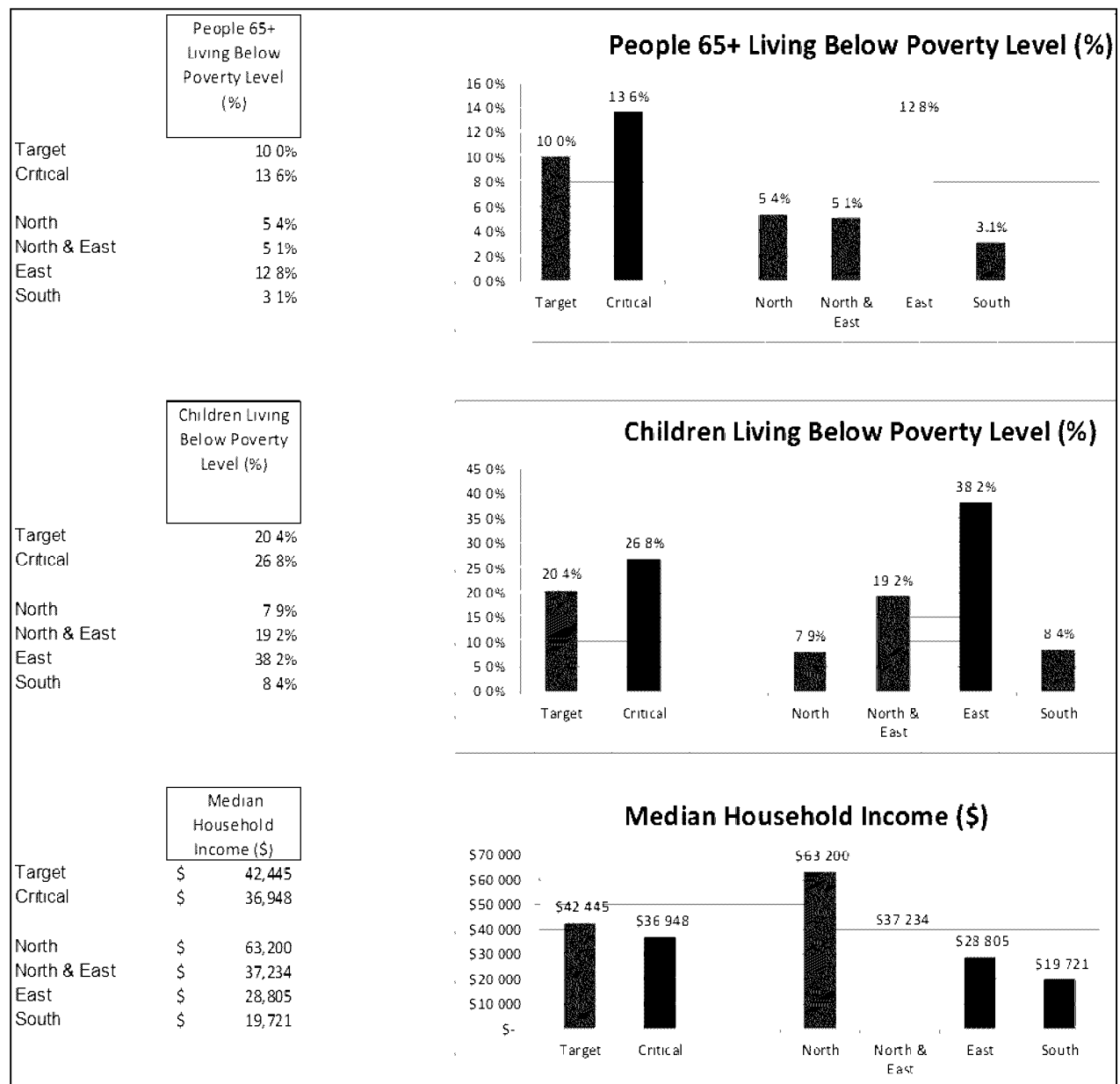
POPULATION DISTRIBUTION						HOUSEHOLD INCOME DISTRIBUTION		
Age Distribution						Income Distribution		
Age Group	2011	% of Total	2016	% of Total	USA 2011 % of Total	2011 Household Income	HH Count	% of Total
0-14	123,037	23.0%	133,031	22.7%	20.2%	<\$15K	14,039	6.8%
15-17	24,098	4.5%	27,248	4.6%	4.2%	\$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		
	Pop Age 25+	% of Total	USA % of Total			2011 Pop	% of Total	USA % of Total
2011 Adult Education Level								
Less than High School	5,908	1.7%	6.3%			415,027	77.5%	64.2%
Some High School	16,379	4.7%	8.8%			71,292	13.3%	12.1%
High School Degree	73,263	21.2%	28.9%			23,593	4.4%	16.1%
Some College/Assoc Degree	92,108	26.6%	28.3%			16,451	3.1%	4.6%
Bachelor's Degree or Greater	158,444	45.8%	27.7%			9,246	1.7%	3.0%
Total	346,102	100.0%	100.0%			535,609	100.0%	100.0%

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The demographics are also broken down by zip codes in service areas so that distinctions can be made that will drive communications and marketing. To assist in building out the picture of what are community looks like and how to “target” messages for an interventions. For this reason this data is invaluable however the data is much too general to develop our implementation strategy for the market. Below is another example of the demographic data and the overview of our markets. In this case we are comparing three of the markets, North, East and South.



Community Health Needs Assessment

The IRS requires a Community Health Needs Assessment (CHNA) and defines that a CHNA exists for each hospital service area and must “define the community it serves and assess the health needs of that community. In assessing the community’s health needs, the hospital facility must take into account input from persons who represent the broad interests of its community, including those with special knowledge of or expertise in public health”. Community Health Network began the process of creating a CHNA in 2011, seeking national models and best practices while attempting to use local resources to collect the necessary data. The Community Benefit department brought together a group of informed practitioners from hospital and community organizations that would also benefit from the data collected. A joint CHNA was not able to become a reality, consequently the Community Benefit strategy chosen was to forge ahead independently and chose the “Healthy Communities Institute” as the sole source of data that represents the best indicators for the social determinants of health and incorporates our hospital data into the secondary data. Our organization will continue to seek collaboration possibilities.

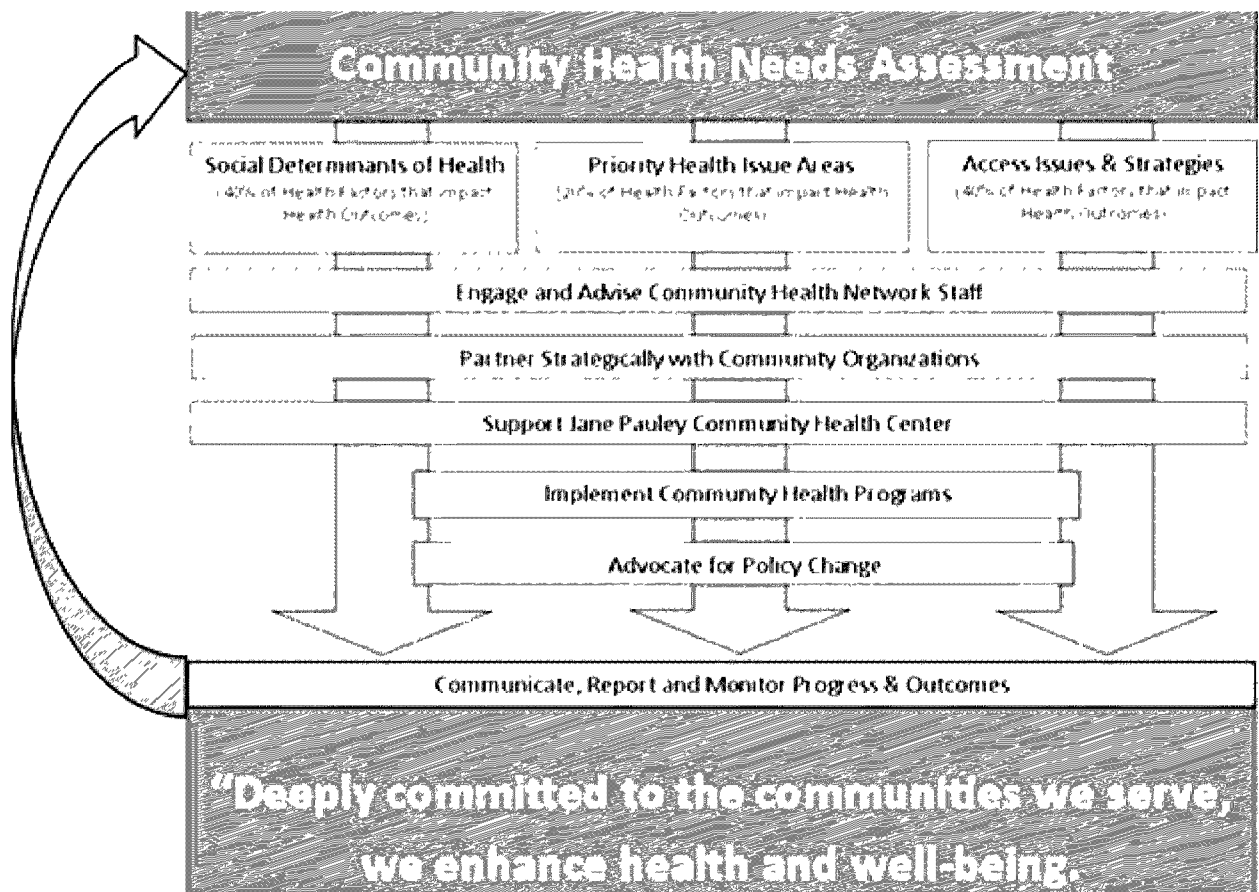
Our website, <http://www.ecommunity.com/aboutus/care.aspx#> displays over 125 health and quality of life indicators updated in real time, offers hundreds of community level resources for common community interventions in the “Promising Practices”. Just by accessing our website, anyone in the network and the community can know the health needs of their community. When they reach the CHNA section as a first time user they are asked to take a survey of what they believe are the health issues of their community, which is then used as primary data in our own CHNA. The website displays national, state, county data, including our own institutional medical and data by county, zip code and census tract. Internally we can analyze financial data and incorporate other sensitive data like crime statistics, which may not be used in a public display but would be valuable in setting strategies for the network.

Using all of the tools available to us, we went through a process of evaluation and started our community assessments with a list of the top community health issues for each of our IRS compliant services areas. The diagram below illustrates the process we used in interpreting our Community Health needs assessment data and transforming the data into a viable and measurable implementation strategy.

Process for Developing Implementation Strategy

The Community Health Needs Assessment was broken down into three categories based on the approach of “America Health Rankings” which are based on a model of Population health that was supported by the Robert Wood Johnson Foundation and

emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work and play. The first area needing to be addressed is Access Issues and strategies. Evidence suggests that access to effective and timely primary care has the potential to improve the overall quality of care and help reduce costs. Some Populations experience additional barriers in access to preventive health services due to lack of transportation to providers' offices, lack of knowledge about preventive care, long waits to get an appointment, low health literacy, and inability to pay the high-deductible of many insurance plans and/or co-pays for receiving treatment. Our first priority therefore is access to quality health services and expanding the capacity needed to address the health issues in the areas we serve. As Don Berwick describes in the "triple aim" of healthcare improvement, the goal is to improve the health of the Population we serve, enhance our patient experience through access, quality, reliability which ultimately will reduce the cost of care.



The second area to be addressed is in priority health issues. There were several factors that helped us select asthma and diabetes as the two priority health issues to be addressed. Although access can help address many critical health issues both asthma and diabetes rank high in the preventable hospital stays for ambulatory-care

sensitive conditions and can usually be addressed in an outpatient setting, and do not normally require hospitalization if the condition is well-managed. The most striking difference between these two diseases is that diagnosis of asthma has immediate consequences as far and hospitalizations short and long term while diabetic hospitalizations are the result of longer term complications. The metrics used to determine these two areas are illustrated below.

	North	South	East	Westview	Anderson	Howard	TOTAL
Age-Adjusted Hospitalization Rate due to Pediatric Asthma	7 out of 16 zip codes	4 out of 9 zip codes	9 out of 11 zip codes	12 out of 12 zip codes	4 out of 9 zip codes	2 out of 2 zip codes	38 out of 59 zip codes
	44%	44%	82%	100%	44%	100%	64%
Age-Adjusted Hospitalization Rate due to Asthma	3 out of 18 zip codes	4 out of 12 zip codes	10 out of 15 zip codes	11 out of 12 zip codes	9 out of 12 zip codes	2 out of 4 zip codes	39 out of 73 zip codes
	17%	33%	67%	92%	75%	50%	53%
Age-Adjusted Hospitalization Rate due to Long-Term Complications of Diabetes	11 out of 17 zip codes	10 out of 12 zip codes	12 out of 13 zip codes	12 out of 12 zip codes	10 out of 11 zip codes	3 out of 3 zip codes	58 out of 68 zip codes
	65%	83%	92%	100%	91%	100%	85%
Gap in Critical Incidence Percentage Impact in Zip Code of Service Areas for Hospitalization Data							
Age-Adjusted Hospitalization Rate due to Congestive Heart Failure	3 out of 19 zip codes	4 out of 17 zip codes	9 out of 16 zip codes	10 out of 12 zip codes	6 out of 13 zip codes	0 out of 4 zip codes	32 out of 81 zip codes
	16%	24%	56%	83%	46%	0%	40%
Age-Adjusted Hospitalization Rate due to Alcohol Abuse	2 out of 17 zip codes	3 out of 11 zip codes	7 out of 14 zip codes	5 out of 12 zip codes	7 out of 11 zip codes	3 out of 4 zip codes	27 out of 69 zip codes
	12%	27%	50%	42%	64%	75%	39%
Age-Adjusted Hospitalization Rate due to COPD	1 out of 19 zip codes	2 out of 16 zip codes	7 out of 16 zip codes	4 out of 12 zip codes	4 out of 13 zip codes	0 out of 4 zip codes	18 out of 80 zip codes
	5%	13%	44%	33%	31%	0%	23%
Age-Adjusted Hospitalization Rate due to Bacterial Pneumonia	0 out of 18 zip codes	4 out of 17 zip codes	1 out of 16 zip codes	2 out of 12 zip codes	7 out of 13 zip codes	0 out of 4 zip codes	14 out of 80 zip codes
	0%	24%	6%	17%	54%	0%	18%
Age-Adjusted Hospitalization Rate due to Dehydration	0 out of 17 zip codes	2 out of 12 zip codes	1 out of 14 zip codes	1 out of 12 zip codes	6 out of 11 zip codes	0 out of 3 zip codes	10 out of 69 zip codes
	0%	17%	7%	8%	55%	0%	10%

The chart above illustrates the 13% gap in the hospitalization data and belies the critical rates of 100% incidence in our smaller markets.

Our third focus area or priority area is the social determinants of health. Don Berwick speaks plainly about Elinor Ostrum, the founder of term “micro-commons”

“Elinor Ostrom showed that it was possible to safeguard commonly owned resources like water and forests, writes former Medicare administrator and author of the term “Triple Aim”, Donald M. Berwick,

‘Her work should inspire us to look for ways to prevent health care costs from overwhelming another shared resource – the public coffers”

In our community benefit plan, the “public coffer” Berwick refers to is referenced by our strategy to adhere to the IRS guidelines to “relieve or reduce the burden of government or other community efforts”

So as it happened in 1954, so it goes in 2013. The Community Health Network in consort with the communities we serve have set our sights to develop and implement community strategies to improve the overall health of the communities we serve. Ostroms’ design principles echoed by Berwick capture a way of seeing the whole system of health care. Rather than seeing the system as a conglomerate of organizations, using Ostroms’ vernacular – the health systems are made up of “micro commons” and are the strength that need to be reinforced and enhanced by local strategic leadership. Only those with local knowledge of existing programs and remaining challenges can knit a stronger tapestry of health care delivery. The communities look to us to solve health issues. Their definition of a healthy community goes beyond the diseases we treat in our hospitals and clinics. It is this implementation strategy that will rectify the disparity between their perceptions and our abilities.

The Community Benefit Plan was developed from the perspective that health care does not happen exclusively in the institutions – it happens in the community. It is a place-based community driven approach, extending the health outside the hospital walls for the benefit of all. Just as Elinor Ostroms Nobel Prizewinning research emphasizes collaboration and cooperation as essential, so does our Community Benefit Plan.

Data Driven

Although most health care providers consider Florence Nightingale the founder of modern nursing, Nightingale was as much a celebrated British social reformer and statistician who came to prominence while serving as a nurse during the Crimean War. Like Ostrom, Nightingale believed that the problems of a community were best solved when the citizens were educated to govern themselves. She supported bills for increased self-government and improved local education. As important as her approach to cleanliness and social order, Nightingale became a pioneer of the data driven approach in health care. In fact, she was a master in the visual presentation of

statistics. She used methods such as the pie chart, and developed a pie chart called “the polar area diagram” which was her way to display diseases and Population impact of care. Today Nightingale would be gratified to see we are adopting her data driven approach through our Community Health Needs Assessment and would agree that the zip code you live in is a better determinant of your health expectancy than your genetic code.

Engaging and Advising Community Health Network Staff

Charity Care Strategy

As an example of how we engage and advise staff the current charity care policy was crafted in response to community need and available resources. The health network does not have the resources to meet all of the needs identified in our community health needs assessments. We do not have the resources to offer charity care to anyone who comes to us for care. Consequently using a data driven approach we developed a Charity Care policy that reflects a strategy to target areas of highest need and restrict our charity care resources to these “Health Districts”. The process in defining our Health Districts is a similar process as used with the previous prioritizations. It was developed to identify or more precisely illuminate the needs in the communities we serve and target our resources for optimization. Clearly we do not have the funds to offer charity care throughout all counties or even our own service areas. What resources we do have we need to use in a way that will make the biggest difference and to do so we need to focus in a smaller geographic area. A few points to clarify how we identified “Health Districts”:

- We started with all the zip codes in our service areas (80) and **ONLY** those zip codes
- All criteria are judged “worst” by credible organizations not our own – so the Census Bureau has determined through census data and their measures for poverty that a zip code is at critical level or a criteria has been set by Healthy People 2020
- We did **NOT** use the highest level of charity care expenditure as an initial screen - however as would be expected the highest level of charity care expenditure was contained in these zip codes except in the South market

The Identifications of Health Districts

We used all 80 service area zip codes and selected all those zip codes identified as having median household incomes that were below the target set by the US Census

Bureau (below \$43,417 in our geographic area) We came up with a total of 20 zip codes

To make sure that this one indicator would not stand alone and we would capture or identify other zip codes “in need” or “at risk” we ran several other reports and came up with additional zip codes included in our “Health Districts”.

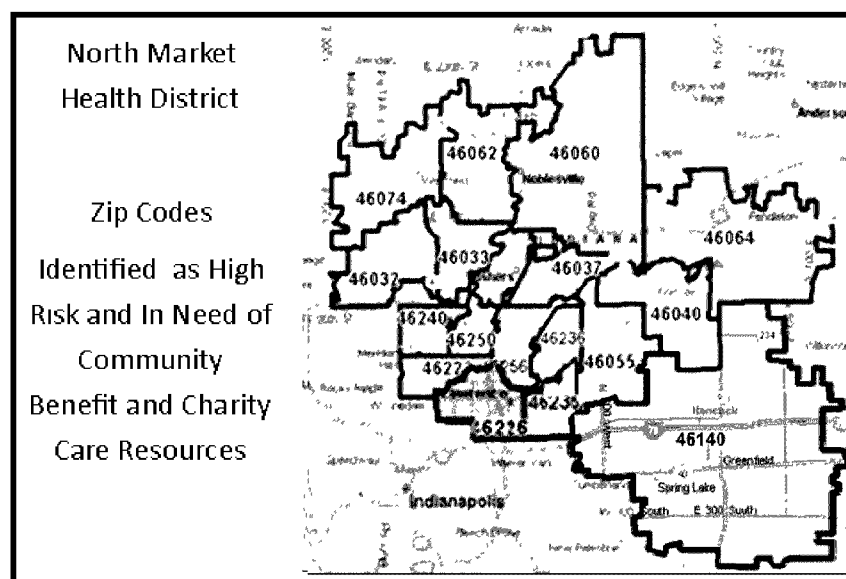
We ran a report to list all those zip codes that identified more than 15% of the zip code Population living in poverty in that specific zip code We captured an additional 3 zip codes

We ran a report to identify families in a specific zip code that pay more than 30% of the annual income on rent (these families would have little discretionary funds available) Any zip code that had more than 47% of the total zip code Population spending 30% (The critical level as identified by the US Census Bureau) 2 zip codes were added

We screened the service area zip codes for “Children Living in Poverty” Any zip code that had more than 21% of their children living in poverty were added, we added 3 zip codes

The final screen we ran was People 65+ living in poverty If there were any additional zip codes that had more than 10% of their total Population 65+ living in poverty we added those zip codes No additional zip codes were added because the zip codes at highest risk or “in need” were already identified in previous screens

Finally three other zip codes were added to the list in the South Market, 46217, 46142 and 46143 The reason for the addition of these zip codes was because of the known immigration Population and the fast changes in these zip codes Population They are the highest at risk or in need zip codes for the south market and they had the highest charity care expenditures in that market



Partner Strategically with Community Organizations

Since our founding in 1954, we have established a 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 values of the organizations they respect and trust. For several years the network has taken on the issue of access and that will remain our number one focus in our prioritized issues. The priority health issues that have been identified by the community health needs assessment are the two chronic diseases diabetes and asthma. Access, asthma and diabetes will be the top priorities however other areas of concern may be adopted as the community drives the plan and we will ultimately report our progress to those we serve. The fourth priority therefore is community driven initiatives.

We continue to take a collective approach that involves our systematic collection of the knowledge and views of informants on healthcare services and needs. These include online surveys, focus groups and one on one discussion. Valuable information is often available from the data we collect from providers, clinicians, and general practitioners, as well as from users of our services. Although such an approach blurs the distinction between need and demand and between science and vested interest, the intimate, detailed knowledge of interested parties might otherwise be overlooked. Furthermore, this collective approach is essential if policies are to be sensitive to local circumstances. Eliciting local views is not the same as being bound by them. Socioeconomic factors, particularly high poverty rates, are associated with some aspects of health system performance, but not all. There are significant variations within areas with low levels of poverty as well as within areas with high poverty levels.

This approach allows sensitivity to local circumstances as local concerns may justifiably attach priorities to particular services. Local experience and involvement will make any needs assessment easier to publicize and defend. Each facility in our network will have prioritized activities and programs determined by the input of the communities they serve which may be different from the overall corporate strategy. As discussed earlier is access to care. This access priority is illustrated by our school health strategies in the community benefit budget. Our priority health issues are asthma and diabetes, both are dramatically impacted in lifestyles and socioeconomic situations defined in the social determinants of health. Both are best addressed where children are located – in schools. But to address these health issues the partner (schools) need to see the impact in their terms of success - such as better grades and better attendance. Keeping both goals and outcomes out in front may slow the timeline down but in the end builds a support system that support a culture of health.

Support Jane Pauley Community Health Center

The Jane Pauley Community Health Center serves the local community, regardless of insurance or income, with an emphasis on integrating medical and behavioral health along with access to various other social services. The center offers primary health care services, including preventive and annual exams, well-child care, acute care and certain procedures. The center also focuses on the management of chronic diseases, such as diabetes, cardiac disease and depression. The Jane Pauley Community Health Center was established in 2009 with generous support from Community Health Network and the Community Health Network Foundation. It is named after Jane Pauley, a 1968 Warren Central High School graduate who grew up in the area and is well known as the former anchor of NBC-TV's "Today" and "Dateline" programs.

Implement Community Health Programs

In Johnson County, one of the most successful community health needs assessment and community benefit plans was initiated over 12 years ago by the collaboration of many organizations in our south market and service area. The Partnership for a Healthier Johnson County has had success while most other initiatives like it have failed. It illustrates the success of our long-term strategy adopted from the beginning and illustrated in the introduction of the Partnership website "Our health partners include hospitals, the health department and hundreds of individuals from businesses, schools, social service agencies and civic and faith-based organizations. The mission of Partnership is to plan and implement collaborative, measurable strategies to improve the health of the residents of Johnson County. This strategy developed 12

years ago continues to be our “Best Practice” and sets the stage for who we participate with and how we measure the success of our participation. Each service area and often combined service areas have unique neighborhood and community initiatives that we support.

Advocate for Policy Change

Everyone knows that tobacco use is the number one cause of preventable death, as well as preventable disease in the United States. With all the awareness and educational resources being spent the last effort was in changing policy. It has been successful. Smoking kills more people in Indiana than alcohol, AIDS, car crashes, illegal drugs, murders, and suicides combined! Cigarette smoking is the number one preventable cause of premature death in Indiana. The United States Surgeon General, in his 1986 report on involuntary smoking concluded that involuntary smoking is a cause of disease, including lung cancer, in healthy nonsmokers. The Center for Disease Control and Prevention is officially warning people at risk for heart disease to avoid all buildings and gathering places that allow smoking, the agency said as little as 30 minutes exposure can have serious and lethal effect. And still the state of Indiana has one of the highest incidence rates of smoking and one of the lowest rates of changing policy to help manage preventative strategies.

Community Health Network as a leader among all of the health care organizations in Indiana possess the expertise, the tradition of clinical innovation, and the institutional commitment to promote healthy activities and behaviors, which prevent illness and disease and improve the health of our community. In 2005 only a handful of health care organizations in the state of Indiana had a tobacco free environment and Community Health Network with implementation of their policy in 2006 was among the leaders, and the first hospital system in Marion County to go smoke free. It was changing policy that made the big difference. We use policy change as the last intervention but sometimes it is the only intervention that will shift our culture to a community that values health.

Communicate, Report and Monitor Progress and Outcomes

Each service area of each network entity will be reviewed and evaluated for the CHNA. The results will be displayed in all upcoming Community Benefit Reports with outcomes of any interventions. This data will give us a baseline and an opportunity to measure our interventions in a way that has never, to this point, been possible.

Our community benefit plan re-examines the social contract that began in 1954 with the community and citizens of the eastside. Now we ask ourselves whether twentieth century assumptions, programs and services are adequate and appropriate for twenty

first century problems and issues. The winning strategy that has been adopted by our health system and is a key driver in most innovation around the affordable care act and the adoption of its tenants is the “Triple Aim.” Developed by Berwick and executed by many health organizations it sums up what our community benefit plan hopes to do, Improve the health of the Population we serve, enhance our patient experience through access, quality, reliability and ultimately reduce the cost of care.

Priority Issue / Significant Health Need	Intervention	Tracking / Outcomes
<i>Access</i>	Provide outreach and interventions that improve the access to health care for the underserved and vulnerable Populations	<p>Increase to 100% the number of Primary Care Physicians in the Community Health Network accepting Medicaid patients</p> <p>Increase volume of patients referred to and treated at the Jane Pauley Community Health Center for uninsured and Medicaid services.</p> <p>Focus Charity Care in Health Districts that have the highest need.</p>
<i>Asthma</i>	Provide outreach, education and intervention in the community that ultimately decreases the number of hospital admissions in our service area and Health Districts for pediatric asthma and overall increases the health of children.	Tracked through comparative county and state of Indiana hospitalization data and nationally through Healthy Community Institute.
<i>Diabetes</i>	Provide outreach, education and intervention in the community that ultimately decreases the number of hospital admissions in our service area and Health Districts for long term and short term complications of diabetes in the adult Population	Tracked through comparative county and state of Indiana hospitalization data and nationally through Healthy Community Institute.

<i>Community Driven Initiatives</i>		
Priority Issue / Significant Health Need	Intervention	Tracking / Outcomes
CHE	<p>Eastside Economic Development Committee (Wellness Opportunity Zone)</p> <p>Serve 360^o</p>	<p>Complete Emerson Ave. Corridor Project. Support community driven projects and encourage data driven measurement approach to drive success and resource allocation. At least one data driven project in the master plans for the community driven activities.</p> <p>100% of all CHE Leadership participate in community projects.</p>
CHN	<p>Healthy Hamilton County</p> <p>Binford Redevelopment and Growth</p> <p>Serve 360^o</p>	<p>Support community driven projects and encourage data driven measurement approach to drive success and resource allocation. At least one data driven project in the master plans for the community driven activities.</p> <p>100% of all CHN Leadership participate in community projects.</p>
CHS	<p>Partnership for A Healthier Johnson County</p> <p>Serve 360^o</p>	<p>Support community driven projects and encourage data driven measurement approach to drive success and resource allocation. At least one data driven project in the master plans for the community driven activities.</p> <p>100% of all CHS Leadership participate in community projects.</p>

CHA	Madison County Coalition – United Way Serve 360 ^o	Support community driven projects and encourage data driven measurement approach to drive success and resource allocation. At least one data driven project in the master plans for the community driven activities. 100% of all CHA Leadership participate in community projects.
Westview	Westview Wellness Initiatives Serve 360 ^o	Support community driven projects and encourage data driven measurement approach to drive success and resource allocation. At least one data driven project in the master plans for the community driven activities. 100% of all Westview Leadership participate in community projects.
Howard	United Way Healthy Communities Serve 360 ^o	Support community driven projects and encourage data driven measurement approach to drive success and resource allocation. At least one data driven project in the master plans for the community driven activities. 100% of all Howard Leadership participate in community projects.

END OF IMPLEMENTATION DOCUMENT

7. Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If “no,” explain in section C which needs it has not addressed and the reasons why it has not addressed such needs.

“No”

Just as Nobel Prize winner Elinor Ostrom’s academic habits emphasized collaboration and cooperation, so did the content of her study and so does our community benefit plan. To address all of the needs identified in the community health needs assessment would be to achieve what no community has been able to do which is maintain optimal health. However we do believe that our plan and execution will weave together a resilient web that can address many needs identified by the communities we serve.

As we move into a new century with a host of ecological health pressures the answer to “What is healthcare for?” becomes important. We need a paradigm shift to transfer the institution led paradigm to a community led one that accounts for the future of society and the environment and is informed by decision making with patients and their communities. A place based community driven approach. Healthcare begins in the community not in the institution. We need to extend the health outside the hospital walls for the benefit of all. We need to see health as owned by the community and as a “commons”, a “Health Commons” – encompassing all of the physical, financial, human, and social capital resources relevant to the delivery of health care and/or the promotion of Population health in a geographic region.

Traditionally, economics taught that common ownership of resources results in excessive exploitation, as when fishermen overfish a common pond. This is the so-called tragedy of the commons, and it suggests that common resources must be managed either through privatization or government regulation, in the form of taxes, say, or limits on use. Professor Ostrom studied cases around the world in which communities successfully regulated resource use through cooperation. Her work has important applications for climate change policy today. Professor Ostrom inspired the Data Governance Council with her work demonstrating that people could effectively self-organize to govern common resources, such as fields, fish, lakes, rivers, and data. Her inspiration came not from text-books and formulas, but from field work with real people working together to govern the use of these common resources without government intervention or regulation. Self-

Organization and Self-Governance are not just nice theories. They are solutions to common human problems that have existed for milenia. These ideas are the foundation for our community benefit plan and implementation strategies.

8. a. Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?

No

Part VI / 7 State filing of a community benefit report

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