

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 **SAINT ALPHONSUS MEDICAL CENTER - ONTARIO, INC.** Employer identification number **27-1789847**

Part I Charity Care and Certain Other Community Benefits at Cost

	Yes	No
1a Does the organization have a charity care policy? If "No," skip to question 6a	<input checked="" type="checkbox"/>	<input type="checkbox"/>
1b If "Yes," is it a written policy?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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 checked="" 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 _____ %		<input checked="" type="checkbox"/>
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 _____ %		<input checked="" type="checkbox"/>
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"?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5a Does the organization budget amounts for free or discounted care provided under its charity care policy?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
b If "Yes," did the organization's charity care expenses exceed the budgeted amount?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6a Does the organization prepare an annual community benefit report?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
b If "Yes," does the organization make it available to the public?	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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	266	455,490.		455,490.	3.57%
b Unreimbursed Medicaid (from Worksheet 3, column a)	1	1,967	1,644,055.	1,391,582.	252,473.	1.98%
c Unreimbursed costs - other means-tested government programs (from Worksheet 3, column b)						
d Total Charity Care and Means-Tested Government Programs ...	2	2,233	2,099,545.	1,391,582.	707,963.	5.55%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	7	5,998	60,232.		60,232.	.47%
f Health professions education (from Worksheet 5)	1	8	7,475.		7,475.	.06%
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions to community groups (from Worksheet 8)	6		20,253.		20,253.	.16%
j Total. Other Benefits	14	6,006	87,960.		87,960.	.69%
k Total. Add lines 7d and 7j	16	8,239	2,187,505.	1,391,582.	795,923.	6.24%

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	1	100	50,948.	50,948.	.40%
9	Other					
10	Total	1	100	50,948.	50,948.	.40%

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?		X
2 Enter the amount of the organization's bad debt expense (at cost)		
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		
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	3,762,057.
6 Enter Medicare allowable costs of care relating to payments on line 5	6	3,959,234.
7 Subtract line 6 from line 5. This is the surplus or (shortfall)	7	<197,177.>
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				
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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 3C: PATIENTS WHO QUALIFY FOR CHARITY CARE DISCOUNTS ARE IDENTIFIED AS SOON AS POSSIBLE, EITHER BEFORE SERVICES ARE PROVIDED OR AFTER AN INDIVIDUAL HAS RECEIVED SERVICES TO STABILIZE A MEDICAL CONDITION. ALL AVAILABLE FINANCIAL RESOURCES SHALL BE EVALUATED BEFORE DETERMINING FINANCIAL ASSISTANCE ELIGIBILITY. CONSIDERATION OF FINANCIAL RESOURCES IS REVIEWED AND DETERMINED NOT ONLY OF THE PATIENT, BUT ALSO OF OTHER PERSONS HAVING LEGAL RESPONSIBILITY TO PROVIDE FOR THE PATIENT. ELIGIBILITY FOR CHARITY CARE DISCOUNTS SHALL BE DETERMINED BASED ON 130% OF THE ANNUALLY UPDATED HUD GEOGRAPHIC VERY-LOW INCOME GUIDELINES, AVAILABLE ASSETS AND ANY EXTENUATING CIRCUMSTANCES. THUS, THE STANDARDS OF ELIGIBILITY FOR THE APPLICATION OF CHARITY DISCOUNTS MUST CONSIDER ASSETS, AS WELL AS INCOME.

PART I, LINE 6A: SAINT ALPHONSUS MEDICAL CENTER - ONTARIO PREPARES AN ANNUAL COMMUNITY BENEFIT REPORT, WHICH IT SUBMITS TO THE STATE OF OREGON. IN ADDITION, SAINT ALPHONSUS MEDICAL CENTER - ONTARIO 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.

SAINT ALPHONSUS MEDICAL CENTER - ONTARIO ALSO WILL BE INCLUDING A COPY OF

Part VI Supplemental Information

ITS MOST RECENTLY FILED SCHEDULE H ON BOTH ITS OWN WEBSITE AND TRINITY HEALTH'S WEBSITE.

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, \$401,438, 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 I, LINE 7, COLUMN (F).

PART III, LINE 4: SAINT ALPHONSUS MEDICAL CENTER - ONTARIO 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

Part VI Supplemental Information

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.

TO CALCULATE THE AMOUNT IN QUESTION 3, A REVIEW WAS PERFORMED ON ACTUAL BAD DEBT FILES SUBMITTED TO THE HOSPITAL'S COLLECTION AGENCY IN 6/10, 7/10, AND 8/10. TOTAL CHARGES SENT TO COLLECTIONS WERE \$806,205. THE REVIEW WAS PERFORMED ON ACCOUNTS WITH BALANCES GREATER THAN \$5,000 AND INCLUDED ACCOUNT NOTES AND DETERMINATIONS MADE PER DISCUSSIONS WITH FINANCIAL COUNSELORS, COLLECTORS, ETC. SOME PATIENTS COULD HAVE BEEN CHARITY ELIGIBLE IF THEY HAD COMPLIED WITH SUBMISSION OF REQUIRED DOCUMENTATION, BUT FAILED TO DO SO, THEREFORE THEIR ACCOUNTS CONTINUED THROUGH THE SELF PAY PROCESS. THOSE ACCOUNTS TOTALED \$84,904 WHICH EQUATES TO APPROXIMATELY 10%.

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, SAINT ALPHONSUS MEDICAL CENTER - ONTARIO DOES NOT BELIEVE ANY MEDICARE SHORTFALL SHOULD BE TREATED AS COMMUNITY BENEFIT.

PART III, LINE 8: COSTING METHODOLOGY FOR LINE 6 - MEDICARE COSTS WERE

Part VI Supplemental Information

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: SAINT ALPHONSUS MEDICAL CENTER - ONTARIO'S COLLECTION POLICY CONTAINS THE CRITERIA FOR FINANCIAL ASSISTANCE, AND CONTAINS THE FOLLOWING VERBIAGE FOR ARRANGEMENTS WITH OUTSIDE COLLECTION AGENCIES: THE ORGANIZATION'S CENTRALIZED BUSINESS OFFICE (CBO) WILL BE REQUIRED TO AUDIT ITS THIRD PARTY COLLECTION AGENTS AT LEAST ANNUALLY FOR ADHERENCE TO THESE STANDARDS.

PART VI, LINE 2: NEEDS ASSESSMENT - SAINT ALPHONSUS MEDICAL CENTER - ONTARIO IS CURRENTLY PARTNERING WITH SAINT ALPHONSUS HEALTH SYSTEM AND THE MALHEUR COUNTY DISTRICT HEALTH DEPARTMENT TO ASSESS THE HEALTH NEEDS OF OUR EXTENDED COMMUNITY. THIS COMPREHENSIVE ASSESSMENT WILL BE COMPLETED BY FISCAL YEAR END 2011. IN THE FUTURE, SAINT ALPHONSUS MEDICAL CENTER - ONTARIO WILL COMPLETE A COMMUNITY NEEDS ASSESSMENT EVERY THREE YEARS. A COMMUNITY NEEDS ASSESSMENT IS A POINT-IN-TIME EFFORT TO MEASURE THE HEALTH AND WELL BEING OF THE COMMUNITY. IT WILL SERVE AS THE BASIS FOR SAINT ALPHONSUS MEDICAL CENTER - ONTARIO'S STRATEGIC AND SUBSEQUENT ACTION PLANNING TO 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

Part VI Supplemental Information

OBJECTIVES.

THE SAINT ALPHONSUS 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

THE SAINT ALPHONSUS 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.

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

SAINT ALPHONSUS MEDICAL CENTER-ONTARIO 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

Part VI Supplemental Information

QUALITY AND QUANTITY OF SERVICES FOR ALL WHO MAY NEED CARE IN A COMMUNITY

IN ACCORDANCE WITH AHA RECOMMENDATIONS, SAINT ALPHONSUS MEDICAL CENTER-ONTARIO 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

SAINT ALPHONSUS MEDICAL CENTER-ONTARIO 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. ALL SELF-PAY PATIENTS ARE OFFERED FINANCIAL ASSISTANCE FORMS. EACH PATIENT RECEIVES INFORMATION ABOUT PAYMENT OPTIONS AND HOW TO APPLY FOR CHARITY CARE. PATIENTS ALSO ARE SCREENED FOR MEDICAID ELIGIBILITY, UTILIZING FINANCIAL ASSISTANCE FORMS.

FINANCIAL COUNSELORS MAKE AFFIRMATIVE EFFORTS TO HELP PATIENTS APPLY FOR PUBLIC AND PRIVATE PROGRAMS FOR WHICH THEY MAY QUALIFY AND THAT MAY HELP

Part VI Supplemental Information

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.

SAINT ALPHONSUS MEDICAL CENTER-ONTARIO 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. SELF-PAY INPATIENTS AND SURGERY PATIENTS ARE VISITED BY AN ASSOCIATE FROM PATIENT FINANCIAL SERVICES WHO ASSISTS THEM IN COMPLETING FINANCIAL ASSISTANCE FORMS FOR COUNTY INDIGENT ASSISTANCE, MEDICAID, SOCIAL SECURITY AND HOSPITAL CHARITY CARE.

SAINT ALPHONSUS MEDICAL CENTER-ONTARIO HAS ESTABLISHED A WRITTEN POLICY FOR THE BILLING, COLLECTION AND SUPPORT FOR PATIENTS WITH PAYMENT OBLIGATIONS. SAINT ALPHONSUS MEDICAL CENTER-ONTARIO 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. THE MEDICAL CENTER 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.

PART VI, LINE 4: COMMUNITY INFORMATION - THE PRIMARY SERVICE AREA OF SAINT ALPHONSUS MEDICAL CENTER-ONTARIO ENCOMPASSES A FOUR COUNTY REGION OF

Part VI Supplemental Information

SOUTHWESTERN IDAHO AND EASTERN OREGON, INCLUDING WASHINGTON, PAYETTE,
MALHEUR AND BAKER COUNTIES.

AREA HOSPITAL FACILITIES INCLUDE SAINT ALPHONSUS REGIONAL MEDICAL CENTER
(BOISE), ST. LUKE'S, IDAHO ELKS REHABILITATION CENTER, TREASURE VALLEY
HOSPITAL, SAINT ALPHONSUS MEDICAL CENTER-NAMPA, WEST VALLEY MEDICAL
CENTER, AND WALTER KNOX MEMORIAL HOSPITAL.

SAINT ALPHONSUS' SERVICE AREA IS PRIMARILY COMPOSED OF SMALL RURAL
COMMUNITIES WITHIN THE WEST END OF THE TREASURE VALLEY, BORDERED BY
EXTENSIVE FARMLANDS, RUGGED MOUNTAINOUS TERRAIN AND DESERT. THE REGION
DIRECTLY EAST HAS EXPERIENCED RAPID POPULATION GROWTH SINCE 2000, WITH
GROWTH OF 25.5% BETWEEN 2000 AND 2006. CLOSER TO ONTARIO THE GROWTH HAS
BEEN MUCH LOWER, WITH PAYETTE COUNTY IN IDAHO SEEING THE BIGGEST GROWTH.
THE ONTARIO REGION IS A DIVERSE COMMUNITY ENJOYING JAPANESE, LATINO,
BASQUE, AND WESTERN AMERICAN CULTURES.

WITH MEDIAN HOUSEHOLD INCOMES OF \$36,403 IN MALHEUR COUNTY AND \$40,707 IN
PAYETTE COUNTY, AREA RESIDENTS ARE SIGNIFICANTLY BELOW THE STATE MEDIANS
OF \$50,165 (OR), AND \$47,561 (ID). THE POVERTY LEVEL STANDS AT 21.3% IN
MALHEUR COUNTY AND 14.6% IN PAYETTE, COMPARED TO STATE AVERAGES OF 13.5%
(OR) AND 12.5% (ID) AND A NATIONAL AVERAGE OF 13.2%. ANECDOTALLY, CURRENT
UNEMPLOYMENT APPEARS TO BE HIGHER THAN IT HAS BEEN IN MANY YEARS.

MEDICALLY UNDERSERVED POPULATIONS AND HEALTH PROFESSIONAL SHORTAGE AREAS
WITHIN OUR SERVICE AREA INCLUDE A SHORTAGE OF PRIMARY CARE, SPECIALTY
PHYSICIANS, ADDICTION TREATMENT, AND MENTAL HEALTH SERVICES.

Part VI Supplemental Information

PART VI, LINE 5: COMMUNITY BUILDING ACTIVITIES - SAINT ALPHONSUS

MEDICAL CENTER-ONTARIO IS A PARTNER IN THE COMMUNITIES IT SERVES. HOWEVER,
WE DO NOT HAVE THE BUDGET TO PROVIDE EXTENSIVE PROACTIVE SERVICES, DUE TO
OUR SIZE AND THE EXTENSIVE CHARITY CARE WE PROVIDE.

IN ADDITION, OUR MANAGERS AND SENIOR LEADERS ARE INVOLVED WITH A NUMBER OF
AREA ORGANIZATIONS LIKE AREA CHAMBERS OF COMMERCE, AND SERVICE
ORGANIZATIONS PROMOTING VARIOUS HEALTH TOPICS. SAINT ALPHONSUS MEDICAL
CENTER-ONTARIO WAS ALSO INSTRUMENTAL IN STARTING (AND STILL SPONSORING)
THE FOUR RIVERS HEALTHY COMMUNITY COALITION, WHICH IS WORKING ON A NUMBER
OF PROJECTS IN THE AREA. IN ADDITION, WE ASSIST THE FOLLOWING GROUPS WITH
FREE MEETING SPACE:

-ALCOHOLICS ANONYMOUS

-AMBULATORY CARE NURSING MEETINGS

-BARIATRIC SUPPORT GROUP

-CLIFF BENTZ (STATE REPRESENTATIVE)

-COJJC JUVENILE JUSTICE

-DEPRESSION SUPPORT GROUP

-OR. DEPT OF HUMAN SERVICES

-DAVITA DIALYSIS

-ONTARIO CHAMBER

SENIOR LEADERS AND DIRECTORS ASSIST THE FOLLOWING COMMUNITY ORGANIZATIONS
AS WELL: SNAKE RIVER ECONOMIC DEVELOPMENT ASSOCIATION, CHAMBERS OF
COMMERCE IN THREE AREA COMMUNITIES AND PROJECT DOVE, A LOCAL NON-PROFIT
ADDRESSING DOMESTIC ABUSE.

AS A MEDICALLY UNDERSERVED AREA, SAINT ALPHONSUS MEDICAL CENTER - ONTARIO

Part VI Supplemental Information

HAS ALSO BEEN VERY AGGRESSIVE IN RECRUITING PHYSICIANS TO THIS AREA. THE RECRUITMENT STRATEGY IS IN RESPONSE TO NEEDS IDENTIFIED DURING OUR STRATEGIC PLANNING PROCESS, WHICH INCLUDED A VARIETY OF DISCUSSIONS AND FOCUS GROUPS WITH COMMUNITY MEMBERS, AND KEY PARTNERS AND STAKEHOLDERS.

PART VI, LINE 6: OTHER INFORMATION - SAINT ALPHONSUS MEDICAL CENTER-ONTARIO STRONGLY SUPPORTS HEALTHCARE WORKFORCE DEVELOPMENT EFFORTS, INCLUDING ANNUAL FINANCIAL SUPPORT TO THE TREASURE VALLEY COMMUNITY COLLEGE NURSING PROGRAM. IN ADDITION, SAINT ALPHONSUS MEDICAL CENTER-ONTARIO SERVES AS A KEY CLINICAL TRAINING SITE FOR NURSES AND OTHER ALLIED HEALTH PROFESSIONALS.

PART VI, LINE 7: SAINT ALPHONSUS MEDICAL CENTER-ONTARIO 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, 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.

Part VI Supplemental Information

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

PART VI, LINE 8, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:

OR