

## **Introduction to the IRS Form 990 Schedule H**

As a not-for-profit hospital, we operate 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 fall 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)

## **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)**

**Hospitals**

OMB No. 1545-0047

**2009**

**Open to Public  
Inspection**

Department of the Treasury  
Internal Revenue Service

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

Name of the organization **MOUNT CARMEL NEW ALBANY SURGICAL HOSPITAL** Employer identification number **87-0790288**

**Part I Charity Care and Certain Other Community Benefits at Cost**

	Yes	No
<b>1a</b> Does the organization have a charity care policy? If "No," skip to question 6a .....	<input checked="" type="checkbox"/>	
<b>b</b> If "Yes," is it a written policy? .....	<input checked="" type="checkbox"/>	
<b>2</b> If the organization has multiple hospitals, indicate which of the following best describes application of the charity care policy to the various hospitals. <input checked="" type="checkbox"/> Applied uniformly to all hospitals <input type="checkbox"/> Applied uniformly to most hospitals <input type="checkbox"/> Generally tailored to individual hospitals		
<b>3</b> Answer the following based on the charity care eligibility criteria that applies to the largest number of the organization's patients. <b>a</b> 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 checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %	<input checked="" type="checkbox"/>	
<b>b</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 checked="" type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	<input checked="" type="checkbox"/>	
<b>c</b> 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.		
<b>4</b> Does the organization's policy provide free or discounted care to the "medically indigent"? .....	<input checked="" type="checkbox"/>	
<b>5a</b> Does the organization budget amounts for free or discounted care provided under its charity care policy? .....	<input checked="" type="checkbox"/>	
<b>b</b> If "Yes," did the organization's charity care expenses exceed the budgeted amount? .....		<input checked="" type="checkbox"/>
<b>c</b> If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care? .....		
<b>6a</b> Does the organization prepare an annual community benefit report? .....	<input checked="" type="checkbox"/>	
<b>b</b> If "Yes," does the organization make it available to the public? .....	<input checked="" type="checkbox"/>	

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

<b>7 Charity Care and Certain Other Community Benefits at Cost</b>						
<b>Charity Care and Means-Tested Government Programs</b>	<b>(a)</b> Number of activities or programs (optional)	<b>(b)</b> Persons served (optional)	<b>(c)</b> Total community benefit expense	<b>(d)</b> Direct offsetting revenue	<b>(e)</b> Net community benefit expense	<b>(f)</b> Percent of total expense
<b>a</b> Charity care at cost (from Worksheets 1 and 2) .....	1	184	925,722.	0.	925,722.	1.18%
<b>b</b> Unreimbursed Medicaid (from Worksheet 3, column a) .....	4	136	2,158,048.	719,278.	1,438,770.	1.83%
<b>c</b> Unreimbursed costs - other means-tested government programs (from Worksheet 3, column b) .....						
<b>d Total</b> Charity Care and Means-Tested Government Programs ...	5	320	3,083,770.	719,278.	2,364,492.	3.01%
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4) .....						
<b>f</b> Health professions education (from Worksheet 5) .....						
<b>g</b> Subsidized health services (from Worksheet 6) .....						
<b>h</b> Research (from Worksheet 7) .....						
<b>i</b> Cash and in-kind contributions to community groups (from Worksheet 8) .....						
<b>j Total.</b> Other Benefits .....						
<b>k Total.</b> Add lines 7d and 7j .....	5	320	3,083,770.	719,278.	2,364,492.	3.01%

**MOUNT CARMEL NEW ALBANY SURGICAL  
HOSPITAL**

**Part II Community Building Activities** Complete this table if the organization conducted any community building activities.

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing					
2	Economic development					
3	Community support					
4	Environmental improvements					
5	Leadership development and training for community members					
6	Coalition building					
7	Community health improvement advocacy					
8	Workforce development					
9	Other					
10	<b>Total</b>					

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

**Section A. Bad Debt Expense**

	Yes	No
1 Does the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? .....	1	X
2 Enter the amount of the organization's bad debt expense (at cost) .....	2	351,962.
3 Enter the estimated amount of the organization's bad debt expense (at cost) attributable to patients eligible under the organization's charity care policy .....	3	70.
4 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, and rationale for including other bad debt amounts in community benefit.		

**Section B. Medicare**

5 Enter total revenue received from Medicare (including DSH and IME) .....	5	17,828,999.
6 Enter Medicare allowable costs of care relating to payments on line 5 .....	6	21,149,087.
7 Subtract line 6 from line 5. This is the surplus or (shortfall) .....	7	-3,320,088.
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other		

**Section C. Collection Practices**

9a Does the organization have a written debt collection policy? .....	9a	X
b 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 .....	9b	X

**Part IV Management Companies and Joint Ventures**

(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				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				



**Part VI** Supplemental Information

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 I, LINE 6A: MOUNT CARMEL NEW ALBANY SURGICAL HOSPITAL REPORTS ITS  
COMMUNITY BENEFIT INFORMATION AS PART OF THE CONSOLIDATED COMMUNITY  
BENEFIT INFORMATION REPORTED BY TRINITY HEALTH IN ITS ANNUAL REPORT,  
AVAILABLE AT WWW.TRINITY-HEALTH.ORG.

IN ADDITION, MOUNT CARMEL NEW ALBANY SURGICAL HOSPITAL INCLUDES A COPY OF  
ITS MOST RECENTLY FILED SCHEDULE H ON TRINITY HEALTH'S WEBSITE AS WELL AS  
MOUNT CARMEL HEALTH SYSTEM'S WEBSITE (WWW.MOUNTCARMELHEALTH.COM).

PART I, LINE 7: THE BEST AVAILABLE DATA WAS USED TO CALCULATE THE  
COST AMOUNTS REPORTED IN ITEM 7. FOR CERTAIN CATEGORIES, PRIMARILY TOTAL  
CHARITY CARE AND MEANS-TESTED GOVERNMENT PROGRAMS, SPECIFIC COST-TO-CHARGE  
RATIOS WERE CALCULATED AND APPLIED TO THOSE CATEGORIES. THE COST-TO-CHARGE  
RATIO WAS DERIVED FROM WORKSHEET 2, RATIO OF PATIENT CARE COST-TO-CHARGES.  
IN OTHER CATEGORIES, THE BEST AVAILABLE DATA WAS DERIVED FROM THE  
HOSPITAL'S COST ACCOUNTING SYSTEM.

PART I, LINE 7F: THE FOLLOWING NUMBER, \$946,192, REPRESENTS THE AMOUNT  
OF BAD DEBT EXPENSE INCLUDED IN TOTAL FUNCTIONAL EXPENSES IN FORM 990,  
PART IX, LINE 25. PER IRS INSTRUCTIONS, THIS AMOUNT WAS EXCLUDED FROM THE  
DENOMINATOR WHEN CALCULATING THE PERCENT OF TOTAL EXPENSE FOR SCHEDULE H,

**Part VI** Supplemental Information

PART I, LINE 7, COLUMN (F).

PART III, LINE 4: MOUNT CARMEL NEW ALBANY SURGICAL HOSPITAL IS INCLUDED IN THE CONSOLIDATED FINANCIAL STATEMENTS OF TRINITY HEALTH. THE FOLLOWING IS THE TEXT OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS FOOTNOTE FROM THOSE STATEMENTS: "SUBSTANTIALLY ALL OF THE CORPORATION'S RECEIVABLES ARE RELATED TO PROVIDING HEALTHCARE SERVICES TO PATIENTS. ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR AMOUNTS THAT COULD BECOME UNCOLLECTIBLE IN THE FUTURE. THE CORPORATION'S ESTIMATE FOR ITS ALLOWANCE FOR DOUBTFUL ACCOUNTS IS BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS BY PAYOR."

COSTING METHODOLOGY FOR LINES 2 AND 3: AMOUNTS ARE CALCULATED ON LINE 2 USING A COST TO CHARGE RATIO METHODOLOGY.

ANY DISCOUNTS PROVIDED OR PAYMENTS MADE TO A PARTICULAR PATIENT ACCOUNT ARE APPLIED TO THAT PATIENT ACCOUNT PRIOR TO ANY BAD DEBT WRITE-OFF AND ARE THUS NOT INCLUDED IN BAD DEBT EXPENSE. AS A RESULT OF THE PAYMENT AND ADJUSTMENT ACTIVITY BEING POSTED TO BAD DEBT ACCOUNTS, WE ARE ABLE TO REPORT BAD DEBT EXPENSE NET OF THESE TRANSACTIONS.

THE ORGANIZATION IDENTIFIES MANY CHARITY PATIENTS AT THE TIME OF SERVICE AND INCLUDES A CHARITY APPLICATION WITH EVERY STATEMENT PER OHIO LAW. THE AMOUNT ON LINE 3 WAS OBTAINED BY A THIRD PARTY VENDOR, QUALINK, WHO REVIEWS ACCOUNTS ASSIGNED TO BAD DEBT WHO MAY QUALIFY FOR HCAP, OHIO'S PROGRAM FOR THE INDIGENT POPULATION, IN ORDER TO IDENTIFY ANY REMAINING DOLLARS THAT MAY QUALIFY FOR CHARITY.

**Part VI** Supplemental Information

PART III, LINE 8: SIMILAR TO CHA RECOMMENDATIONS, WHICH STATE THAT SERVING MEDICARE PATIENTS IS NOT A DIFFERENTIATING FEATURE OF TAX-EXEMPT HEALTHCARE ORGANIZATIONS AND THAT THE EXISTING COMMUNITY BENEFIT FRAMEWORK ALLOWS COMMUNITY BENEFIT PROGRAMS THAT SERVE THE MEDICARE POPULATION TO BE COUNTED IN OTHER COMMUNITY BENEFIT CATEGORIES, MOUNT CARMEL NEW ALBANY SURGICAL HOSPITAL DOES NOT BELIEVE ANY MEDICARE SHORTFALL SHOULD BE TREATED AS COMMUNITY BENEFIT.

PART III, LINE 8: COSTING METHODOLOGY FOR LINE 6 - MEDICARE COSTS WERE OBTAINED FROM THE FILED MEDICARE COST REPORT. THE COSTS ARE BASED ON MEDICARE ALLOWABLE COSTS AS REPORTED ON WORKSHEET B, COLUMN 27, WHICH EXCLUDE DIRECT MEDICAL EDUCATION COSTS. INPATIENT MEDICARE COSTS ARE CALCULATED BASED ON A COMBINATION OF ALLOWABLE COST PER DAY TIMES MEDICARE DAYS FOR ROUTINE SERVICES AND COST TO CHARGE RATIO TIMES MEDICARE CHARGES FOR ANCILLARY SERVICES. OUTPATIENT MEDICARE COSTS ARE CALCULATED BASED ON COST TO CHARGE RATIO TIMES MEDICARE CHARGES BY ANCILLARY DEPARTMENT.

PART III, LINE 9B: THE ORGANIZATION'S COLLECTION POLICY CONTAINS THE CRITERIA FOR FINANCIAL ASSISTANCE, AND CONTAINS THE FOLLOWING VERBIAGE FOR ARRANGEMENTS WITH OUTSIDE COLLECTION AGENCIES: THE AGREEMENT MUST DEFINE THE STANDARDS AND SCOPE OF PRACTICES TO BE USED BY OUTSIDE COLLECTION AGENTS ACTING ON BEHALF OF THE MINISTRY ORGANIZATION, ALL OF WHICH MUST BE IN COMPLIANCE WITH THIS POLICY.

PART VI, LINE 2: NEEDS ASSESSMENT-MOUNT CARMEL HEALTH SYSTEM, WHICH INCLUDES MOUNT CARMEL NEW ALBANY SURGICAL HOSPITAL, IS COMMITTED TO HELPING ASSESS AND ADDRESS THE HEALTHCARE NEEDS OF THE COMMUNITIES IT SERVES THROUGH ITS OWN PROGRAMS AND SERVICES AND IN PARTNERSHIP WITH

**Part VI** Supplemental Information

OTHERS.

MOUNT CARMEL HEALTH SYSTEM ASSESSES THE HEALTH NEEDS OF THE COMMUNITY THROUGH COMMUNITY HEALTH NEEDS ASSESSMENTS EVERY THREE (3) YEARS. A COMMUNITY HEALTH NEEDS ASSESSMENT IS A POINT-IN-TIME EFFORT TO MEASURE THE HEALTH AND WELL BEING OF THE COMMUNITY. IT SERVES AS THE BASIS FOR MOUNT CARMEL'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 HEALTH NEEDS ASSESSMENT ALSO SERVES AS A BENCHMARK FOR FUTURE ASSESSMENT OF RELATIVE PROGRESS TOWARD ESTABLISHED COMMUNITY HEALTH OBJECTIVES.

MOUNT CARMEL'S COMMUNITY HEALTH 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

MOUNT CARMEL'S COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS INVOLVES THE GATHERING OF TWO TYPES OF DATA: QUANTITATIVE (DEMOGRAPHICS, HEALTH INDICATORS, ETC.) AND QUALITATIVE (PUBLIC SURVEYS, FORUMS, FOCUS GROUPS). WHILE MOUNT CARMEL CONDUCTS SOME OF ITS OWN ORIGINAL RESEARCH IN

**Part VI** Supplemental Information

COMPLETING THE COMMUNITY NEEDS ASSESSMENT, IT ALSO RELIES UPON THE AVAILABILITY OF DATA COLLECTED BY OTHERS WHENEVER POSSIBLE TO AVOID UNNECESSARY DUPLICATION. THE DATA HELP SUPPORT SHORT-TERM AND LONG-TERM DECISIONS ABOUT ALLOCATION OF COMMUNITY HUMAN AND CAPITAL RESOURCES.

MOUNT CARMEL'S MOST RECENT COMMUNITY NEEDS ASSESSMENT WAS RELEASED IN JANUARY 2007. BESIDES ITS BOARD OF TRUSTEES, MOUNT CARMEL SHARES THE FINDINGS OF ITS COMMUNITY NEEDS ASSESSMENTS WITH OTHER NON-PROFIT ORGANIZATIONS AND GOVERNMENT OFFICIALS/ENTITIES AND SEEKS TO FORM COLLABORATIVE PARTNERSHIPS WITH THEM WHEN POSSIBLE TO AVOID UNNECESSARY DUPLICATION OF EFFORTS IN ADDRESSING IDENTIFIED COMMUNITY HEALTH NEEDS.

THE MOUNT CARMEL HEALTH SYSTEM IS IN THE PROCESS OF CONDUCTING A NEW SURVEY WHICH WILL BE COMPLETED BY JANUARY 30TH, 2012.

PART VI, LINE 3: PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE - MOUNT CARMEL HEALTH SYSTEM, INCLUDING MOUNT CARMEL NEW ALBANY SURGICAL HOSPITAL, 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.

**Part VI** Supplemental Information

IN ACCORDANCE WITH AMERICAN HOSPITAL ASSOCIATION (AHA) RECOMMENDATIONS,  
MOUNT CARMEL 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
- 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

MOUNT CARMEL HEALTH SYSTEM IS COMMITTED TO EFFECTIVELY COMMUNICATING WITH  
PATIENTS REGARDING PATIENT PAYMENT OBLIGATIONS. FINANCIAL COUNSELING IS  
PROVIDED TO PATIENTS ABOUT THEIR PAYMENT OBLIGATIONS AND HOSPITAL BILLS.  
INFORMATION ABOUT MOUNT CARMEL'S PATIENT FINANCIAL ASSISTANCE PROGRAM 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. THIS  
INFORMATION IS COMMUNICATED THROUGH PATIENT FINANCIAL SERVICES ASSOCIATES  
IN PATIENT REGISTRATION, CUSTOMER SERVICE, AND BILLING AND COLLECTIONS --  
ALL OF WHOM RECEIVE TRAINING REGARDING FEDERAL, STATE AND LOCAL PUBLIC  
FINANCIAL ASSISTANCE PROGRAMS AND MOUNT CARMEL'S PATIENT FINANCIAL  
ASSISTANCE PROGRAM. IN ADDITION, THE EXTERNAL COLLECTION AGENCIES AND  
EXTERNAL MEDICAID ELIGIBILITY VERIFICATION VENDOR WITH WHOM MOUNT CARMEL  
WORKS ALSO RECEIVE TRAINING REGARDING THESE PROGRAMS. ALL MOUNT CARMEL

**Part VI Supplemental Information**

PATIENT FINANCIAL STATEMENTS INCLUDE A FINANCIAL ASSISTANCE APPLICATION AND PHONE NUMBER FOR PATIENTS TO CALL WITH QUESTIONS.

FINANCIAL COUNSELORS MAKE AFFIRMATIVE EFFORTS TO HELP PATIENTS APPLY FOR PUBLIC AND PRIVATE PROGRAMS FOR WHICH THEY MAY QUALIFY AND WHICH MAY ASSIST THEM IN OBTAINING AND PAYING FOR HEALTHCARE SERVICES. MOUNT CARMEL HEALTH SYSTEM UTILIZES BOTH INTERNAL RESOURCES AND AN EXTERNAL VENDOR TO ASSIST PATIENTS IN APPLYING FOR MEDICAID. INPATIENTS, EMERGENCY DEPARTMENT PATIENTS, CLINIC PATIENTS, AND PATIENTS RECEIVING HIGH-COST OUTPATIENT SERVICES ARE SCREENED TO DETERMINE WHETHER THEY QUALIFY FOR FEDERAL, STATE OR LOCAL PUBLIC FINANCIAL ASSISTANCE PROGRAMS OR MOUNT CARMEL'S PATIENT FINANCIAL ASSISTANCE PROGRAM. 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.

MOUNT CARMEL HEALTH SYSTEM OFFERS FINANCIAL SUPPORT TO PATIENTS WITH LIMITED FINANCIAL MEANS WHO DO NOT QUALIFY FOR PUBLIC PROGRAMS LIKE MEDICAID OR OTHER PUBLIC ASSISTANCE. NOTIFICATION ABOUT FINANCIAL ASSISTANCE, INCLUDING CONTACT INFORMATION, IS COMMUNICATED VIA SIGNS THAT ARE PROMINENTLY DISPLAYED IN ALL PATIENT REGISTRATION AREAS. BROCHURES PLACED IN PATIENT REGISTRATION AREAS EDUCATE PATIENTS IN GREATER DETAIL ABOUT THE AVAILABILITY OF FEDERAL, STATE AND LOCAL ASSISTANCE PROGRAMS AS WELL AS MOUNT CARMEL'S PATIENT FINANCIAL ASSISTANCE PROGRAM.

SUMMARIES OF FEDERAL, STATE AND LOCAL PUBLIC FINANCIAL ASSISTANCE PROGRAMS AND MOUNT CARMEL'S OWN PATIENT FINANCIAL ASSISTANCE PROGRAM ALSO ARE MADE AVAILABLE THROUGH MOUNT CARMEL SERVICES THAT DIRECTLY INTERACT WITH THE

**Part VI** Supplemental Information

COMMUNITY, INCLUDING MOUNT CARMEL COMMUNITY OUTREACH AND MOUNT CARMEL HEALTH STATIONS CLINICS; OTHER ORGANIZATIONS THAT SERVE THE UNINSURED AND UNDERINSURED SUCH AS ACCESS HEALTH COLUMBUS; SOCIAL SERVICES AGENCIES LIKE CATHOLIC SOCIAL SERVICES AND HOMELESS SHELTERS; AND FEDERALLY QUALIFIED HEALTH CENTERS LIKE HEART OF OHIO FAMILY HEALTH CENTERS, AND LOWER LIGHTS CHRISTIAN HEALTH CENTER. INFORMATION REGARDING PATIENT FINANCIAL ASSISTANCE PROGRAMS ALSO IS AVAILABLE ON MOUNT CARMEL'S WEBSITE.

IN ADDITION TO ENGLISH, PATIENT FINANCIAL ASSISTANCE INFORMATION IS ALSO AVAILABLE IN SPANISH AND SOMALI FOR THOSE WITH LIMITED ENGLISH PROFICIENCY, REFLECTING OTHER PREDOMINANT LANGUAGES SPOKEN IN THE COMMUNITIES SERVED BY MOUNT CARMEL. MOUNT CARMEL ALSO HAS INTERPRETING SERVICES AVAILABLE FOR LIMITED ENGLISH PROFICIENCY PATIENTS WHO SPEAK OTHER LANGUAGES.

MOUNT CARMEL HEALTH SYSTEM HAS ESTABLISHED A WRITTEN POLICY FOR THE BILLING, COLLECTION AND SUPPORT FOR PATIENTS WITH PAYMENT OBLIGATIONS. MOUNT CARMEL HEALTH SYSTEM MAKES EVERY EFFORT TO ADHERE TO THE POLICY AND IS COMMITTED TO IMPLEMENTING AND APPLYING THE POLICY FOR ASSISTING PATIENTS WITH LIMITED MEANS IN A PROFESSIONAL, CONSISTENT MANNER. MOUNT CARMEL HEALTH SYSTEM EDUCATES STAFF MEMBERS WHO WORK CLOSELY WITH PATIENTS (INCLUDING THOSE WORKING IN PATIENT REGISTRATION, 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.

PART VI, LINE 4: COMMUNITY INFORMATION - MOUNT CARMEL HEALTH SYSTEM, WHICH INCLUDES MOUNT CARMEL NEW ALBANY SURGICAL HOSPITAL, PREDOMINATELY

**Part VI** Supplemental Information

SERVES CENTRAL OHIO, WHICH INCLUDES FRANKLIN AND FIVE CONTIGUOUS COUNTIES (DELAWARE, FAIRFIELD, LICKING, MADISON AND PICKAWAY). THIS REGION IS HOME TO NEARLY 1.7 MILLION RESIDENTS. AMONG CENTRAL OHIO HOUSEHOLDS, 20% HAVE A HOUSEHOLD INCOME OF LESS THAN \$25,000, AND ANOTHER 26% HAVE A HOUSEHOLD INCOME OF BETWEEN \$25,000 AND \$50,000.

OVER THE NEXT FIVE YEARS, CENTRAL OHIO'S POPULATION IS EXPECTED TO EXPERIENCE A HIGH GROWTH RATE (18%) IN ADULTS AGE 55 AND OLDER AND A SLIGHT DECLINE IN ADULTS BETWEEN THE AGES OF 18 AND 34. IN 2009, APPROXIMATELY 33% OF THE POPULATION OVER AGE 25 HELD A BACHELOR'S OR HIGHER DEGREE, NEARLY FIVE AND A HALF PERCENTAGE POINTS HIGHER THAN THE NATIONAL AVERAGE.

CENTRAL OHIO FEATURES A DIVERSE EMPLOYER BASE, INCLUDING MANUFACTURING, TRADE, EDUCATION, SERVICE, FINANCE AND AGRICULTURE. THE OCTOBER 2010 UNEMPLOYMENT RATE WAS 8.4%, A DECLINE OF 0.4 PERCENTAGE POINTS OVER NOVEMBER 2009.

ACCORDING TO THE 2008-2009 OHIO FAMILY HEALTH SURVEY, 138,625 ADULTS IN FRANKLIN COUNTY BETWEEN THE AGES OF 18-64, OR ABOUT 19% OF THAT POPULATION, DO NOT HAVE HEALTH INSURANCE. THIS NUMBER IS SLIGHTLY HIGHER THAN THE STATEWIDE PERCENTAGE OF 17% UNINSURED ADULTS IN THAT AGE GROUP.

PART VI, LINE 6: OTHER INFORMATION - ONE HUNDRED PERCENT OF MOUNT CARMEL'S SURPLUS REVENUE IS INVESTED BACK INTO SUPPORTING THE ORGANIZATION'S HEALTHCARE MINISTRY. MOUNT CARMEL HEALTH SYSTEM IS GOVERNED BY A 15-MEMBER BOARD OF TRUSTEES, WITH A MAJORITY OF THE SEATS ALLOCATED TO COMMUNITY REPRESENTATIVES AND LEADERS. OUR GOVERNANCE

**Part VI** Supplemental Information

STRUCTURE ENSURES THAT THE COMMUNITY AND ITS INTERESTS ARE STRONGLY REPRESENTED IN IMPORTANT DECISION-MAKING.

MOUNT CARMEL HEALTH SYSTEM MAINTAINS AN OPEN MEDICAL STAFF - MEDICAL STAFF PRIVILEGES ARE EXTENDED TO ALL QUALIFIED PHYSICIANS. MOUNT CARMEL ACTIVELY RECRUITS, AND EMPLOYS DOCTORS TO SERVE IN UNDER-SERVED AREAS OF THE COMMUNITY. MOUNT CARMEL HEALTH SYSTEM ALSO HELPS TRAIN MEDICAL PROFESSIONALS BY OPERATING A GRADUATE MEDICAL EDUCATION PROGRAM THAT TRAINS PHYSICIANS IN FAMILY PRACTICE, INTERNAL MEDICINE, OBSTETRICS & GYNECOLOGY, GENERAL SURGERY, ORTHOPEDIC SURGERY AND TRANSITIONAL YEAR (FOR PHYSICIANS WHO WANT TO PURSUE SUB-SPECIALTY TRAINING.)

SYSTEM WIDE SENIOR LEADERSHIP MEMBERS SERVE ON A NUMBER OF BOARDS FOR COMMUNITY AGENCIES SUCH AS THE WESTSIDE HEALTH ADVISORY BOARD, FRANKLINTON AREA COMMISSION, HILLTOP BUSINESS ASSOCIATION, THE NEW ALBANY CHAMBER OF COMMERCE, AND THE LIFELINE OF OHIO (LOOP) BOARD.

PART VI, LINE 7: MOUNT CARMEL NEW ALBANY SURGICAL HOSPITAL 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 2010, THIS INCLUDED NEARLY \$456 MILLION IN SUCH COMMUNITY BENEFITS. THEREFORE,

**Part VI** Supplemental Information

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.

FOR MORE INFORMATION ABOUT TRINITY HEALTH, VISIT [WWW.TRINITY-HEALTH.ORG](http://WWW.TRINITY-HEALTH.ORG).