

Introduction to the IRS Form 990 Schedule H

Battle Creek Health System is a not-for-profit hospital that operates for one purpose: to further our healing ministry. We do this by:

- Reinvesting our profits back into the communities through various programs and services
- Making sure that care is available to everyone — regardless of his or her ability to pay.
- Using compassion as the cornerstone our work to improve the health of our communities. Patients and their families are always treated as people first — attending to the needs of the whole person — body, mind, and spirit.
- Providing a range of special benefits to the community, such as programs to manage care for persons with chronic diseases, health education and disease prevention initiatives, outreach for the elderly, and care for persons who are poor or uninsured.

The IRS grants us tax exemption as a “charitable, community-oriented organization.” Without this status, we could not continue to deliver the same level of community benefits that are so important and necessary.

The federal government recently ruled that health care entities like ours report their community benefit programs. This includes a wide array of activities and services that need to be categorized and explained – in detail – on the following IRS form called “990 Schedule H.” This document requires us to report information on:

- Charity care (financial assistance) and other community benefits
- Community building activities
- Medicare, bad debt and collection practices
- Management companies and joint ventures
- Facilities comprising the organization

The following terms and definitions will help you better understand each section of the report. Should you choose to not print the document, you can also hover your computer’s mouse over the terms for a brief definition.

PART I: Charity Care and Certain Other Community Benefit at Cost

1a Charity Care Policy: A Trinity Health Ministry Organization's designated procedure/methodology for classifying patients who cannot afford health care services due to inadequate resources and/or are uninsured or underinsured. Care is then provided without charge, or at amounts less than the established rates. Because Trinity Health does not pursue collection of amounts determined to qualify for charity care, they are not reported as net patient service revenue in the consolidated statements of operations and changes in net assets. The cost of charity care is calculated using a cost-to-charge ratio methodology.

3 Charity Care Eligibility: A patient's ability to meet Trinity Health-specified qualifications/criteria to receive financial assistance for medical care, based on the Ministry Organization's official Charity Care Policy.

3a Federal Poverty Guidelines (FPGs): Issued annually by the Department of Health and Human Services (HHS). FPGs are a simplification of the government's designated "federal poverty thresholds," which are highly statistical to calculate the number of Americans living in poverty each year. FPGs are more administrative, and help determine financial eligibility for certain federal programs. The poverty guidelines are sometimes loosely referred to as the "federal poverty level" (FPL), but that phrase is ambiguous and should be avoided, especially in situations (e.g., legislative or administrative) where precision is important.

4 Medically indigent: Persons whom the organization has determined are unable to pay some or all of their medical bills because the bills exceed a certain percentage of their family income and/or assets (e.g., due to catastrophic costs or conditions), even though they have income or assets that otherwise exceed the generally applicable eligibility requirements for free or discounted care under the organization's Charity Care Policy.

6a annual community benefit report: Published each November within Trinity Health's Annual Report, this is a detailed account of all costs associated with dedicated staff, community health needs and/or asset assessments, as well as other costs associated with community benefit strategy and operations.

7a Charity care at cost: Free or discounted health care services provided to persons who meet the organization's criteria for financial assistance and are therefore deemed unable to pay for all or a portion of such services.

7b Unreimbursed Medicaid: When Medicaid, a state health care program for qualifying low-income residents, does not reimburse Trinity Health for the full cost of health care services provided to patients. Trinity Health then "absorbs" these costs at a financial loss.

7c Unreimbursed costs – Other means-tested government programs: Government programs for which eligibility for benefits or coverage is determined by the recipient's income or asset level. (e.g., The State Children's Health Insurance Program (SCHIP) is a means-tested government program.)

7e Community health improvement services and community benefit operations:

The activities to be reported on this line are two different categories of activities:

1. **Community health improvement services:** Activities and services for which no patient bill exists. These services are not expected to be financially self-supporting, although some may be supported by outside grants or funding. Some examples include free clinic services, programs directed at improving women's health, free or low cost prescription medications, and rural and urban outreach programs. The Ministry Organization actively collaborates with community groups and agencies to assist those in need in providing such services.
2. **Community Benefit Operations:** Costs associated with dedicated staff, community health needs and or assets assessments, and other costs associated with community benefit strategy and operations.

7f Health professions education: Programs that result in a degree, certificate, or training that is necessary to be licensed to practice as a health professional, as required by state law; or continuing education that is necessary to retain state license or certification by a board in the individual's health profession specialty.

7g Subsidized health services: Clinical services that are provided, despite a financial loss to the organization. The financial loss is measured after removing losses, measured by cost, associated with bad debt, charity care, Medicaid and other means-tested government programs. Despite the financial loss, the service is provided because:

1. It meets an identified community need, such as providing needed access to care for low-income individuals
2. If the service were no longer offered, access to health services would be impaired, or
3. Providing the service would become the responsibility of government or another tax-exempt organization.

7h Research: Any study or investigation of which the goal is to generate generalized knowledge made available to the public, such as knowledge about:

1. Underlying biological mechanisms of health and disease, natural processes or principles affecting health or illness;
2. Evaluation of safety and efficacy of interventions for disease such as clinical trials and studies of therapeutic protocols;
3. Laboratory based studies; epidemiology, health outcomes and effectiveness
4. Behavioral or sociological studies related to health, delivery of care, or prevention
5. Studies related to changes in the health care delivery system; and
6. Communication of findings and observations (including publication in a medical journal)

This category only includes research internally funded or research funded by a tax-exempt or government entity.

7i Cash and in-kind contributions to community groups: Cash contributions made to entities and community groups that share the organization's goals and mission. In-kind contributions include the cost of hours donated by staff to the community while on the organization's payroll, indirect cost of space donated to tax-exempt community groups (such as for meetings), and the financial value of donated food, equipment, and supplies.

PART II Community Building Activities Community Building activities include programs that address the root causes of health problems, such as poverty, homelessness and environmental problems. They support community assets by offering the expertise and resources of the health care organization.

1. **Physical improvements and housing** (Examples include: Community gardens; neighborhood improvement and revitalization projects; contributions to community-based assisted living and senior and low-income housing projects)
2. **Economic development** (Examples include: Assisting small business development in neighborhoods with vulnerable populations and creating new employment opportunities in areas with high rates of joblessness; participation in an economic/labor development council; chamber of commerce or Rotary Club)
3. **Community support** (Examples include: Childcare and mentoring programs for vulnerable populations or neighborhoods; neighborhood support groups; violence prevention programs; disaster readiness and public health emergency activities)
4. **Environmental improvements** (Examples include: Efforts to reduce community environmental hazards in the air; water and ground; residential improvements; such as helping to paint public housing apartments; or lead/radon programs; Neighborhood/community improvements; Adopt-a-Road)
5. **Leadership development and training for community members** (Examples include: Life or civic skills training programs; medical interpreter training for community members; community leadership development; cultural skills training)
6. **Coalition building** (Examples include: Hospital representation to community coalitions related to community health; Disease management programs; Collaborative partnerships with community groups to improve community health)
7. **Community health improvement advocacy** (Examples include: Local, state and national advocacy on behalf of such areas as: access to health care, public health, transportation, housing; Advocacy for social justice and human rights, including costs associated with advocating for social justice, environmental responsibility and human rights, such as fair treatment to workers)
8. **Workforce development** These programs address community-wide workforce issues — not the workforce needs of the health care organization. (Examples include: Physician/other health professional recruitment for areas identified by the government as medically underserved; Partnerships with community colleges and universities to address the health care workforce shortage; School-based programs on health care careers; Health care career mentoring projects)

More examples of community building activities can be found on the CHA website at: <http://www.chausa.org/Pub/MainNav/ourcommitments/CommunityBenefits/whatcounts/>

Part VI: Supplemental Information

2 Needs assessment Trinity Health's designated evaluation process that involves the hospital assessing the health care needs of the community it serves by periodically

consolidating data and perspectives about the health and social needs of the community. The assessment data assists in the development of a plan for the entire community, with a linkage between the organization's mission and strategic plan, with special attention given to those most in need. A needs assessment is performed by the hospital in partnership with the community, or as a result of other agencies (e.g. public health or private such as United Way). If the hospital cannot perform the assessment, an outside vendor conducts it, then supplies the results.

3 Patient education of eligibility for assistance 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 charity care policy.

4 Community information Describes the geographic area (e.g., urban, suburban, rural), the demographics of the community or communities (e.g., population, average income, percentages of community residents with incomes below the federal poverty guideline, percentage of the hospital's and community's patients who are uninsured or Medicaid recipients), the number of other hospitals serving the community or communities, and whether one or more federally-designated medically underserved areas or populations are present in the community.

5 Community building activities Includes programs that address the root causes of health problems, such as poverty, homelessness and environmental problems. They support community assets by offering the expertise and resources of the health care organization.

**SCHEDULE H
(Form 990)**

Department of the Treasury
Internal Revenue Service

Hospitals

▶ **To be completed by organizations that answer "Yes" to Form 990, Part IV, line 20.**
▶ **Attach to Form 990.**

OMB No. 1545-0047

2008

**Open to Public
Inspection**

Name of the organization **BATTLE CREEK HEALTH SYSTEM** Employer identification number **38-2776791**

Part I Charity Care and Certain Other Community Benefits at Cost (Optional for 2008)

	Yes	No
1a Does the organization have a charity care policy? If "No," skip to question 6a		
1b If "Yes," is it a written policy?		
2 If the organization has multiple hospitals, indicate which of the following best describes application of the charity care policy to the various hospitals. <input type="checkbox"/> Applied uniformly to all hospitals <input type="checkbox"/> Applied uniformly to most hospitals <input type="checkbox"/> Generally tailored to individual hospitals		
3 Answer the following based on the charity care eligibility criteria that applies to the largest number of the organization's patients.		
a Does the organization use Federal Poverty Guidelines (FPG) to determine eligibility for providing <i>free</i> care to low income individuals? If "Yes," indicate which of the following is the family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input type="checkbox"/> Other _____ %		
b Does the organization use FPG to determine eligibility for providing <i>discounted</i> care to low income individuals? If "Yes," indicate which of the following is the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %		
c If the organization does not use FPG to determine eligibility, describe in Part VI the income based criteria for determining eligibility for free or discounted care. Include in the description whether the organization uses an asset test or other threshold, regardless of income, to determine eligibility for free or discounted care.		
4 Does the organization's policy provide free or discounted care to the "medically indigent"?		
5a Does the organization budget amounts for free or discounted care provided under its charity care policy?		
b If "Yes," did the organization's charity care expenses exceed the budgeted amount?		
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?		
6a Does the organization prepare an annual community benefit report?		
b If "Yes," does 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.

7 Charity Care and Certain Other Community Benefits at Cost						
Charity Care and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Charity care at cost (from Worksheets 1 and 2)	1	8,366	4,464,882.		4,464,882.	2.27%
b Unreimbursed Medicaid (from Worksheet 3, column a)	1	25,067	30,284,787.	26,545,320.	3,739,467.	1.90%
c Unreimbursed costs - other means-tested government programs (from Worksheet 3, column b)	2	3,353	2,488,664.	1,529,155.	959,509.	.49%
d Total Charity Care and Means-Tested Government Programs	4	36,786	37,238,333.	28,074,475.	9,163,858.	4.66%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	53	79,776	1,401,637.	12,437.	1,389,200.	.71%
f Health professions education (from Worksheet 5)	8	335	925,714.		925,714.	.47%
g Subsidized health services (from Worksheet 6)	3	3,342	158,590.	50,983.	107,607.	.05%
h Research (from Worksheet 7)						
i Cash and in-kind contributions to community groups (from Worksheet 8)	17		146,420.		146,420.	.07%
j Total Other Benefits	81	83,453	2,632,361.	63,420.	2,568,941.	1.30%
k Total (line 7d and 7j)	85	120,239	39,870,694.	28,137,895.	11,732,799.	5.96%

Part II Community Building Activities Complete this table if the organization conducted any community building activities.
(Optional for 2008)

	(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	3	295	7,400.		7,400.	
3 Community support	2	1,954	6,213.		6,213.	
4 Environmental improvements						
5 Leadership development and training for community members	1	848	8,598.		8,598.	
6 Coalition building	9	6,365	720,562.		720,562.	.37%
7 Community health improvement advocacy	1	4	2,979.		2,979.	
8 Workforce development	2	79	8,229.		8,229.	
9 Other	9	3,736	29,142.		29,142.	.01%
10 Total	27	13,281	783,123.		783,123.	.38%

Part III Bad Debt, Medicare, & Collection Practices (Optional for 2008)

Section A. Bad Debt Expense

- Does the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?
- Enter the amount of the organization's bad debt expense (at cost)
- Enter the estimated amount of the organization's bad debt expense (at cost) attributable to patients eligible under the organization's charity care policy
- Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense. In addition, describe the costing methodology used in determining the amounts reported on lines 2 and 3, or rationale for including other bad debt amounts in community benefit.

	Yes	No
1		
2		
3		
5		
6		
7		
9a		
9b		

Section B. Medicare

- Enter total revenue received from Medicare (including DSH and IME)
- Enter Medicare allowable costs of care relating to payments on line 5
- Enter line 5 less line 6 - surplus or (shortfall)
- Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit and the costing methodology or source used to determine the amount reported on line 6, and indicate which of the following methods was used:
 Cost accounting system Cost to charge ratio Other

Section C. Collection Practices

- Does the organization have a written debt collection policy?
- If "Yes," does the organization's collection policy contain provisions on the collection practices to be followed for patients who are known to qualify for charity care or financial assistance? Describe in Part VI

Part IV Management Companies and Joint Ventures (Optional for 2008)

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1				
2				
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14				

Part VI Supplemental Information (Optional for 2008)

Complete this part to provide the following information.

- 1 Provide the description required for Part I, line 3c; Part I, line 6a; Part I, line 7g; Part I, line 7, column (f); Part I, line 7; Part III, line 4; Part III, line 8; Part III, line 9b, and Part V. See Instructions.
- 2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves.
- 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 charity care policy.
- 4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 **Community building activities.** Describe how the organization's community building activities, as reported in Part II, promote the health of the communities the organization serves.
- 6 Provide any other information important to describing how the organization's hospitals 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.).
- 7 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.
- 8 If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART VI, LINE 2: NEEDS ASSESSMENT - BATTLE CREEK HEALTH SYSTEM ASSESSES THE HEALTH NEEDS OF THE COMMUNITY THROUGH COMMUNITY NEEDS ASSESSMENTS EVERY THREE YEARS. A COMMUNITY NEEDS ASSESSMENT IS A POINT-IN-TIME EFFORT TO MEASURE THE HEALTH AND WELL BEING OF THE COMMUNITY. IT SERVES AS THE BASIS FOR BATTLE CREEK HEALTH SYSTEM'S STRATEGIC AND SUBSEQUENT ACTION PLANNING TO DEVELOP HEALTH POLICY, ALLOCATE RESOURCES, IMPROVE OR EXPAND EXISTING SERVICES, IMPLEMENT NEW PROGRAMS AND COLLABORATE WITH OTHER COMMUNITY HEALTHCARE PROVIDERS. A COMMUNITY NEEDS ASSESSMENT ALSO SERVES AS A BENCHMARK FOR FUTURE ASSESSMENT OF RELATIVE PROGRESS TOWARD ESTABLISHED COMMUNITY HEALTH OBJECTIVES.

THE BATTLE CREEK HEALTH SYSTEM COMMUNITY NEEDS ASSESSMENT PROVIDES THE OPPORTUNITY TO:

- GAIN INSIGHTS INTO THE NEEDS AND ASSETS OF THE COMMUNITIES SERVED
- IDENTIFY AND ADDRESS THE NEEDS OF VULNERABLE POPULATIONS WITHIN THE COMMUNITY
- ENHANCE HOSPITAL/COMMUNITY RELATIONSHIPS AND THE OPPORTUNITY FOR COLLABORATIVE COMMUNITY ACTION, INCLUDING INVOLVEMENT WITH COALITIONS, PARTNERSHIPS, BOARDS, COMMITTEES, COMMISSIONS, ADVISORY GROUPS AND PANELS
- PROVIDE THE INFORMATION REQUIRED FOR COMMUNITY OUTREACH PLANNING

Part VI Supplemental Information (Optional for 2008)

THE BATTLE CREEK HEALTH SYSTEM COMMUNITY NEEDS ASSESSMENT PROCESS INVOLVES THE GATHERING OF TWO TYPES OF DATA: QUANTITATIVE (DEMOGRAPHICS, HEALTH INDICATORS, ETC.) AND QUALITATIVE (PUBLIC SURVEYS, FORUMS, FOCUS GROUPS). THE DATA HELPS SUPPORT SHORT-TERM AND LONG-TERM DECISIONS ABOUT ALLOCATION OF COMMUNITY HUMAN AND CAPITAL RESOURCES.

THE BATTLE CREEK HEALTH SYSTEM COMMUNITY NEEDS ASSESSMENT IS CURRENT AS OF SEPTEMBER 2009. THE ASSESSMENT WAS CONDUCTED BY BATTLE CREEK HEALTH SYSTEM AND INCLUDED SIGNIFICANT REVIEW OF COMMUNITY DATA, INTERVIEWS WITH KEY COMMUNITY LEADERS, ANALYSIS AND SUMMARY BY AN INDEPENDENT COMMUNITY WRITER, AND ASSESSMENT AND REVIEW BY OUR COMMUNITY BENEFIT MINISTRY TEAM.

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

BATTLE CREEK HEALTH SYSTEM IS COMMITTED TO:

- PROVIDING ACCESS TO QUALITY HEALTHCARE SERVICES WITH COMPASSION, DIGNITY AND RESPECT FOR THOSE WE SERVE, PARTICULARLY THE POOR AND THE UNDERSERVED IN OUR COMMUNITIES

- CARING FOR ALL PERSONS, REGARDLESS OF THEIR ABILITY TO PAY FOR SERVICES

- ASSISTING PATIENTS WHO CANNOT PAY FOR PART OR ALL OF THE CARE THEY

RECEIVE

- BALANCING NEEDED FINANCIAL ASSISTANCE FOR SOME PATIENTS WITH BROADER FISCAL RESPONSIBILITIES IN ORDER TO SUSTAIN VIABILITY AND PROVIDE THE QUALITY AND QUANTITY OF SERVICES FOR ALL WHO MAY NEED CARE IN A COMMUNITY

IN ACCORDANCE WITH AHA RECOMMENDATIONS, BATTLE CREEK HEALTH SYSTEM HAS ADOPTED THE FOLLOWING GUIDING PRINCIPLES WHEN HANDLING THE BILLING, COLLECTION AND FINANCIAL SUPPORT FUNCTIONS FOR OUR PATIENTS:

- PROVIDE EFFECTIVE COMMUNICATIONS WITH PATIENTS REGARDING HOSPITAL BILLS

Part VI Supplemental Information (Optional for 2008)

- MAKE AFFIRMATIVE EFFORTS TO HELP PATIENTS APPLY FOR PUBLIC AND PRIVATE FINANCIAL SUPPORT PROGRAMS

- OFFER FINANCIAL SUPPORT TO PATIENTS WITH LIMITED MEANS

- IMPLEMENT POLICIES FOR ASSISTING LOW-INCOME PATIENTS IN A CONSISTENT MANNER

- IMPLEMENT FAIR AND CONSISTENT BILLING AND COLLECTION PRACTICES FOR ALL PATIENTS WITH PATIENT PAYMENT OBLIGATIONS

BATTLE CREEK HEALTH SYSTEM COMMUNICATES EFFECTIVELY WITH PATIENTS REGARDING PATIENT PAYMENT OBLIGATIONS. FINANCIAL COUNSELING IS PROVIDED TO PATIENTS ABOUT THEIR PAYMENT OBLIGATIONS AND HOSPITAL BILLS. INFORMATION ON HOSPITAL-BASED FINANCIAL SUPPORT POLICIES AND EXTERNAL PROGRAMS THAT PROVIDE COVERAGE FOR SERVICES ARE MADE AVAILABLE TO PATIENTS DURING THE PRE-REGISTRATION AND REGISTRATION PROCESSES AND/OR THROUGH COMMUNICATIONS WITH PATIENTS SEEKING FINANCIAL ASSISTANCE.

FINANCIAL COUNSELORS MAKE AFFIRMATIVE EFFORTS TO HELP PATIENTS APPLY FOR PUBLIC AND PRIVATE PROGRAMS FOR WHICH THEY MAY QUALIFY AND THAT MAY HELP THEM OBTAIN AND PAY FOR HEALTHCARE SERVICES. EVERY EFFORT IS MADE TO DETERMINE A PATIENT'S ELIGIBILITY PRIOR TO OR AT THE TIME OF ADMISSION OR SERVICE. HOWEVER, DETERMINATION FOR FINANCIAL SUPPORT CAN BE MADE DURING ANY STAGE OF THE PATIENT'S STAY AFTER STABILIZATION OR COLLECTION CYCLE.

BATTLE CREEK HEALTH SYSTEM OFFERS FINANCIAL SUPPORT TO PATIENTS WITH LIMITED MEANS. THIS SUPPORT IS AVAILABLE TO UNINSURED AND UNDERINSURED PATIENTS WHO DO NOT QUALIFY FOR PUBLIC PROGRAMS OR OTHER ASSISTANCE. NOTIFICATION ABOUT FINANCIAL ASSISTANCE, INCLUDING CONTACT INFORMATION, IS AVAILABLE THROUGH THE FINANCIAL COUNSELING DEPARTMENT, EMERGENCY DEPARTMENT

Part VI Supplemental Information (Optional for 2008)

ASSOCIATES, ADMITTING AND REGISTRATION ASSOCIATES, THE CUSTOMER SERVICE DEPARTMENT, AND CASHIERS. THIS INCLUDES, BUT IS NOT LIMITED TO, THE PUBLICATION OF PATIENT BROCHURES AND NOTICES OR MESSAGING INCLUDED ON PATIENT BILLS. SUMMARIES OF HOSPITAL PROGRAMS ARE MADE AVAILABLE TO THE DEPARTMENT OF HUMAN SERVICES, THE FAMILY HEALTH CENTER AND PHYSICIAN OFFICES. INFORMATION REGARDING FINANCIAL ASSISTANCE PROGRAMS IS ALSO AVAILABLE FROM FINANCIAL COUNSELORS FOR ALL PATIENTS WHO ARE ADMITTED. IN ADDITION TO ENGLISH, THIS INFORMATION IS ALSO AVAILABLE IN SPANISH, REFLECTING THE OTHER PRIMARY LANGUAGE SPOKEN BY THE POPULATION SERVICED BY OUR HOSPITAL.

BATTLE CREEK HEALTH SYSTEM HAS ESTABLISHED A WRITTEN POLICY FOR THE BILLING, COLLECTION AND SUPPORT FOR PATIENTS WITH PAYMENT OBLIGATIONS. WE MAKE EVERY EFFORT TO ADHERE TO THE POLICY AND ARE COMMITTED TO IMPLEMENTING AND APPLYING THE POLICY FOR ASSISTING PATIENTS WITH LIMITED MEANS IN A PROFESSIONAL, CONSISTENT MANNER. BCHS EDUCATES STAFF MEMBERS WHO WORK CLOSELY WITH PATIENTS (INCLUDING THOSE WORKING IN PATIENT REGISTRATION AND ADMITTING, FINANCIAL ASSISTANCE, CUSTOMER SERVICE, BILLING AND COLLECTIONS) ABOUT THESE POLICIES WITH AN EMPHASIS ON TREATING ALL PATIENTS WITH DIGNITY AND RESPECT REGARDLESS OF THEIR INSURANCE STATUS OR THEIR ABILITY TO PAY FOR SERVICES. TRAINING IS PROVIDED IN COMPLETING FINANCIAL ASSISTANCE APPLICATIONS, COMPLETING ALL TYPES OF DEPARTMENT OF HUMAN SERVICES APPLICATIONS FOR ASSISTANCE, EFFECTIVE COMMUNICATION SKILLS WITH DIVERSE POPULATIONS AND CUSTOMER RELATIONS THROUGHOUT THE PATIENT'S CARE EXPERIENCE.

PART VI, LINE 4: COMMUNITY INFORMATION - BATTLE CREEK HEALTH SYSTEM SERVES APPROXIMATELY 250,000 PEOPLE IN SOUTH CENTRAL MICHIGAN. BCHS WAS

Part VI Supplemental Information (Optional for 2008)

FORMED THROUGH THE MERGER OF BATTLE CREEK'S TWO ACUTE CARE HOSPITALS - LEILA Y. POST MONTGOMERY HOSPITAL AND COMMUNITY HOSPITAL. WE OPERATE AS A 50-50 JOINT VENTURE SPONSORED BY TRINITY HEALTH (ONE OF THE NATION'S LARGEST CATHOLIC SYSTEMS) AND BCHS COMMUNITY PARTNERS (REPRESENTING THE COMMUNITY'S HALF-INTEREST IN THE VENTURE).

THE BCHS MAIN CAMPUS IS IN BATTLE CREEK, A MEDIUM-SIZED COMMUNITY OF ABOUT 50,000 THAT IS BEST KNOWN AS HOME TO THE KELLOGG COMPANY. BCHS IS THE ONLY ACUTE CARE HOSPITAL IN BATTLE CREEK, BUT STRONG HOSPITAL COMPETITORS ARE LOCATED IN MARSHALL (10 MILES TO THE EAST) AND KALAMAZOO (TWO TERTIARY CARE HOSPITALS 20 MILES TO THE WEST). MAJOR EMPLOYERS IN BATTLE CREEK INCLUDE POST CEREALS, AUTO-PARTS SUPPLIERS DENSO AND II STANLEY, AND THE FEDERAL GOVERNMENT THROUGH BOTH A VA HOSPITAL AND A MAJOR DEFENSE DEPARTMENT CATALOGING SERVICE. BATTLE CREEK HEALTH SYSTEM IS AMONG THE AREA'S TOP FIVE EMPLOYERS.

THE PRIMARY SERVICE AREA FOR BCHS IS THE FOUR ZIP CODES THAT INTERSECT IN THE CENTER OF THE CITY OF BATTLE CREEK. ABOUT 70% OF ADMISSIONS COME FROM THESE FOUR ZIP CODES, WITH MOST REMAINING PATIENTS LOCATED IN A SECONDARY SERVICE AREA GENERALLY BOUNDED BY THE CITY OF HASTINGS ON THE NORTH, ALBION ON THE EAST, COLDWATER ON THE SOUTH, AND GALESBURG TO THE WEST. POPULATION GROWTH IS MINIMAL WITH MANY YOUNG FAMILIES AND SINGLES LEAVING THE AREA TO FIND EMPLOYMENT. OVER THE COMING FIVE YEARS, THE REGION IS PROJECTED TO LOSE POPULATION.

INDICATORS OF HEALTH, WEALTH AND EDUCATION GENERALLY PORTRAY BATTLE CREEK (AND CALHOUN COUNTY) AS A STRUGGLING COMMUNITY IN A STRUGGLING STATE. WHILE MANY SPEAK OF MICHIGAN BEING IN THE MIDST OF A "ONE STATE

Part VI Supplemental Information (Optional for 2008)

DEPRESSION," BATTLE CREEK AND CALHOUN COUNTY HAVE FELT RECESSION/DEPRESSION LONGER AND DEEPER.

THE PER CAPITA INCOME IN CALHOUN COUNTY IS 12% BELOW THE STATE AVERAGE, AND 15.2% OF CALHOUN COUNTY RESIDENTS ARE UNINSURED (3 POINTS ABOVE STATE AVERAGE). FORTY-ONE PERCENT OF CALHOUN COUNTY CHILDREN THROUGH AGE 18 ARE ENROLLED IN MEDICAID, COMPARED WITH 33% STATEWIDE.

OUR COMMUNITIES ARE PREDOMINANTLY WHITE, EVENLY SPLIT BETWEEN MALES AND FEMALES, WITH MEDIAN INCOMES BELOW THE STATE AVERAGE. OUR POPULATION IS DECLINING AMONG THE YOUNG AND INCREASING IN THE 50+ AGE GROUPS. WHILE MORE THAN 80% OF RESIDENTS IN BATTLE CREEK REPORT THAT THEY HAVE INSURANCE, A RECENT STUDY INDICATES THAT PERHAPS ONE-THIRD OF THE POPULATION IN OUR GEOGRAPHY WILL BE WITHOUT HEALTH INSURANCE AT SOME POINT DURING THE YEAR. OUR HEALTH STATISTICS REFLECT BELOW AVERAGE ECONOMICS AND EDUCATION, WITH HIGH RATES OF OBESITY, HYPERTENSION, SMOKING, TEEN PREGNANCY, AND DIABETES. MINORITY RESIDENTS REPORT GREATER DIFFICULTY ACCESSING HEALTH CARE THAN DO WHITES AND THERE ARE CONCERNS WITH TRANSLATION SERVICES AMONG HISPANICS. CALHOUN COUNTY IS DESIGNATED A HEALTH PROFESSIONAL SHORTAGE AREA, INDICATING CONCERNS WITH THE DIFFICULTY TO RECRUIT MEDICAL PROFESSIONALS.

PART VI, LINE 5: COMMUNITY BUILDING ACTIVITIES - BCHS IS PROUD OF THE EXTENSIVE COLLABORATION AMONG HEALTH CARE ORGANIZATIONS IN THE REGION. NOTABLE ARE THE REGIONAL HEALTH ALLIANCE (WHICH HAS ACTIVE INITIATIVES TO IMPROVE MINORITY HEALTH, INFANT MORTALITY, SCHOOL WELLNESS, TEEN PREGNANCY, HEALTHY LIFESTYLES, AND ACCESS TO CARE), 5-C (FOCUSED ON CANCER PREVENTION STRATEGIES), AND CALHOUN COUNTY PATHWAYS TO HEALTH (A BCHS-LED NATIONAL DEMONSTRATION PROJECT ADVANCING CREATIVE NEW STRATEGIES TO DEVELOP

Part VI Supplemental Information (Optional for 2008)

PATIENT-CENTERED MEDICAL HOMES AS A STRATEGY TO MANAGE CHRONIC DISEASE).

ALREADY RECOGNIZED AS A NATIONAL MODEL FOR TRANSFORMING CARE DELIVERY, CALHOUN COUNTY PATHWAYS TO HEALTH BEGAN IN THE SPRING OF 2006 AT THE CALL OF BCHS PRESIDENT AND CEO PATRICK GARRETT. THE VISION WAS TO ADVANCE MORE PATIENT-CENTERED CARE FOR THE HIGH PATIENT POPULATIONS SUFFERING FROM DIABETES AND HEART DISEASE.

PATHWAYS WAS CREATED UNDER THE LEADERSHIP OF INTEGRATED HEALTH PARTNERS (A 50/50 JOINT VENTURE OF BCHS AND OUR MEDICAL STAFF). OPERATING AS A MULTI-STAKEHOLDER INITIATIVE, IT NOW INCLUDES CONSUMERS, EMPLOYERS, PHYSICIANS, HEALTH CARE ORGANIZATIONS, HEALTH PLANS, AND COMMUNITY SUPPORT AGENCIES WORKING TOGETHER TO REDEFINE THE PHYSICIAN OFFICE EXPERIENCE, BUILD PERSONAL RESPONSIBILITY AMONG PATIENTS, AND IMPROVE COMMUNITY OUTCOMES. IN SIMPLEST FORM, PATHWAYS IS ABOUT PUTTING THE PATIENT AT THE CENTER OF THE HEALTH CARE VISIT. IT COMBINES INNOVATIVE PRACTICE-REDESIGN COLLABORATIVES FOR PHYSICIAN OFFICES (SEVERAL DOZEN PRIMARY CARE OFFICES HAVE PARTICIPATED TO DATE), THE POWER OF A DISEASE REGISTRY (WITH DATA CONNECTED TO PROVIDERS), TRAINING ON THE CHRONIC CARE MODEL, AND TARGETED OUTREACH TO MINORITY POPULATIONS WHO SUFFER DISPROPORTIONATELY FROM THESE DISEASES. AN EMPLOYER/HEALTH PLAN COLLABORATIVE IS ALSO TESTING THE IMPACT OF BENEFIT REDESIGN TO ENCOURAGE COMPLIANCE AND HEALTHIER LIFESTYLES.

COMMUNITY HEALTHCARE CONNECTIONS IS ANOTHER NOTABLE EXAMPLE OF OUR COMMITMENT TO COMMUNITY HEALTH. THIS YEAR SAW THE MERGER OF TWO SIGNIFICANT SAFETY NET ORGANIZATIONS WITH DEEP CONNECTIONS TO BATTLE CREEK HEALTH SYSTEM. THE NURSING CLINIC AND CALHOUN HEALTH PLAN JOINED FORCES IN A NEW ORGANIZATION CALLED COMMUNITY HEALTHCARE CONNECTIONS (CHC). BCHS WAS

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DEEPLY INVOLVED IN THE MERGER, AS A MAJOR FUNDER OF BOTH ENTITIES AND BY PROVIDING SEVERAL BOARD MEMBERS AND A FACILITATOR FOR THE MERGER DISCUSSIONS.

THE MERGED CHC WILL HELP ENSURE SUSTAINABILITY FOR BOTH ORGANIZATIONS, ENHANCE THE ABILITY TO DELIVER QUALITY SERVICES ACROSS OUR COUNTY, PROVIDE A NEW COLLABORATIVE FRAMEWORK, AND CREATE EFFICIENCIES ALLOWING MORE RESOURCES TO BE FOCUSED ON CARE.

BCHS PARTNERS SUPPORTS THE WORK OF CHC TO ASSIST THE HOMELESS, UNINSURED AND INDIGENT IN OUR MIDST THROUGH FREE, URGENT, NON-EMERGENT MEDICAL CARE; REFERRALS TO A MEDICAL HOME; A PRESCRIPTION DRUG ACCESS PROGRAM; SPECIALTY REFERRAL AND COORDINATION; THE DENTAL PARTNERSHIP PROGRAM FOR URGENT DENTAL CARE NEEDS; AND THE PREVENTIVE DENTAL SERVICES INITIATIVE, PROVIDING FREE CLEANINGS AND SCREENINGS.

BCHS FOUNDED SENIOR HEALTH PARTNERS WITH A MISSION TO IMPROVE THE HEALTH AND WELL-BEING OF OLDER ADULTS IN CALHOUN AND SURROUNDING COUNTIES. WITHIN THAT FRAMEWORK, OUR PARTNERS (BATTLE CREEK HEALTH SYSTEM, SUMMIT POINTE, AND CENTRACARE REGIONAL 3B AREA AGENCY ON AGING) ARE ENGAGED IN A WIDE VARIETY OF SCREENINGS, SERVICES AND PROGRAMS TO SUPPORT SENIORS IN GREATER BATTLE CREEK. MOST OF THOSE WE SERVE ARE FINANCIALLY AT-RISK.

NOTABLE PROGRAM OFFERINGS INCLUDE 'LUNCH AND LEARN' SESSIONS THAT BRING BCHS MEDICAL STAFF TO DELIVER FREE EDUCATIONAL SEMINARS ON A VARIETY OF HEALTH TOPICS; ONGOING RN VISITS TO SUBSIDIZED SENIOR HOUSING CENTERS; FREE EXERCISE CLASSES AND 'MATTER OF BALANCE' FALLS TRAINING; BCHS CARE-A-VAN VISITS, HEALTH FAIRS, AND COMMUNITY SCREENINGS; CAREGIVER SUPPORT GROUPS;

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AND LEADERSHIP IN THE DEVELOPMENT OF PROGRAMMING AND EDUCATION AROUND ALZHEIMER'S AND PARKINSON'S DISEASE.

BCHS PARTICIPATES IN DOZENS OF COMMUNITY INITIATIVES DESIGNED TO ATTACK HEALTH CARE ISSUES- SOMETIMES WE ARE A LEADER AND SOMETIMES A PARTICIPANT AND SUPPORTER. HEALTH SYSTEM LEADERSHIP EXTENDS TO THE INDIVIDUAL GIFT OF TIME WITH MANY EXECUTIVES SERVING ON BOARDS WITH COMMUNITY ORGANIZATIONS. TWO OF THE LAST FOUR COMMUNITY UNITED WAY CAMPAIGNS HAVE BEEN CHAIRED BY BCHS LEADERSHIP. IN A RECENT YEAR, EACH OF THE SEVEN MEMBERS OF THE BCHS EXECUTIVE LEADERSHIP TEAM WAS CHAIRING AT LEAST ONE COMMUNITY NON-PROFIT ORGANIZATION.

PART VI, LINE 6: OTHER INFORMATION - BATTLE CREEK HEALTH SYSTEM IS A UNIQUE JOINT VENTURE SPONSORED BY TRINITY HEALTH (ONE OF THE NATION'S LARGEST CATHOLIC SYSTEMS) AND BCHS COMMUNITY PARTNERS (REPRESENTING THE COMMUNITY'S HALF-INTEREST IN THE SYSTEM). OUR GOVERNANCE STRUCTURE INCLUDES TWO NON-PROFIT BOARDS OF DIRECTORS: (1) BCHS COMMUNITY PARTNERS WHICH HOLDS RESERVED POWERS REPRESENTING THE COMMUNITY OWNERSHIP OF THE SYSTEM, AND (2) BCHS BOARD OF TRUSTEES WHICH SERVES THE ROUTINE GOVERNANCE RESPONSIBILITIES.

BCHS COMMUNITY PARTNERS HAS 13 MEMBERS, ALL DRAWN FROM THE LOCAL COMMUNITY. BCHS BOARD OF TRUSTEES HAS 15 MEMBERS, PRIMARILY DRAWN FROM THE LOCAL COMMUNITY. THREE MEMBERS OF THE BCHS BOARD AND BCHS COMMUNITY PARTNERS SERVE CONCURRENTLY ON BOTH IN ORDER TO FACILITATE EXCHANGE OF INFORMATION.

BATTLE CREEK HEALTH SYSTEM MAINTAINS AN OPEN MEDICAL STAFF. OUR STANDARDS FOR ACCEPTANCE TO THE MEDICAL STAFF ARE VERY HIGH, BUT ALL QUALIFIED

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PHYSICIANS IN THE COMMUNITY ARE ENCOURAGED AND WELCOME TO JOIN.

THE BCHS EMERGENCY DEPARTMENT (ED) IS AN ACTIVE SERVICE THAT CARES FOR BETWEEN 45,000-50,000 PATIENTS EACH YEAR. THE ED CARES FOR ANYONE, REGARDLESS OF ABILITY TO PAY. ELEVEN PERCENT OF OUR ED PATIENTS ARE UNINSURED, AND AN ADDITIONAL 29% ARE ON MEDICAID. THE EMERGENCY DEPARTMENT TRULY SERVES AS THE FINAL SAFETY NET FOR BOTH EMERGENT AND PRIMARY CARE IN OUR COMMUNITY.

CONSISTENT WITH OUR NON-PROFIT STATUS, BATTLE CREEK HEALTH SYSTEM USES OPERATING MARGIN AS A CATALYST FOR REINVESTMENT IN FACILITIES, TECHNOLOGY, STAFF AND MEDICAL SERVICES FOR THE COMMUNITY.

PART VI, LINE 7: BATTLE CREEK HEALTH SYSTEM IS A MEMBER ORGANIZATION OF TRINITY HEALTH, THE FOURTH-LARGEST CATHOLIC HEALTH CARE SYSTEM IN THE COUNTRY. BASED IN NOVI, MICHIGAN, TRINITY HEALTH ANNUALLY REQUIRES THAT ALL MEMBER ORGANIZATIONS DEVELOP, AND ARE HELD ACCOUNTABLE FOR ACHIEVING, COMMUNITY BENEFIT GOALS THAT INCLUDE DEVELOPING NEEDED SERVICES OR EXPANDING ACCESS TO SERVICES FOR LOW-INCOME INDIVIDUALS. AS A NOT-FOR-PROFIT HEALTH SYSTEM, TRINITY HEALTH REINVESTS ITS PROFITS BACK INTO THE COMMUNITY THROUGH PROGRAMS TO SERVE THE POOR AND UNINSURED, MANAGE CHRONIC CONDITIONS LIKE DIABETES, HEALTH EDUCATION AND PROMOTION INITIATIVES, AND OUTREACH FOR THE ELDERLY. IN FISCAL YEAR 2009, THIS INCLUDED NEARLY \$400 MILLION IN SUCH COMMUNITY BENEFITS. THEREFORE, TRINITY HEALTH TAKES A SYSTEMS APPROACH IN ITS COMMUNITY BENEFIT PLANNING AND IMPLEMENTATION, AND IS CONSEQUENTLY ABLE TO ENSURE THAT ITS MEMBER HOSPITALS AND OTHER ENTITIES/AFFILIATES ARE HELPING PROMOTE AND ADDRESS THE HEALTH NEEDS OF THEIR RESPECTIVE COMMUNITIES.

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FOR MORE INFORMATION ABOUT TRINITY HEALTH, VISIT WWW.TRINITY-HEALTH.ORG.