Prepared by Dan Hodgins, Vice President Community Benefit

Community Benefit Report

Fiscal Year 2015

Figure 1. Part I Schedule H

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No. 1545-0047

2015

Open to Public Inspection

Name of the organization	Employer identification number
Community Health Network	35 0983617

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

Part I: 1.a & b

Figure 2. Actual 2015 Community Health Network Financial Assistance Policy

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

APPROVED FOR:

- ☑ COMMUNITY HEALTH NETWORK FOUNDATION, INC.
- ☑ COMMUNITY HEALTH NETWORK, INC.
- ☑ COMMUNITY HOSPITAL SOUTH, INC.
- ☑ COMMUNITY HOSPITALS OF INDIANA, INC.
- ☑ COMMUNITY HOWARD REGIONAL HEALTH
- ☑ COMMUNITY PHYSICIAN NETWORK
- ☑ INDIANA PROHEALTH NETWORK, INC.
- ☑ VISIONARY ENTERPRISES, INC.
- ☑ COMMUNITY HEART AND VASCULAR HOSPITAL
- ☑ COMMUNITY HOSPITAL WESTVIEW

Original Date:	04/01/2006		
Effective Date:	01/01/2016		
Revised/Reviewed	Change Summary	Revised/Reviewed	Change Summary
12/13/05	Revised Section 4.1	2/12/2008	Addition Section 3.3
02/03/06	Revised Section 3.5	2/2/2009	Update Poverty Guidelines and 1.16.1
06/16/06	Delete Section 1.11.5	11/5/2010	Revised
11/01/06	Addition Section 3.9-3.12	1/1/2012	Major Revision- Sliding Scale/ policy; restructure
01/15/07	Addition Section 6	12/13/13	Revised
1/29/2007	Revised Section 3.5	10/7/2014	Revised
3/29/2007	Delete Attachment C and Section 1.11.3	10/29/2014	ADDED SECTION 8.16
1/29/2008	Update Poverty Guidelines	12/17/2015	UPDATED PER 501R

POLICY

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

PURPOSE

To ensure policy and procedures exist for identifying those patients for whom service is to be rendered free of charge, or at a discount, based solely on ability to pay, financial condition and availability of third-party funding. To clearly differentiate those patients eligible for Financial Assistance based on established guidelines, from those patients with financial resources who are unwilling to pay.

PHILOSOPHY

The Community Health Network, in keeping with its mission, serves the medical needs of the community, regardless of race, creed, color, sex, national origin, sexual orientation, handicap, residence, age, ability to pay, or any other classification or characteristic. We recognize the need to render care to the sick that do not possess the ability to pay. Medically necessary health care services will be provided to these patients with no expected reimbursement, or at a reduced level of reimbursement, based upon established criteria, recognizing the need to maintain the dignity of the patient and family during the process. We expect all responsible parties with the ability to pay, to meet their financial obligations in a timely and efficient manner, in accordance with our collection policies. The amount of free or

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Figure 2. Actual 2015 Community Health Network Financial Assistance Policy (cont.)

COMMUNITY HEALTH NETWORK
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discounted care considered will be reviewed and approved without jeopardizing our continued financial viability.

DEFINITIONS

Amount Generally Billed (AGB): The amount generally billed to insured patients for emergent or medically necessary care as calculated by reviewing the prior 12 month closed claim reimbursement rate for Medicare and Commercial Insurance. AGB is updated annually.

Applicant: Patient or Guarantor requesting screening for the Financial Assistance Program. This may include an individual or a family (multiple wage earners within the same home) that fulfill the definition of "Family" below.

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

Emergency Care: Immediate care that is necessary to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions, and/or serious dysfunction of any organs or body parts

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

Family Income: Family Income is determined using the Census Bureau definition, which uses the following income when computing Federal Poverty Guidelines: earnings, unemployment compensation, workers' compensation, social security, supplemental security income, public assistance, veteran's payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources; Non-cash benefits (such as food stamps and housing subsidies) do not count; Determined on a before tax basis; Excludes capital gains and losses; If a person lives with family, includes the income of all family members (non-relatives, such as housemates, do not count).

Gross Charges: The full amount charged by Community for items and services before any discounts, contractual allowances or deductions are applied.

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

Medically Necessary: Hospital services or care rendered, both outpatient and inpatient, to a patient in order to diagnose, alleviate, correct, cure or prevent the onset or worsening of conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a

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Figure 2. Actual 2015 Community Health Network Financial Assistance Policy (cont.)

COMMUNITY HEALTH NETWORK
NETWORK POLICY & PROCEDURE

TITLE: Financial Assistance Program

handicap, or result in overall illness of infirmity.

Presumptive Eligibility: The process by which Community may use previous eligibility determinations and/or information from sources other than the individual to determine eligibility for financial assistance.

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

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

Urgent Care: Medically necessary care to treat medical conditions that are not immediately life-threatening, but could result in the onset of illness or injury, disability, death or serious impairment or dysfunction if not treated within 12-24 hours.

Cost of Care: In cases where discounts or the Financial Assistance Policy may apply, adjustments will be made to total gross charges unless otherwise specified.

1.0 Policy Terms

1.1. Provision of Financial Assistance: Annually, Community will establish a percentage of total consolidated operating expenses to be allotted for Financial Assistance as a component of the larger category of Community Benefits. Further, we will monitor our ratio of Community Benefit cost to total consolidated operating expense and benchmark against pre-determined components of the applicable market with a goal of providing Community Benefits in total at a ratio better than average within the applicable market served.

1.2. Non-discrimination: We will render services to our patients who are in need of Medically Necessary Services regardless of the ability of the Responsible Party to pay for such services. The determination of full or partial Financial Assistance will be based on the ability to pay and financial condition and will not be based on race, creed, color, sex, national origin, sexual orientation, handicap, residence, age, or any other classification or characteristic. Further, and following a determination of Financial Assistance Program eligibility, and in accordance with the Affordable Care Act (ACA), the eligible individual will not be charged more for emergency or other medically necessary services than the amounts generally billed to individuals who have insurance covering such services.

1.3. Available Services: All available medically necessary health care services, inpatient and outpatient, will be available to all individuals under this policy. Specifically, the following healthcare services fall within the scope of the Financial Assistance Program at Community:

- Emergency Medical Services provided in an Emergency department setting at any Community Health Network hospital (RC 450,451),
- Services delivered in any setting that if delayed would result in an adverse change in the health status of a patient,
- Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting,
- Medically necessary services, as rendered or referred by a physician and evaluated

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Figure 2. Actual 2015 Community Health Network Financial Assistance Policy (cont.)

COMMUNITY HEALTH NETWORK
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on a case by case basis. Such necessary services delivered in a non-emergency setting may be performed at the discretion of Community and its physicians at a pre-determined site of service/level of care in order to be deemed eligible for financial assistance.

- Those applicants approved for financial assistance may be asked to participate in Community's IPCT program. Should the applicant be asked to become a part of the program, on-going participation will be a requirement for subsequent financial assistance.

1.4. Program Exclusions:

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

- Cosmetic procedures (plastics)
- Bariatric procedures
- Infertility Services
- Certain orthopedic procedures as determined by the network.

1.4.2. Charity Care is not considered a substitute for personal responsibility and patient or guarantor will be expected to contribute to the cost of care based upon the ability to pay. For this reason, the following will be excluded from provision of charity coverage:

1.4.2.1. Coverage under the Community program will only be provided to citizens of the United States or legally documented aliens and applicants may be asked to provide documentation related to their citizenship or legal status.

1.4.2.2. Coverage will exclude applicants residing outside of the state of Indiana. See Attachment A.

1.4.2.3. Coverage will exclude provision of Charity Care for any co-payment amount an applicant may be contractually obligated to pay to Community Health per the terms and conditions existing between the applicant and their insurance carrier. Further, it is the expectation that fifty-percent (50%) of any deductibles be paid, in advance, of scheduling medical treatment.

1.4.2.4 For uninsured patients, coverage will exclude an initial portion as described below that an applicant will be responsible for as their contribution to the cost of care received. This "applicant contribution" portion will apply to each episode of care, except for recurring visits billed every 30 days as a single account. The applicant contribution portions are as follows:

- Twenty dollars ($20.00) for each primary care visit,
- Thirty-five dollars ($35.00) for each specialty care visit,
- One-hundred twenty-five dollars ($125.00) for each outpatient and/or emergency room visit.

1.4.2.5 Coverage exceptions may be made in the case of financial hardships due to excessive medication costs, extensive hospitalizations or other extenuating circumstances. Determination of coverage of these special circumstances will be reviewed on a case by case basis and requests for such exceptions must be submitted, in writing, to the Vice President, Revenue Cycle or Executive Director, Patient Financial Services with supporting documentation detailing the special circumstances. In such cases, it is generally determined that the household is responsible for medical expenses

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Figure 2. Actual 2015 Community Health Network Financial Assistance Policy (cont.)

COMMUNITY HEALTH NETWORK
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equal to 25% of their annual income. Guarantors do not have to live in a health care district to claim financial hardship. Reference Section 3.1, Liability Limitation for additional information on medical hardship.

2.0 Determination of Eligibility

2.1. Emergency Services: In keeping with the Emergency Medical Treatment and Labor Act (EMTALA), as amended from time to time, no determination of eligibility will be attempted until after an appropriate medical screening examination and necessary stabilizing treatment have been provided. If the patient requires Emergency Services, the determination of eligibility will be made after services have been rendered.
2.2. Non-Emergency Services: In non-emergency situations the determination of eligibility for Financial Assistance will be made *before* providing services. If complete information on the patient's insurance or the responsible party's financial situation is unavailable prior to rendering services or at the time of services, the determination of eligibility will be made after rendering services.
2.3. All efforts will be made to establish eligibility for Financial Assistance before the patient leaves the facility/first patient visit concludes.

3.0 Confidentiality and Participation

3.1. The need for Financial Assistance may be a sensitive and deeply personal issue for the patient/family. Confidentiality of information and preservation of individual dignity will be maintained for all who seek Financial Assistance. Orientation and training of staff and the selection of personnel who will implement this policy and procedure will be guided by these values. No information obtained in the Financial Assistance application may be released unless the patient/responsible party gives express written permission for such release.
3.2. Staff Information: All employees in patient registration, billing, collections, patient accounting, finance and emergency services areas will understand the fundamentals of the Financial Assistance Policy and be able to direct questions to the appropriate staff member(s).
3.3. Staff Training: All staff with public and patient contact will be trained to understand the basic information related to the Financial Assistance Policy and will provide responsible parties with printed material explaining the Financial Assistance Program.
3.4. Financial Assistance Appeals Committee: The network will maintain a Financial Assistance Appeals Committee or process that provides for at least three (3) members to review appeals from those whose applications have been denied or which do not provide for a level of Financial Assistance to which the responsible parties believe they are eligible.
3.5. Physician Participation: We will encourage and support physicians not employed by Community who possess admitting privileges and others who provide services to our patients to establish and implement a Financial Assistance Program for the patients they see in connection with services rendered by Community. We will provide qualification status for individual patients, upon request, to physicians who are making efforts to financially clear their patient. Such communication will reveal minimum necessary information.

4.0 Collection Efforts

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Figure 2. Actual 2015 Community Health Network Financial Assistance Policy (cont.)

COMMUNITY HEALTH NETWORK
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TITLE: Financial Assistance Program

4.1. Notwithstanding any other provision of any other policy at Community regarding billing and collection matters, Community will not engage in any extraordinary collection actions before it makes reasonable efforts to determine whether an individual who has an unpaid bill from Community is eligible for financial assistance under this policy. The actions Community may take in the event of nonpayment and the process and timeframes for taking these actions are more fully described in Community's Billing and Collections Policy. A free copy of this policy may be obtained on line at ecommunity.com or by calling the Customer Service.

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

5.0 Notification/Duty to Inform

Community will undertake the following efforts to widely publicize its Financial Assistance Policy:

5.1. Written Notification - A Financial Assistance Program Summary (Attachment C) will be posted in each patient registration and waiting area and available online at ecommunity.com. In the case of services rendered in the home, the Financial Assistance Summary will be provided to the responsible party during the first in-home visit. All publications and informational materials related to the Financial Assistance Program will be translated into languages appropriate to the population in the service area.
5.2. Oral Notification: All points of access will make every effort to inform each responsible party about the existence of Community's Financial Assistance Program in the appropriate language during any pre-admission, registration, admission or discharge process. Additionally, the post- service collection process will integrate notification of the availability of assistance into the standard process when collection efforts fail.
5.3. Statement Notification: Statements will provide information about the Financial Assistance Program.
5.4. "About Your Bill: Frequently Asked Questions:" Copies of these documents will be available in patient registration areas, through the Business Offices and Patient Financial Counselors, as well as available online at ecommunity.com.
5.5. Community will make available a notice titled "Registering for Services: What You Need to Know". This notice will be available in patient registration areas and through the Business Offices and Patient Financial Counselors.
5.6. Community will make a plain language summary of the policy available online at ecommunity.com. All publications and informational materials related to the Financial Assistance Program published on the website will be translated into languages appropriate to the population in the service area. We will provide this website to any individual who asks how to access the plain language summary of the policy.
5.7. Community will make reasonable efforts to inform and notify residents of the community served about the Financial Assistance Policy in a manner reasonably calculated to reach those members of the community who are most likely to require financial assistance. Modes of delivery of this information may include newsletters, brochures and/or the provision of on-line access.

6.0 Uniformity Across Network

Figure 2. Actual 2015 Community Health Network Financial Assistance Policy (cont.)

COMMUNITY HEALTH NETWORK
NETWORK POLICY & PROCEDURE

TITLE: Financial Assistance Program

6.1. This Policy applies to all Community Health Network corporations that provide healthcare items and services to patients as adopted by the applicable Boards of Directors and in accordance with the guidance provided by 501r requirements. The only exclusions to this are certain business units operating separate Financial Assistance Program due to regulations or statutory requirements. Such entities listed in Table 1.3.
6.2. Reporting: Reporting of Financial Assistance shall be in accordance with all applicable laws, rules and regulations including Indiana Code 16-21-9-7, as amended and re-codified from time to time. Such report will be made available to the public upon request.
6.3. Corporate Responsibility: Each corporation's principal executive officer or officers and the principal financial officer or officers, or persons performing similar functions, will certify in each annual report, that the signing officer has reviewed the report and based on the officer's knowledge, the report does not contain any untrue statements of a material fact or omits to state a material fact.
6.4. Accounting: Accounting for Financial Assistance will be in accordance with the Community Benefits Accounting Policy.
6.5. Internal Record Keeping: Application for Financial Assistance: When required, *completed* applications will be kept on file for at least five (5) years. A copy of the application and all correspondence regarding the application, approval, denial and/or appeal will be maintained and available in the network's imaging system. All debt discharged shall be recorded in a manner in keeping with the resources available to each corporation/business unit and in a manner that permits access to such information for record keeping, reporting and analysis purposes.
6.6. Automatic Discounts for the Uninsured: All automatic discounts for the Uninsured will be coded specifically as an "automatic discount for the Uninsured" in a manner in keeping with the resources available to each corporation/business unit and in a manner that permits access to such information for record keeping, reporting and analysis purposes. Applicants who are determined to qualify for the applicable charity discount will not be provided the automatic discount for the uninsured.
6.7. Prohibition on Medical Record Documentation: No records will be placed in or notations made in a patient's health (medical) record regarding financial matters, including whether the patient paid all or part of any medical bills.

7.0 Extenuating Circumstances for Presumptive Eligibility

7.1. The financial clearance process may include investigation and collection of relevant documentation to verify available income from all qualifying sources (current and past), family size, and other factors that may affect the network's decision to extend charity care or assistance to an individual. Any individual that follows the financial clearance process and ultimately meets the network's financial guidelines will receive free care or substantially discounted services according to the applicant's financial resources.
7.2. Generalized Patient Situation: The following are examples that can serve as guidelines for Charity Care consideration:

- Uninsured patients who lack the ability to pay,
- Insured patients who lack the ability to pay for services not covered by their insurer, excluding applicable insurer co-payments,
- Deceased patient without an estate,

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Figure 2. Actual 2015 Community Health Network Financial Assistance Policy (cont.)

COMMUNITY HEALTH NETWORK
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- Unsupported disabled patient with little or no income,
- Patients involved in a medical catastrophe resulting in financial hardship.

7.3. Interested Party Requests: Requests for consideration of discharge of debt may be proposed by sources other than the responsible party, such as the patient's physician(s), family members, community or religious groups, social services organizations, or Community personnel. We will inform the responsible party of such a request and it will be processed as any other such request.

7.4. Conversion from Uninsured: When an uninsured patient has been given a discount on an account(s) and the patient subsequently qualifies for free care for those accounts, total gross charges will be applied to the traditional Charity Care component of Community Benefit.

7.5. Presumptive Eligibility for Financial Assistance: There may be instances when a patient is unable to complete the financial assistance application and/or supply the necessary supporting documentation. In such cases, the financial counselor shall complete the enrollment form on behalf of a patient and search for evidence of financial need. For non-Medicare Traditional enrolled applicants, Community staff will use all available resources to verify such information including public databases, credit reports, or other directories. Such examples include:

- Current enrollment in State assistance program (food stamps, welfare, certain pharmaceutical assistance programs, etc.)- AUTOMATIC Eligibility.
- Natural Disaster victim as designated by federally published zip codes- AUTOMATIC Eligibility.
- Low-income housing resident, supported by a county appraisal district record- AUTOMATIC Eligibility.
- Patient is eligible for other unfunded state or local assistance programs
- Patient receives free care from a community clinic and is referred to Community for further treatment
- Unfavorable credit history (delinquent accounts; charge-offs; bankruptcy filing within past year; no credit).
- Lack of family support for incapacitated patient.
- Mental incompetence as declared by a licensed medical professional.
- A deceased patient with no estate and with no other responsible party for payment has met the criteria necessary for us to write-off the discharged debt to Charity Care.

7.6. We will assume a homeless patient, with no evidence of assets through communication with the patient, credit reports and other appropriate means and with, to the best of our knowledge, no responsible party, financial assistance from a Government Benefit Plan or Government Sponsored Health Care for the Indigent for payment, has met the criteria necessary to write-off discharged debt to Charity Care.

7.7. Terms of the Community Financial Assistance Program will only be applicable to those individuals who are demonstrated to be citizens of the United States or legally documented aliens and have provided proof of citizenship or legal status as needed.

7.8. When a Medicaid patient is admitted for inpatient or outpatient services and has unpaid accounts for dates of service within thirty (30) days prior to the patient's Medicaid effective date; and to the best of our knowledge, there is no responsible party, financial assistance from a Government Benefit Plan or Government Sponsored Health Care for the Indigent for payment, we will assume the patient has met the criteria necessary to write-off the discharged debt to Charity Care.

7.9. Upon verbal confirmation of family size and income by the applicant, outside financial information such as "propensity to pay" scoring information provided by an outside vendor may be used as a

Figure 2. Actual 2015 Community Health Network Financial Assistance Policy (cont.)

COMMUNITY HEALTH NETWORK
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TITLE: Financial Assistance Program

screening tool for the manual verification of eligibility for the Community Financial Assistance Program.

8.0 Program Administration and Process

8.1. Financial Assistance Application: Upon request from Community the Financial Assistance Application must be completed by the patient or the financial counselor on their behalf and submitted to the network for review before financial assistance will be considered (See ***Attachment B Financial Assistance Program Applications)***. The following items may be requested to substantiate financial need of an individual patient:

- Recent W-2s, recent payment stub to verify income level, previous year's tax forms, bank or credit union statements for checking and savings accounts and other statements from financial or legal institutions to verify additional sources of qualifying income.
- External data that provides information on a patient's or guarantor's ability to pay.
- Proof of non-qualification for any other State/Government Financial Assistance Programs (i.e. Medicaid or other grant-based county or city programs).

8.2. Substantial effort will be made by Community and its business associates to identify alternative sources of payment via patient qualification from other programs before financial assistance will be granted. This effort will require cooperation from the patient/guarantor. Lack of cooperation with this phase of the determination process will disqualify the patient from the Community Health Network Financial Assistance Program.

8.3. Collection of Family Size and Income Data are the key drivers of the calculation to determine qualification for financial assistance. Community's definitions of family size and income are located in the "Definitions" section of this policy. For purposes of determining the scope of documentation required with the application:

8.3.1. When the patient is a non-emancipated minor: Biological mother and father and/or step parent(s) if child is adopted and all persons on the tax return(s), filer(s) and dependents of same; or, in the event that that another person not listed herein signed for financial responsibility, the person who signed plus the spouse and all dependents on that person(s) tax return(s).

8.3.2. When the patient is <u>not</u> a minor or is an emancipated minor: The patient, the spouse and the dependents of same on the tax return(s) of the patient and/or spouse; or, in the event that another person not listed herein signed for financial responsibility, the person who signed plus the spouse and all dependents on that person(s) tax return(s).

8.4. Family income, family size, FPL%, and other data may be obtained and used to corroborate provided details leading to eligibility for Community's Financial Assistance Program.

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

8.6. Assistance Levels: For uninsured and underinsured applicants, a sliding scale assistance protocol will be applied to each patient account as follows:

- Patients (applicants) with income levels less than 200% of the current year's Federal Poverty Level (FPL) will qualify for 100% financial assistance,
- Patients (applicants) with income levels ranging from 200% to 300% of the current year's federal poverty level (FPL) will qualify for partial assistance determined by a sliding scale detailed in table 1.1.,

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Figure 2. Actual 2015 Community Health Network Financial Assistance Policy (cont.)

COMMUNITY HEALTH NETWORK
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TITLE: Financial Assistance Program

- Patients (applicants) with income levels greater than 300% of Federal Poverty Level (FPL) will not be eligible for the Financial Assistance Program unless approved by the Executive Director, Patient Financial Services. These patients may be eligible to receive discounted rates on a case-by-case basis based on their specific situation, such as catastrophic illness, at the discretion of Community through an appeal process.
- Patients (applicants) who are uninsured and do not meet these income requirements will receive a discount of 60% on gross charges for facility services, based on Amount Generally Billable (AGB), and a discount of 25% on gross charges for professional services for medically necessary and emergency care services they receive.

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

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

8.9. Financial Assistance Coverage Date Span: It is preferred, but not required, that a request for Charity Care and a determination of financial need occur prior to the rendering of services. However, the determination may be completed at any point during the collection cycle. The following restrictions apply:

8.9.1. Financial Assistance applications must be received within 240 days (120 days Notification Period + 120 days Application Period) from first patient statement to be considered for provision of financial assistance. Upon receipt of application within notated Application Period, extraordinary collection actions will cease. Patient must cooperate with submitting supporting documentation upon request within a reasonable timeframe.

8.9.2. Prospective Coverage through Financial Assistance Program:
Patients will be granted extended prospective financial assistance eligibility for a period of thirty (30) days from the date of qualification if the patient is a resident of Community's health service district.

8.10. Application Process: An application for financial assistance will be provided to any requesting party. This may be done in person or by mail. Assistance in completing the application will be available and provided to the responsible party as required and such inquiries may be directed to the Manager, Customer Service at (317) 355-5555. If the qualification for financial assistance cannot be determined through the use of external databases or other programs designed to establish financial need, the patient will also be provided a list of additional documentation that will be required to substantiate their financial situation. If required, the application and all required supplemental documentation must be

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Figure 2. Actual 2015 Community Health Network Financial Assistance Policy (cont.)

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TITLE: Financial Assistance Program

received before a decision can be made regarding the provision of financial assistance.
8.11. The responsible party ("applicant") will have fifteen (15) calendar days following the initial date of request on the application to complete and return the application. The applicant may request an extension of fifteen (15) calendar days for good cause and such extension shall not be unreasonably denied. Failure to return a complete application within said fifteen (15) days or, if extended, thirty (30) days will result in denial of the application and no discharge of debt.
8.12. All patients submitting an application will have their respective accounts at issue logged in appropriate database for future use.
8.13. Using the documentation provided or results determined through the use of external databases or other programs designed to establish financial need, the Financial Counselor will use the current year's Financial Assistance Program criteria to determine the "scope of eligibility" as detailed in section 4 of this policy.
8.14. Patient Approval/Denial Notification Requirements: Upon receipt of a complete application or analysis of information provided by external databases or other programs designed to establish financial need, it will be approved or denied within thirty (30) days following the date of receipt. The applicant will be given or mailed a letter indicating approval or denial and, if approved, the amount of debt discharged, any balance due and the date due.
8.15 Exception process: Upon receipt of a denial notification for financial assistance, responsible party ("applicant") may request charges to be further reviewed by Appeal Committee. Appeal Committee will be responsible for confirming or overturning financial ruling.

Figure 2. Actual 2015 Community Health Network Financial Assistance Policy (cont.)

COMMUNITY HEALTH NETWORK
NETWORK POLICY & PROCEDURE

TITLE: Financial Assistance Program

Table 1.1
Sliding Scale for Charity Discounts

Calculated % of FPL	Discount %	CDM-Adjustment
≤ 200%	100%	0910
201%-225%	90%	0910
226%-250%	80%	0910
251%-275%	70%	0910
276%-300%	60%	0910

Table 1.2
Eligible Providers

In addition to care delivered at a Community Health Network facility, emergency and medically necessary care delivered by the providers listed below are also covered under this Financial Assistance Program.

Community Health Network Physicians

Table 1.3

Care provided by any of the providers listed below at a Community Health Network facility will NOT be covered under this policy since they are not employed by Community Health Network. As such, the bills received by Community Health Network patients for care provided by any of the following providers will NOT be eligible for the discounts described in the Financial Assistance Program. The patient may contact the provider directly to see if there are discounts or assistance available from the provider.

Mid America Clinical Laboratories
AmeriPath
Community Anesthesia Associates
Community Rehab Hospital
EmCare
Radiology of Indiana (formerly Irvington Radiologists)
Northwest Radiology
Radiology Associates of Indianapolis
Southeast Anesthesia
Urology of Indiana
Josephson Wallack Munshower Neurology (JWM)
Medical Associates
Northside Radiology Consultants, LLC
Intensivists, Dr. Malik and Dr. Kabir
Emergency Physicians of Community Hospital Anderson

Figure 2. Actual 2015 Community Health Network Financial Assistance Policy (cont.)

COMMUNITY HEALTH NETWORK
NETWORK POLICY & PROCEDURE

TITLE: Financial Assistance Program

Community Pathology and Nuclear Medicine, PC
Urology of Indiana
Josephson, Wallack, Munshower Neurology (JWM)
Central Indiana Orthopedics (CIO)
Gallahue Mental Health Services
The Jane Pauley Center, a Federally Qualified Healthcare Center (FQHC)

Approved By:

Bryan Mills
President and Chief Executive Officer
Effective Date: January 1, 2016

Page 13 of 13

Figure 2. Actual 2015 Community Health Network Financial Assistance Policy (cont.)

COMMUNITY HEALTH NETWORK
NETWORK POLICY & PROCEDURE

TITLE: Financial Assistance Program

Attachment A

Community is committed to serving the populations within its service/catchment area as defined by those individuals residing in the state of Indiana. Residence in the state of Indiana will be eligible for the Community Financial Assistance Program.

Page 14 of 13

Figure 2. Actual 2015 Community Health Network Financial Assistance Policy (cont.)

COMMUNITY HEALTH NETWORK
NETWORK POLICY & PROCEDURE

TITLE: Financial Assistance Program

ATTACHMENT "B"

Attachment B
FINANCIAL ASSISTANCE PROGRAM APPLICATIONS

Page 15 of 13

Figure 2. Actual 2015 Community Health Network Financial Assistance Policy (cont.)

Community Physician Network

APPLICATION FOR FINANCIAL ASSISTANCE

Thank you for giving us the opportunity to serve your health care needs and for expressing interest in our Financial Assistance Program.

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

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

APPLICANT NAME_____TELEPHONE #_____EMAIL .

_____SOCIAL SECURITY NUMBER - - DATE OF

BIRTH _____/__/_____

STREET ADDRESS_____ CITY _____ STATE _____ ZIP_____

Please submit unaltered copies of the following documents:
The first two pages of your most recent ***Federal 1040*** tax return and your spouse's if you filed separately.
The last three paycheck stubs for all income earners in the household (including Social Security, pensions, etc.).
Bank statements for the past two months for all accounts in the household including business accounts.

ADITIONAL QUALIFICATION INFORMATION

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

Applicant/Patient Signature _____Date _____

Spouse Signature (if co-applicant) _____ Date _____

Thank you for your application and for the opportunity you have given us to serve your health care needs. Please return your completed application and all supporting documentation to: Fax Number 317-355-8778, Email billinghelp@ecommunity.com or U. S. Mail Address 1500 N. Ritter Ave. Indianapolis, IN 46219. Please call 355-5555 if you have any questions or need assistance with this application. We will notify you of our decision in writing within 30 business days of the receipt of your application.

CHN Financial Assistance Long Form App Revised February 2014

Figure 2. Actual 2015 Community Health Network Financial Assistance Policy (cont.)

Community Physician Network

APPLICATION FOR FINANCIAL ASSISTANCE

Thank you for giving us the opportunity to serve your health care needs and for expressing interest in our Financial Assistance Program. Although you have met the initial screening qualifications for financial assistance we need additional information to complete the application process. The information you provide will be held in strict confidence and will not be used for any purpose other than to assess your need for financial assistance. We will not share this information with any person or organization outside of Community Health Network. It is very important that you return this application to us within two (2) weeks to avoid denial for financial assistance.

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

APPLICANT NAME _____ TELEPHONE # _____ EMAIL _____

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

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE / DEPENDENT FAMILY INFORMATION (please include an additional page if more space is needed to list dependents)

What is your monthly household, pre-tax, spendable income from all sources such as, but not limited to: wages, salaries, tips, commissions, pensions, Social Security, interest, investments, rent, royalties, alimony,

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

Applicant/Patient Signature _____ Date _____

Spouse Signature (if co-applicant) _____ Date _____

Thank you for your application and for the opportunity you have given us to serve your health care needs. Please return your completed application to: Fax Number (317-355-8778), E-mail Address (billinghelp@ecommunity.com) or U. S. Mail Address (1500 N. Ritter Ave. Indianapolis, IN 46219). Please call 355-5555 if you have questions or need assistance filling out this application. We will notify you of our decision in writing within 30 days of the receipt of your application.

CHN Medicare Financial Assistance App Revised 2012

Figure 2. Actual 2015 Community Health Network Financial Assistance Policy (cont.)

Community Physician Network

Renewal Application for Financial Assistance

Thank you for your continued interest in the Community Health Network Financial Assistance Program. Please complete this application and return it within seven (7) days so we can evaluate your ongoing need for financial assistance. The information you provide will be held in strict confidence and will not be used for any purpose other than to assess your need for financial assistance. We will not share this information with any person or organization outside of Community Health Network.

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

Applicant Name _____ **Telephone #** _____ **Email** _____

Street Address _____ **City** _____ **State** _____ **Zip** _____

Social Security Number ___-__-____ **Date of Birth** __ /__/ ____

Spouse / Dependent Family Information (please include an additional page if more space is required to list dependents)				
	Name	**Relationship**	**SSN**	**Date of Birth**
1				
2				
3				

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

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

Applicant / Patient Signature _____ **Date:** _____

Spouse Signature (if co-applicant) _____ **Date:** _____

Thank you for your application and for the opportunity you have given us to serve your health care needs. Please return your completed application to: Fax Number (317-355-8778), Email Address (billinghelp@ecommunity.com) or U.S mail address (1500 N. Ritter Avenue, Indianapolis, IN 46219). We will notify you of our decision in writing with 10 business days of receipt of your application.

Figure 2. Actual 2015 Community Health Network Financial Assistance Policy (cont.)

Attachment C

FINANCIAL ASSISTANCE PROGRAM SUMMARY

Figure 2. Actual 2015 Community Health Network Financial Assistance Policy (cont.)

Community Health Network

Financial Assistance Program Summary (Revised 12/17/2015)

Community Health Network serves the medical needs of the community, regardless of race, creed, color, sex, national origin, sexual orientation, handicap, age, ability to pay, or any other classification or characteristic.

We recognize the need to provide care to the sick that do not have the ability to pay. Patients who meet the requirements of our Financial Assistance Program can receive medically necessary healthcare services at a significantly reduced cost based on verified financial need. Community understands and honors the need to maintain the dignity of the patient and family during the application process.

Patients who identify themselves as unable to pay all or a part of their medical care have the right to request financial assistance. An application process is consistently followed to determine if patients meet the requirements of the Financial Assistance Program, or if they may qualify for other forms of assistance. Financial assistance is not considered a substitute for personal responsibility. Patients are expected to cooperate with Community's procedures and fulfill the documentation requirements needed to qualify for the assistance program. In addition, patients are expected to contribute to the cost of their care based on their ability to pay. Individuals who have the financial ability are encouraged to purchase insurance to ensure access to future healthcare services, protect their overall health and protect their assets.

Although other factors, such as bankruptcy, catastrophic healthcare expenses, household assets, etc., are sometimes considered, the primary qualification for financial assistance is household size and household income compared to the annually adjusted federal poverty line. A household consists of head of household, spouse and all "dependents" as defined by federal IRS guidelines. The following table shows the financial assistance level that patients may qualify for under Community's Financial Assistance Program.

Individuals eligible for financial assistance will not be charged more for emergency or other medically necessary services than the amounts generally billed to individuals who have insurance covering such services.

Figure 2. Actual 2015 Community Health Network Financial Assistance Policy (cont.)

Community Health Network Financial Assistance Table 2015

The following table shows the financial assistance level that patients may qualify for under Community's financial assistance program.

% of Federal Poverty Line	<200%	200-225%	226-250%	251-275%	276-300%	>300%
Financial Assistance Level	100%	90%	80%	70%	60%	0%

Household Size	Federal Poverty Line	Monthly Household Income Range					
1	$981	< 1,962	1,962 - 2,206	2,207 - 2,452	2,453 - 2,696	2,697 - 2,943	> 2,943
2	$1,328	< 2,655	2,655 - 2,986	2,987 - 3,318	3,319 - 3,650	3,651 - 3,983	> 3,983
3	$1,674	< 3,248	3,248 - 3,766	3,767 - 4,185	4,186 - 4,603	4,604 - 5,022	> 5,022
4	$2,021	< 4,042	4,042 - 4,546	4,547 - 5,052	5,053 - 5,557	5,558 - 6,063	> 6,063
5	$2,368	< 4,735	4,735 - 5,326	5,327- 5,918	5,919 - 6,510	6,511 - 7,102	> 7,102
6	$2,714	< 5,428	5,428 - 6,106	6,107 - 6,785	6,786- 7,463	7,464 - 8,143	> 8,143
7	$3,061	< 6,122	6,122 - 6,886	6,887 - 7,652	7,653 - 8,417	8,418 - 9,183	> 9,183
8	$3,408	< 6,815	6,815 - 7,667	7,668 - 8,519	8,520 - 9,371	9,372 - 10,223	> 10,223
Each Additional	$338	< 676	676 - 763	764 - 847	848 - 932	933 - 1,014	> 1,014

House hold income is calculated on a gross income basis before taxes, deductions and withholding and includes all sources of income such as wages, salaries, tips, pension, social security, rent, royalties, disability, alimony, child support, unemployment, etc. Income for all members of the household must be included in your calculation. It is important that you accurately estimate your income. Before granting Financial Assistance we will verify your household size and income through external data bases, tax returns, bank statements, vouchers, pay stubs and other relevant documentation as required.

This table is updated annually in accordance with the most recently published Federal Poverty Line.

If you have additional questions or want to apply for financial assistance please contact a patient financial service professional or financial counselor at:

Community Health Network
6435 Castleway West Drive
Indianapolis, IN 46250
317-355-5555 or
Toll Free 866-721-4205

Community Surgery Centers and Stones Crossing
6626 E. 75th Street, Suite 325
Indianapolis, IN 46250
317-621-0300

Community Hospital Anderson
1515 N. Madison Avenue
Anderson, IN 46011
765-298-3300 or
Toll Free 866-298-3300

Community Howard Regional Health
6435 Castleway West Drive
Indianapolis, IN 46250
765-453-8461

Community Westview Hospital
6435 Castleway West Drive
Indianapolis, IN 46250
317-644-5058 or 317-920-7195

Part I: 5.a,b & c.

In fiscal year 2014, the charity care/free care policy was changed from the 2013 policy. The data for utilization of the charity care dollars showed that a high percentage of use was outside the central Indiana area, included individuals from all parts of the country and several from outside the United States. In an effort to apply the financial assistance policy to the largest number of our patients in our service area who may be considered "medically indigent" we developed "Health Districts". In an attempt to focus charity care dollars, it was first decided to concentrate all charity care dollars to our service areas only. In an attempt to focus on the most vulnerable populations we also limited the geographic reach within our service areas to those zip codes with the highest indicators for vulnerability. The indicators established the Health Districts which would identify - or more precisely - illuminate the needs in the communities we serve and optimize our resources in these zip codes; as funds to offer charity care are limited and cannot reach all people throughout our own service areas. What resources we do have we need to use in a way that will make the biggest difference in a smaller geographic area. Below are the indicators and rationale for how we developed the process to identify "Health Districts":

- We started with all the zip codes in our service areas (80) and only those zip codes. So some areas of high poverty in the city are not in our services areas.

- All criteria are judged "worst" by credible organizations –the Census Bureau has determined through census data and other measures for poverty that a zip code is at critical level or has been a criteria set by Healthy People 2020

- We did not use the highest level of charity care expenditure as a screen until the end and only for the south market - however as would be expected the highest level of charity care expenditure was contained in these zip codes. Charity Care had little to do with identifying the "Health Districts" but the correlation is high - as anyone would apply a logical process to the service area zip codes and we did do a check step to make sure the correlation was accurate and then added 3 top charity care zip codes for the Community Hospital South service area.

We used all 80 service area zip codes and used aggregate data culled from 2007 through 2011, a large sample that makes our conclusions all that more accurate. We selected all those zip codes identified as having median household incomes that were below the target set by the US Census Bureau (below $43,417 in our area). We came up with a total of 20 zip codes.

We also wanted to capture or identify other zip codes "in need" or "at risk" so we reviewed several other reports and came up with eight additional zip codes to include in our "Health Districts".

We ran a report to list all those zip codes that identified more than 15% of those people living in poverty in that specific zip code. We captured an additional 3 zip codes.

We ran a report to identify families in a specific zip code that pay more than 30% of the annual income on rent (these families would have little discretionary funds available). Any zip code that had more than 47% of the total zip code population spending 30% was identified and 2 zip codes were added.

We screened the service area zip codes for "Children Living in Poverty". Any zip code that had more than 21% of their children living in poverty were added, we added 3 zip codes.

The final screen we ran was People 65+ living in poverty. If there were any additional zip codes that had more than 10% of their total population living in poverty we added those zip codes. We added no additional zip codes because the zip codes at highest risk or "in need" were already identified in previous screens.

Three other zip codes were added to the list in the South Market, 46217, 46142 and 46143. The reason for the addition of these zip codes was because of the immigration population and the fast changes in these zip codes population. They are also the highest at risk or in need zip codes for the south market and the ones with the highest use of charity care. The following maps identify the Health Districts in each service area for our network.

At the end of 2014 having seen that the Charity Care levels throughout the network were stabilized using the criteria for Charity Care in the "Health Zones". In 2015 the decision was made to open all zip codes in our service areas using the Health Zones criteria and consequently eliminated the Health Zones and use our service area. A success in evaluating and making our process manageable and meaningful for patients and their families.

The Affordable Care Act has created some new realities for hospitals when it comes to the use of Charity Care and we have taken an active role in adjusting our policy by instituting, evaluating and acting to improve a variety of our Charity Care processes. The focus is on helping those newly insured under the ACA and the State of Indiana, HIP 2.0 to navigate their responsibilities with the guidance of our staff. Hospital staff work with patients who never had insurance before and who may not understand the product they purchased on the exchanges. This requires us to take a more active role in helping the patients and families understand their benefits and the possible out-of-pocket expenses they will need to cover. Many don't clearly understand what co-insurance is or an "out-of-pocket max". They don't understand how it works within the Charity Care guidelines. To meet the need, the hospital makes available to all patients and their family's financial counselors and front end staff to more aggressively review with the patients and families the various ACA packages and fees. In 2015, Community Health Network had the highest enrollment in the State of Indiana HIP 2.0 program more than any other health facility in the state.

Our hope for the future is that we have developed and instituted processes that identify and support the true level of charity care in our service areas and provide the appropriate level of support and guidance so that patients and families utilize the maximum amount of

insurance while understanding and managing medical debt in a knowledgeable and manageable way.

Figure 3:. Network Charity Care Levels 2015

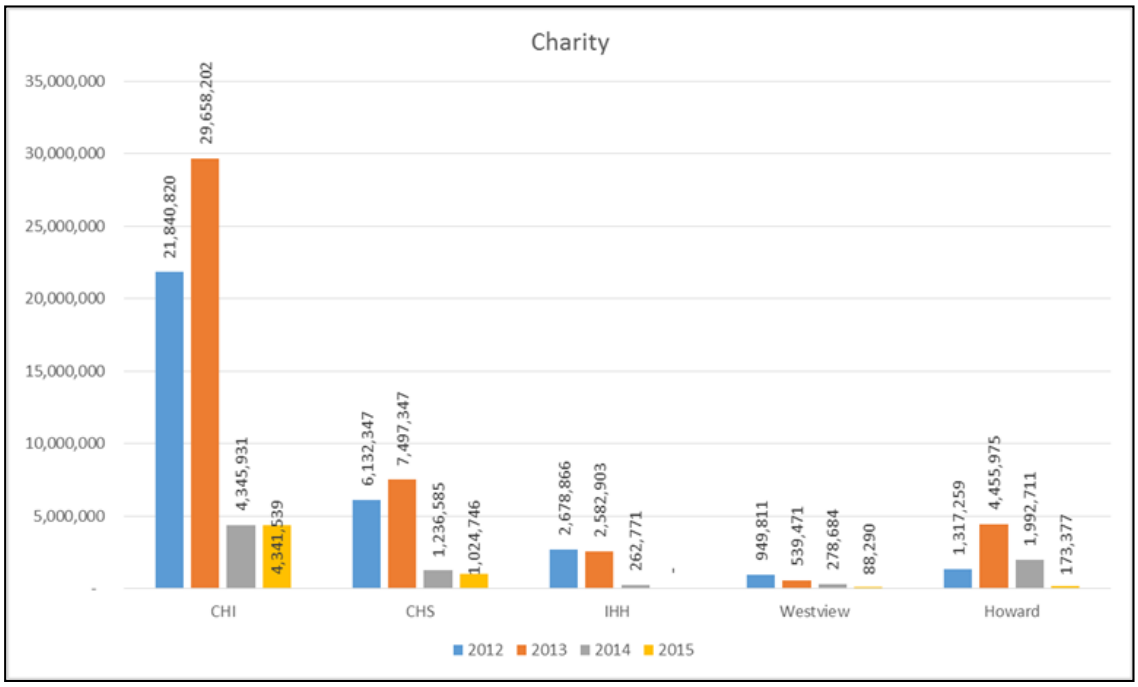


Figure 3. County levels of Adults with Health Insurance

% Adults with Health Insurance							
County	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Hamilton	91.5	88.3	88.6	90.8	90.7	89.3	91.7
Hancock	91.8	84.5	82	86.2	86.3	85.1	88.3
Hendricks	89.1	87.6	87.2	90	87.7	88.8	89.3
Howard	83.3	83.1	77.5	81.8	79	80.6	81.9
Johnson	84.8	83.9	82.2	86.6	82.8	86.1	87.3
Marion	80.6	77.7	75.8	77.1	76.7	75.8	80.3
Morgan	84.1	86.1	79	81.6	82.4	85.7	82.4

Figure 4.County levels of Children with Health Insurance

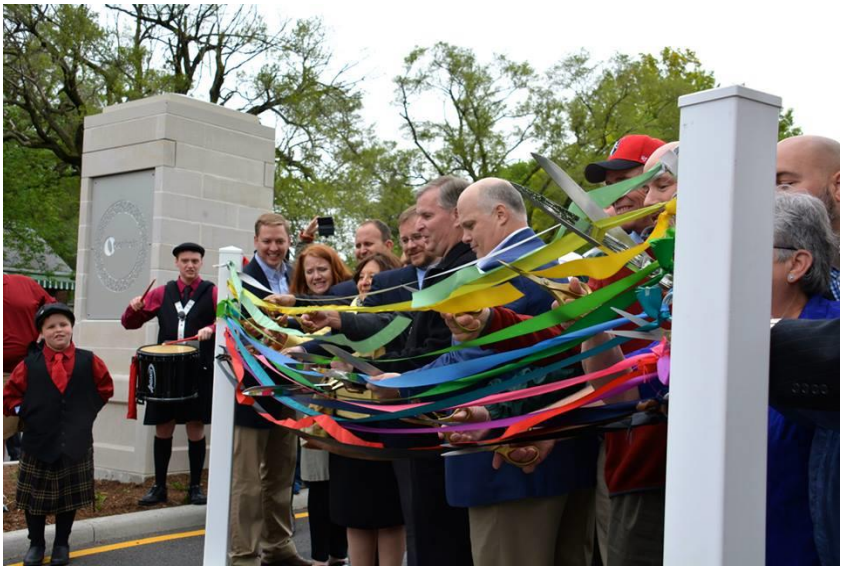
% Children with Health Insurance							
County	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Hamilton	97.6	93.2	95.8	96.2	95.2	94.1	95.5
Hancock	97.2	95.7	85.9	96.6	93.4	98.3	93.6
Hendricks	93.7	89.8	92.2	95.9	96	94.7	92.3
Howard	89.7	86.6	93.9	94.9	94	93.8	93.8
Johnson	93.3	91.7	93.4	94.6	96.8	94	97.5
Marion	89.7	90.6	90.5	91.5	90.7	93.1	93.3
Morgan	94.4	94	84.8	93.4	94.7	94.9	88.2

Figure 5. Part II Schedule H

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

		(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing						
2	Economic development	1		66,110		66,110	0.01
3	Community support						
4	Environmental improvements						
5	Leadership development and training for community members	2		100,602	46,027	54,575	0.01
6	Coalition building	1	6	99		99	
7	Community health improvement advocacy	5	12	5,625,531	687,928	4,937,603	0.59
8	Workforce development	1		1,733,528	54,270	1,679,258	0.20
9	Other						
10	**Total**	10	18	7,525,870	788,225	6,737,645	0.81

1. **Physical improvements and housing:** There have been no additional activities in the area of housing since the last report. Historically we have restored or built 6 homes through various programs including Habitat for Humanity, Building Together, and with network staff and resources. As reported in the last Community Benefit Report, the Emerson Avenue Gateway Project which has been a seven year process to improve the physical environment on the access road to Community Hospital East is now completed. The ribbon cutting is pictured in Figure 4. It is a project that has used community input and planning to complete. The ribbon cutting included many community partners among them Indianapolis Mayor Ballard, Indianapolis Metropolitan Police Department Commander, as well neighborhood leaders. All funds used to complete this project have been previously reported.



2. **Economic development:**

Community Health Network increases its minimum wage to $11 per hour

Community Health Network announced today it is increasing the minimum wage for employees who work in its acute care and ambulatory care services, and at Visionary Enterprises, Inc., to $11 per hour, effective Jan. 4, 2016.
The move will result in a pay increase for more than 400 employees within the network, which employs more than 13,000 across its entire healthcare system.

“There is much discussion across the country focused on increasing the minimum wage and Community Health Network decided to take a proactive step in that direction,” said Bryan Mills, president and CEO of Community Health Network. “We aren’t taking this step because we have to, but rather because it’s the right thing to do.”

Employees impacted by the increase will see the results in paychecks distributed on Jan. 22. Employees were notified of the move just prior to the Christmas holiday.

“Ensuring the best possible employee experience has long been a top priority at Community,” said Mills. “We continue to invest in our team and improve the way we operate to ensure we attract and retain the best talent.”

Community Launchpad

Community Launchpad showcases medical inventions

The Launchpad competition invites employees to pitch their ideas to improve patient outcomes. Among the innovative products are a vest to protect patients from falls, the "Elevation Station" that provides homecare nurses a clean and clear work surface, and IV pump covers to help patients sleep better.

Community Health Network has a plan to foster innovation among its employees and external partners with Community Launchpad, an innovation incubator designed to develop healthcare advancements, improve healthcare delivery, and seed entrepreneurial opportunities to reinvest in future innovations.
Community Launchpad invests in the most promising services, products and technologies that solve needs for patients, while creating a culture of entrepreneurship among its physicians, nurses, clinical and administrative staff.
“We studied conventional centers of innovation across the country, both in and out of the healthcare industry,” said Kyle Fisher, chief strategic development officer for Community Health Network. “In the end, we developed our own two-way incubation portal connecting the talent of our employees with the expertise of outside collaborators. This effort will improve services for our patients, while further distinguishing Community as an even more attractive place for healthcare entrepreneurs to partner with and succeed.”

Key principles for guiding the innovative activity of Community Launchpad include:

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

"Community Launchpad goes beyond a traditional R&D lab or healthcare venture capital fund," said Pete Turner, vice president of innovation for Community Health Network and leader of Community Launchpad. "We've created the engine to advance our core business by thinking boldly, harvesting promising ideas that improve the delivery and quality of care, and moving quickly to bring our solutions to market."

In 2014, a partnership began with Community Launchpad that is intact today with the Metropolitan School District of Lawrence Townships McKenzie Center for Innovation and Technology. The school which is available to students from Lawrence North High School and Lawrence Central High School, houses state-of-the-art equipment and materials in the classrooms and labs. The Center embraces rigorous academic programs and diverse technological career courses, which prepare its college and career-bound students for post-secondary education at two and four-year colleges, military service, workplace entry, or advanced technical training in a variety of business, medical, and industrial fields. The low teacher student ratio, nurturing environment, cutting edge technology, and broad array of career programs, focused and motivated students, dual-credited courses and national certifications are continually cited as advantages by McKenzie students. These students interface with Community Launchpad product development and share in the experience of innovation in the health care area with employees of Community Health Network.

Community Launchpad has 18 unique healthcare advancements generated by employees and physicians which have entered an incubation process that will determine if they are ready to be commercialized.

In 2015 Community Launchpad conducted an innovation competition for all network employees that generated more than 800 patient-first ideas, nine of which

have been added into the commercialization pipeline. The inventors will now participate in a proprietary incubation program, allowing them to explore the business value proposition of their ideas.

Launchpad's innovation platform allows Community employees an opportunity to be connected to leading industry experts specializing in research and design, intellectual property, funding alternatives, and others, to help bring their ideas to market. Some of the innovative ideas generated internally include:

•A patent-pending hospital room device that stops patient falls in real time

•A one-of-a-kind mobile work station that provides home care nurses an uncontaminated surface to conduct medical procedures, while reducing the spread of infectious diseases and pests between homes

•A patent-protected method for administering percutaneous nerve blocks that improves patient safety and reduces health care costs for a multitude of surgeries

•A hands-free toilet sensor that automatically measures a patient's output and charts the results wirelessly into the electronic medical record, improving a caregiver's workflow

•A unique, patient-centered application that blocks out visible light from medical equipment and improves a patient's quality of sleep during their hospital stay

While hundreds of other innovative ideas submitted internally may not advance into the commercialization pipeline, they will be communicated across Community Health Network to drive operational efficiencies and enhance patient experiences.

3. **Community support:**

Serve 360⁰

Building upon a legacy of volunteerism, Community Health Network has launched an unprecedented employee volunteerism initiative to demonstrate its deep commitment to the local communities it serves. Serve 360º offers Community employees a way to live the network's mission (to enhance health and well-being) and cultivate the spirit of volunteer service.

"We have more than 11,000 employees within our network," said Bryan Mills, president and CEO of Community Health Network. "That's a strong force of people, many who can join us as we move forward on this cultural journey to give back. This initiative is one we will continue to foster, whether it's helping those in need, participating in wellness activities, community building and development projects, or lending our assistance to schools and churches. We are committed to improving the quality of life for Central Indiana residents."

"Serve360º" was named to reflect Community's way of completing the circle, collectively giving back to the people and neighborhoods that gave birth to the network and continue to support it. Projects are vetted by a committee and those that are in alignment with the mission of the hospital are given priority. Many community events are staffed by Serve 360º volunteers and every year the amount of time committed by employees grows. Today, the leadership of the network are held accountable for at least one Serve 360º event a year. From staffing a food kitchen to painting a home the purpose is to decrease cost for not for profit organizations serving their community while increasing the economic viability and effectiveness of the organizations. Serve 360º works with community organizations to deliver the volunteer hours necessary to keep expenses low while improving the outcomes for the organizations we serve.

Examples of activities Serve 360º participated in to support the financial viability of community organizations include: Million Meal Marathon, Genessaret Free Clinic, Junior Achievement In a Day, Boys & Girls Club, Read Up Readers and Central Indiana Council on Aging (CICOA) community clean up.

Community Health Network's Susan Vaughn receives 2014 HIMSS Founders Leadership Award

For release: 1/14/2015

Indianapolis, IN---Susan Vaughn, MBA, BSN, RN-BC, PMP, CPHIMS, FHIMSS, has been named the recipient of the 2014 Healthcare Information and Management Systems Society (HIMSS) Founders Leadership Award. The award honors one or more individuals who, in the judgment of the HIMSS Board of Directors, have demonstrated significant leadership within the Society and/or the industry. The HIMSS Board of Directors approved the selection of the award winners at its recent board meeting.

Criteria for winning the Founders Leadership Award include:

- **Demonstrated leadership in healthcare information or management systems**, which may include the development or implementation of systems advancing

health status; unique application of systems, tools and techniques; and served as a leader of an outstanding healthcare institution or company
- **Contributed as a volunteer in the advancement of HIMSS goals and objectives**, which may include service in a leadership capacity for HIMSS or related professional society, or served on governmental healthcare or technology regulatory or advisory groups
- **Actively supported the HIMSS mission and membership growth**, which may include being an acknowledged leader in healthcare information and management systems, and an active supporter, advocate and recruiter for HIMSS members
- **Made outstanding contributions to the principles for which HIMSS stands**, including supporting lifelong learning opportunities, and supporting and promoting HIMSS as the recognized leader in the industry

"We are very proud of Suzy and all of her contributions to health information technology," said Community Health Network's Chief Knowledge and Information Officer Ron Thieme. "Besides her extraordinary work at Community Health Network, such as leading our hospitals to become the first to achieve Meaningful Use Stage 2 in the state of Indiana, Suzy is a recognized leader in health IT in general, most recently serving as president of HIMSS Indiana. "

Vaughn received her bachelor of science degree in nursing from Indiana University and her masters of business administration from Indiana Wesleyan University. Her previous career experience includes various roles in clinical informatics at Bloomington Hospital, in Bloomington, Indiana. Vaughn grew up in Spencer, Indiana, and currently resides in Bloomington.

"HIMSS congratulates its 2014 award and scholarship recipients for their individual achievements and contributions to their own organization in earning this recognition," said Carla Smith, MA, CNM, FHIMSS, executive vice president, HIMSS North America. "We also honor the commitment and expertise of these members who, each day, help move forward our cause to improve healthcare delivery with the best use of information technology and management systems. We are honored to have them as part of our organization and recognize their accomplishments through this awards program."

HIMSS will honor all 2014 scholarship winners at the HIMSS15 Awards Gala on Tuesday, April 14, at the Chicago Hilton Grand Ballroom. For more information about HIMSS, visit himss.org.

Community Health Network launches centralized pricing office and new My Estimate tool; Focus is on consumer convenience, patient experience

For release: 1/28/2015

Indianapolis, IN—Community Health Network is making it easier for consumers to determine their out-of-pocket healthcare expenses with a new tool called *My Estimate*. This is one aspect of the patient-friendly, new centralized pricing office the network has launched as part of its Office of Patient Experience. Community will work directly with a patient's insurer to provide accurate price estimates in advance of services provided—eliminating fears of large, unplanned expenses after patients receive healthcare treatments.

Out-of-pocket price estimates will be provided to patients for inpatient and outpatient procedures when they call **(317) 355-9279—or toll free at 844-786-9503**—Monday through Friday, between 9:00 a.m. and 5:00 p.m. Messages left after hours or on weekends will be returned within 48 hours or the next business day. Online requests can be submitted at **eCommunity.com/myestimate**. Patients can fill out a request form online and a Community pricing analyst will personally contact that patient to review the estimate and answer questions.

"At Community Health Network, our vision is to simply deliver an exceptional experience with every life we touch," said Tom Malasto, chief patient experience officer at Community. "Consumers are facing more exposure to their healthcare costs, and they need access to meaningful information regarding their out-of-pocket expenses. This service is part of our commitment to design services around the needs of those we serve."

In most cases, professional fees, anesthesiologist fees and radiologist reading fees are not included in the estimate. Price estimates are not guaranteed, as services used to compute the estimate may vary from services received due to treatment decisions, unforeseen complications, additional tests or services ordered by a physician, and variation in the clinical needs of each patient.

"Our focus is to serve as patient advocates for all Community patients," said Kipp Finchum, vice president of reimbursement for Community Health Network. "The network wants to arm consumers with the knowledge they need to access quality healthcare in a seamless, painless manner. With one phone call, patients can gain information about out-of-pocket costs and be prepared to move forward with the care they need."

My Estimate is one of a number of transparency tools now available for patients. The Indiana Hospital Association recently launched careINsight, an online price-comparison tool that allows patients to compare full, non-discounted inpatient charges at hospital systems across Indiana, including Community, further helping patients understand their healthcare costs.

Community's Office of Patient Experience was established in 2014 to provide patients with the best medical experience available in Central Indiana, by offering improved access to quality care that is coordinated, easy to use for everyday needs and focused on getting and keeping patients healthy.

Community Launchpad, VisionTech Partners form collaborative partnership focusing on commercialization of healthcare innovations

For release: 2/11/2015

Indianapolis, IN---Community Launchpad and VisionTech Partners have announced a new partnership to develop and advance healthcare innovations.

"Today, two strong organizations that understand the value of collaboration to advance healthcare innovations through commercialization and startups have come together," said Pete Turner, vice president of innovation for Community Launchpad. "The collaboration will focus on identifying emerging medical innovations, where both organizations can mutually apply their skills, programs and networks to bring opportunities to the marketplace."

Community Launchpad is an innovation accelerator and division of Visionary Enterprises, Inc., the wholly-owned, for-profit subsidiary of Community Health Network. VisionTech Partners is an Indianapolis-based company focused on connecting investors to high-potential, early-stage companies. VisionTech Partners' angel investing arm, VisionTech Angels, has chapters in Indianapolis, Lafayette, Bloomington and Warsaw, as well as a virtual angel group.

"Community Launchpad brings the engaged healthcare providers critical to the process of new innovation," said Oscar Moralez, managing director of VisionTech Partners. "This partnership will enrich our shared goals of identifying promising opportunities and providing support to advance the commercialization process."

The agreement includes providing potential pathways to support startup activity, including coaching for entrepreneurs, identifying subject matter expertise, and supporting inventors who are participating in business competitions, seminars and other programs.

"Catalyzing value-added partnerships is a differentiator for Community Launchpad," said Turner. "As an emerging startup, Launchpad's ability to expand knowledge and resources through the experience and expertise of VisionTech Partners increases our capacity to improve healthcare delivery and advance our entrepreneurial platform."

Community Health Network offers the latest, state-of-the-art technology for heart failure patients; CardioMEMS™ sensor provides early detection of worsening heart failure, reduces hospitalizations

For release: 3/3/2015

Indianapolis, IN---Community Health Network is now offering new, state-of-the-art technology aimed at reducing hospitalizations for patients with heart failure**.** Patients suffering from advanced heart failure now have access to new monitoring technology called CardioMEMS™ (Cardio micro electrical mechanical systems). This medical implantable sensor measures pulmonary artery pressure and provides early detection of heart failure as it begins to progress. The new technology may prevent costly hospitalizations. Community is the only healthcare network in Central Indiana currently offering CardioMEMS.

Heart failure is a progressive condition that occurs when the heart is unable to pump enough blood to meet the body's demands, and blood pressure within the heart becomes elevated. Significant heart failure progression over a period of days is known as acute decompensation and leads to hospitalization. Increased pulmonary artery pressures often precede indirect measures of worsening heart failure, such as weight and blood pressure changes, by up to 14 days.

"Because the sensor detects changes before the patient becomes symptomatic, the measurements allow for real-time, personalized and proactive management to reduce the likelihood of hospitalization or readmission," said Waqas Ghumman, MD, medical director of Community Health Network's Center for Advanced Heart Care. "Treatment can be administered before the integrity of the heart muscle is compromised, therefore enhancing the quality of life of the patient."

The CardioMEMS system features a miniature, wireless monitoring sensor that is implanted in the patient's pulmonary artery during a minimally-invasive procedure. The sensor works in combination with a home monitoring device to transmit data to the physician via a secure wireless or landline connection.

Through monitoring of the pulmonary artery pressures using CardioMEMS, physicians can proactively manage medications and other treatment options and get an early indication of worsening heart failure. Clinical trial data has shown a significant reduction in 30-day hospital readmission rates for patients age 65 and older.

Community Heart and Vascular Hospital is among only 64 implant sites in the U.S. currently using this new technology. For more information on the CardioMEMS

system, visit http://health.sjm.com/heart-failure-answers/videos-and-animations/cardiomems.

Community Health Network launches psychiatry residency program; New program will address shortage of psychiatrists in Indiana

For release: 3/5/2015

Indianapolis, IN—Last year, Indiana had 43 counties without a practicing psychiatrist, as the state and the nation continued to deal with a severe shortage of psychiatrists. With an estimated one in four Hoosiers experiencing a medically diagnosable mental health condition each year, that means long wait times to get treatment from a practicing psychiatrist. Community Health Network will address this problem by establishing a psychiatry residency program in 2016 that will utilize Community's broad continuum of behavioral health services to train the next generation of psychiatrists. It will be only the second psychiatry residency program offered in the state of Indiana. "Based on the state's population, there should be 650 psychiatrists in Indiana, but in 2013 that number was down to 356,"said Bryan Mills, president and CEO of Community Health Network. "This comes at a time when Indiana communities are seeing an increase in individuals needing mental health treatment. We think our new psychiatry residency program will begin to address this shortage issue."

Community Health Network received approval to be a multi-specialty sponsoring institution for Graduate Medical Education 2012. The network already has four medical residency programs (family medicine, family medicine osteopathic, podiatry, and proctology). Community's psychiatry residency program received accreditation in February by The Accreditation Council for Graduate Medical Education (ACGME) to accept learners through The National Resident Matching Program® (NRMP®), and will begin recruiting for the first class that begins July 1, 2016. The program will have four openings per year, for four years, and will focus on a continuum of care model that treats patients based on individual needs, covering a range of mental illnesses, including the most severe.

"With the tremendous advances in neuroscience, and the fact that many thousands of uninsured Hoosiers now have mental health coverage, we need a robust psychiatric and mental health workforce in Indiana to meet the demand," said John J. Wernert, M.D., secretary of Indiana's Family and Social Services Administration, the first psychiatrist to hold that position. "Lack of growth and the aging of our psychiatric physicians raise concerns and may have serious implications on the mental health workforce capacity in Indiana. Psychiatrists function as team leaders and integrated

consultants in many medical settings, and are one of the few clinicians with the authority to prescribe and oversee medicine therapy. Shortages in this profession have a direct, trickle-down effect on the supply of mental health services in Indiana."

The American Academy of Child and Adolescent Psychiatry Task Force on Workforce Needs recently identified a number of issues which can be barriers to maintaining an appropriate number of psychiatrists, including inadequate support in academic institutions; decreasing Graduate Medical Education (GME) funding; decreasing clinical revenues in the managed care environment; and a devalued image of the profession.

According to research published in the Indiana Economic Digest, only six medical school students in Indiana enter into a psychiatry residency program each year. Community's residency program will offer an alternative model for the practice of psychiatry, which allows residents to work closely with primary care physicians and clinics and serve as consultants for their patients who may have developing mental health issues.

"One important goal of the new residency program is to train community-based psychiatrists who have the skills to work in an integrated fashion with primary care providers," said Frank Covington, M.D., medical director for Community Health Network's behavioral health product line. "The residency program will offer a very broad array of mental health learning experiences."

According to the National Alliance on Mental Illness (NAMI), 60 percent of adults and nearly 50 percent of youth, ages 8 to 15, received no mental health services for their mental illness last year.

Community Physician Network welcomes new providers

For release: 3/16/2015
Indianapolis, IN--- Community Physician Network, the integrated, multi-specialty physician group at Community Health Network, welcomes the following providers:

Gregory Bell, MD, is a **board-certified rheumatologist** who was born in Fort Wayne, Indiana. He completed his medical degree at Indiana University School of Medicine and his internal medicine residency and rheumatology fellowship at the University of Miami in Florida. Prior to joining Community Physician Network, he was in private practice for 10 years in south Florida. Dr. Bell has extensive knowledge of all

rheumatic conditions and has particular interest in spondyloarthropathies, rheumatoid arthritis, osteoporosis and osteoarthritis. He also has expertise in the use of joint and tendon sheath injections. His office is located at 7910 East Washington Street, Suite 200, Indianapolis.

Jason Cacioppo, MD, is a **plastic surgeon** who specializes in plastic surgery of the breast and breast reconstruction. He completed his medical degree in Houston and returned to his native Chicago for his residency in general surgery at Rush and Cook County Hospital. He completed his plastic surgery training at IU Medical Center, a fellowship in hand surgery in Louisville as well as special training in microsurgery in Belgium. Dr. Cacioppo has expertise in DIEP flap breast reconstruction and has trained many surgeons in this technique over the past seven years. He also specializes in all aspects of hand surgery. Dr. Cacioppo has two office locations: 8040 Clearvista Parkway, Suite 210, Indianapolis, and 1550 East County Line Road, Suite 320, Indianapolis.

Anne Ford, MD, is a **board-certified cardiologist** who was born and raised in Carmel, Indiana. She completed her medical degree at Indiana University School of Medicine and her internal medicine residency and cardiology fellowship at the University of Colorado in Denver, Colorado. Her practice focuses on non-invasive cardiology, and her interests include valvular heart disease, coronary artery disease, women's cardiovascular disease, pulmonary hypertension and preventive cardiology. Dr. Ford's office is located at 1210 A Medical Arts Boulevard, Suite 105, Anderson.

Nitesh Gadeela, MD, is an **interventional cardiologist** who was born and raised in India. He completed medical school at Osmania Medical College in Hyderabad, India, and his internal medicine, cardiology and interventional cardiology training at Michigan State University. Prior to moving to Indiana, he was in private practice in northern Virginia. Dr. Gadeela's offices are located at 1402 East County Line Road, Suite 2400, Indianapolis, and 1155 West Jefferson Street, Suite 201, Franklin.

Matthew Welsch, MD, is a **board-certified orthopedic surgeon** specializing in the treatment and rehabilitation of acute and chronic injuries of the upper extremity. He completed his medical degree at the Medical College of Wisconsin, his residency at Indiana University and his fellowship training at Indiana Hand to Shoulder Center at Indiana University. He is trained in both adult and pediatric conditions involving the hand, wrist, elbow and shoulder, including joint replacement and trauma. Dr. Welsch has three office locations: 9669 East 146th Street, Suite 330, Noblesville; 7930 North Shadeland Avenue, Indianapolis; and 1400 North Ritter Avenue, Suite 510, Indianapolis.

Neelima Yalamanchili, MD, is a **board-certified internal medicine physician** who was born and raised in India. She completed her medical education at J.J.M. Medical College in Davangere, India, and her internal medicine residency at the University of North Dakota. Prior to joining Community Physician Network, Dr. Yalamanchili worked as a hospitalist in Muncie, Indiana, for three years. Dr. Yalamanchili enjoys the prevention and management of a wide variety of diseases and conditions experienced by the adult population. She is fluent in English, Telugu and Kannada. Her office is located at 1601 Medical Arts Boulevard, Suite 201, Anderson.

Eli Lilly and Company Foundation donates $250,000 to expand Community Health Network's Zero Suicides prevention initiative

For release: 3/25/2015

Major gift will save Hoosier lives through a suicide prevention network that responds to a critical Indiana healthcare issue

Indianapolis, IN---Community Health Network Foundation has received a $250,000 donation from the Eli Lilly and Company Foundation that provides funding needed to expand Community Health Network's Zero Suicides initiative. The investment will be used to save Hoosier lives through early intervention and prevention, the construction of a robust Central Indiana crisis network and the utilization of innovative mental health diagnostics and treatment protocols.

This donation allows Community Behavioral Health physicians and leaders to continue implementing a bold plan launched in October 2014 to reduce the number of suicide attempts and deaths among Indiana's youth and adults. Throughout the state, more than twice as many Hoosiers die from suicide than homicide, and suicide is the second leading cause of death among 15-34 year olds and the third leading cause of death among 10-14 year olds.

Community's Zero Suicides strategy brings crisis, telepsychiatry and intensive care coordination services to more than 600 primary care physicians, 11 emergency departments and 13 hospitals located throughout the state. These locations are a mix of Community facilities and other healthcare providers where Community provides behavioral health services, and they are allconnected with 24-hour access to Community Behavioral Health Crisis Center and Hospital, Indiana's largest and most robust acute hospital exclusively providing inpatient behavioral health services.

The Lilly Foundation donation also provides resources needed to build a Central Indiana crisis network that will include Indiana's schools, foster care system, juvenile justice program, primary and specialty healthcare providers, policy makers and suicide survivors. These partners will be trained to identify people at risk of attempting suicide, provide timely intervention and quickly connect them with Community's crisis

providers. Indiana's state government is a key partner in building the statewide crisis network.

Community is Indiana's most comprehensive provider of youth behavioral health services, and announced in 2014 its commitment to becoming the first health care system in the United States to fully implement the Zero Suicides model, developed by the National Action Alliance for Suicide Prevention and other partners.
Community's Zero Suicides initiative is solely funded by individual donations and grants received from the Substance Abuse and Mental Health Services Administration (SAMHSA), The Glick Fund, a fund of Central Indiana Community Foundation, and now the Eli Lilly and Company Foundation. With this announcement, support for the suicide prevention initiative totals $4,029,084.
"The Lilly Foundation is pleased to support this critically important work," said Dr. Ora H. Pescovitz, US Medical Leader for Eli Lilly and Company. "We have far too many Hoosiers—including too many of our children and adolescents—who attempt or commit suicide. It is incumbent upon all of us to do what we can to prevent these terrible tragedies. We believe that Community, as our state's leader in behavioral health, can make a profound difference for the better."
"With this generous support from the Lilly Foundation, we can provide the training and resources needed to save the lives of our state's citizens," said Suzanne Clifford, executive vice president of behavioral health at Community. "Zero suicides is a bold goal, but no other goal is acceptable. With this funding, we will be able to radically expand our ability to provide early intervention, prevention and treatment that will save thousands of lives."
Those concerned about someone who is contemplating suicide can call Community Health Network's crisis hotline at 800-662-3445.

Community Health Network opens first-of-its kind dedicated Cardio-Oncology Clinic

For release: 4/1/2015

Community Heart and Vascular Hospital is first hospital in Indiana to offer a multi-disciplinary program for heart testing and management of patients undergoing cancer treatment

Indianapolis, IN---Thousands of Hoosiers receive chemotherapy treatments each day as they fight for their lives against a variety of cancers. What they may not know is that those life-saving treatments may cause damage to their hearts. Understanding the

connection between heart disease and cancer treatments has driven Community Health Network to launch the first dedicated Cardio-Oncology Clinic in Indiana. "Chemotherapy treatments are crucial to saving the life of a cancer patient," said Sumeet Bhatia, M.D., medical oncologist at Community Health Network. "However, some of the drugs used in treatment can adversely affect the heart. Certain targeted medications have been linked to high blood pressure, abnormal heart rhythms and may increase the risk of blood clots or heart failure. At Community, we are taking proactive steps to take care of the heart while the patient is fighting cancer."

According to the Mayo Clinic, almost every chemotherapy drug has some effect on the cardiovascular system—and patients who are followed by a cardiologist specialized in treating cancer patients can prevent and reduce the negative effects of cancer-fighting drugs on the heart.

"We understand that dealing with cancer can be overwhelming," said Rey Vivo, M.D., cardiologist at Community Heart and Vascular and a leader of the initiative. "We want to reassure patients that we have a program that can look after their heart health before, during and after they receive cancer treatment. Using cardiac imaging and biomarkers, we aim for early detection and treatment of potential cardio-toxicity from cancer therapy."

Community's Cardio-Oncology Clinic, located at Community Heart and Vascular Hospital on the campus of Community Hospital North, began seeing patients in January. Community's cancer patients will receive initial heart assessment screenings at Community Cancer Center North. Those at risk will be seen in the dedicated Cardio-Oncology Clinic, where they will receive an individualized cardiac risk evaluation and treatment plan. Their care will be closely coordinated between cardiologists and oncologists throughout the duration of their treatment schedule.

Community Health Network launches life-saving text service for young people, as part of its Zero Suicides initiative

For release: 4/9/2015

Text HELPNOW to 20121

Indianapolis, IN---In Indiana, more young people die by suicide than by homicide, and it is the second leading cause of death among Indiana teens. To address this growing statewide problem, Community Health Network, in partnership with Mental Health America of Greater Indianapolis, has unveiled a new text service as part of its Zero Suicides for Indiana Youth initiative launched in 2014. Now, young people with suicidal

thoughts or feelings can text HELPNOW to 20121 and instantly connect with a trained mental health responder.
"The text-for-help hotline is a vital piece of our Zero Suicides for Indiana Youth initiative that anyone can access and use," said Suzanne Clifford, executive vice president of behavioral health at Community. "Suicide is a leading cause of death for Indiana's children and teens. This text service is one more important resource to enable them to get the help they need easily and quickly."

Anyone who texts HELPNOW to 20121 will immediately receive confirmation that his or her text has been received and will be asked to provide additional information. The service is staffed by mental health professionals, who are trained through Mental Health America of Greater Indianapolis, to work with individuals experiencing thoughts of suicide or a mental health crisis.

"Texting is a familiar communication platform for today's young adults," said Indiana State Senator Jim Merritt (R-Indianapolis). Community Health Network's dedication and focus on this program will no doubt save lives."

Community Health Network is Indiana's most comprehensive provider of youth behavioral health services. In 2014, Community announced its commitment to becoming one of the first health care systems in the United States to fully implement the Zero Suicide model, developed by the National Action Alliance for Suicide Prevention. At the same time, the Indiana Division of Mental Health and Addiction designated Community as the lead entity for spearheading the state's movement to save young lives.

The text-for-help technology is made possible from a grant offered by The Glick Fund, a fund of the Central Indiana Community Foundation. The grant was received by Community Health Network Foundation in November 2014 and is focused on leveraging Community's robust school-based program to increase support for schools and families.

Community Health Network will invest nearly a quarter of a billion dollars in Indianapolis; New hospital at Community East; new cancer center at Community North

For release: 5/14/2015

Indianapolis, IN—Community Health Network is making a major investment in Indianapolis with two new large building projects totaling nearly a quarter of a billion

dollars. The first will include a $175 million development with a new hospital on the campus of Community Hospital East and a new $60 million cancer center at Community Hospital North. Both projects will break ground this year.
“As healthcare continues to evolve, Community Health Network will strive to provide access to quality care with an emphasis on the overall patient experience,” said Bryan Mills, president and CEO of Community Health Network. “At Community Hospital East, we realized building a new hospital for the future was, in the end, a better avenue than renovating antiquated buildings meant for a different time in our history. At Community Hospital North, increases in patient volume dictated the need for a new cancer center. Our commitment to Indianapolis remains strong.”

The Community Hospital East project changes in scope from the original plan announced last fall. That plan called for major renovation of the decades-old hospital. The redesigned plan calls for the construction of an entirely new hospital, which will take Community East into the future for many years to come. The project includes demolishing four buildings on the campus, building the new hospital tower housing inpatient and procedural rooms and moving its Family Medicine Center from 10th and Mithoeffer to the campus at 1500 N. Ritter. In 2016, a new emergency department, to be located at the back of the hospital, will be built. The redevelopment project is expected to be completed two years sooner than the original plan—and with virtually no disruption to patient care.

“We believe construction of a new hospital will bring dramatic, positive change to the east side,” said Mills. “The new campus will provide the space our East employees need to deliver innovative healthcare in the most efficient manner. Community Hospital East will become a new modern structure that will be a pillar for the east side of Indianapolis.”

Community Health Network will be expanding oncology services with the new cancer center on the campus of Community Hospital North. The $60 million, three-story, 104,000 square foot facility will be built south of Community Heart and Vascular Hospital along Shadeland Avenue. It will also be connected to Community Hospital North.

The new cancer center will keep the facility name, Community Cancer Center North, and was designed with input from patients, physicians and staff. It will feature elements that create a home-like atmosphere. Patients will control their surroundings, including room temperature, lighting, entertainment, food choices, and privacy. The

cancer center will also feature wellness facilities, quiet workspaces, public Wi-Fi, a knowledge center, and a nature garden.

"At Community, we understand that cancer is a life-changing experience for patients and their families," said Jianan Graybill, M.D., radiation oncologist and lead physician on the project. "Our new center was designed to allow them to carry on much of their usual routine and activities as possible while undergoing treatments. They may use the workspaces to conduct business or use Skype to keep distant family members updated."

The Community Hospital East project will break ground in July, followed by an early fall groundbreaking for the cancer center at Community Hospital North.

Community Health Network, Mayor of Indianapolis cut ribbon on Emerson Avenue Corridor Gateway Project

For release: 5/20/2015

$2.1 million was invested to improve east side corridor between 16th Street and 21st Street on Emerson Avenue

Indianapolis, IN---Community Health Network leaders, Mayor Greg Ballard and several east side community leaders stood together today to cut the ribbon on a project that significantly improves a busy Emerson Avenue from 16th Street to 21st Street on the city's east side. The $2.1 million initiative was funded in part by Community Health Network, the City of Indianapolis and the State of Indiana.
"Our city is filled with strong, vibrant neighborhoods, because residents, businesses and local government agencies come together to improve the quality of life for all who call Indianapolis home," said Mayor Ballard. "The new Emerson Avenue streetscape is a terrific example of how thoughtful investment by community partners can transform a neighborhood, and I thank Community Health Network for their commitment to this area."

Enhancements to Emerson Avenue include:

- Improved medians with new plantings and irrigation
- Upgraded signals at 16th and 21st Streets
- New signal at 19th Street
- Special pavements at crosswalks at 16th, 19th and 21st Streets

- Resurfaced roadway pavement (asphalt) from 16th and 21st Streets
- New six foot wide sidewalk along the west side of Emerson Avenue
- Three neighborhood gateway markers
- 34 street trees, 35 ornamental trees, 133 shrubs, 7,000 square foot lawns, 24,000 square foot landscape beds, 1,000 square foot of storm water planters
- 2,600 foot long multi-use trail

"This is another way Community Health Network is showing its neighbors that it is committed to the east side and is here to stay," said Community Health Network East Region President Scott Teffeteller. "This project also shows the value of public-private partnerships. We had a team of people from our network, the Mayor's Office and neighborhood groups who helped design a landscape that stays true to the history of this area. The people of the east side of Indianapolis are well-known for how they come together to address issues and solve problems."

The Emerson Street Corridor Gateway Project received input from a number of neighborhood groups, including:

- Community Heights Neighborhood Association
- Little Flower Neighborhood Association
- Emerson Heights Community Organization
- Irvington Development Association

For more information on the project, visit eCommunity.com/east.

Community Health Network sponsors the Indiana Fever "Choices for Champions" event for students at Indiana Farmers Coliseum

For release: 5/27/2015

Program promotes healthy life choices, anti-bullying techniques, importance of self-esteem

Indianapolis—According to research from the Indiana Youth Institute, Indiana has the highest rate of students who have contemplated suicide (19%) and the country's second-highest rate of students who have attempted suicide (11%). To combat these alarming numbers, Community Health Network is sponsoring the Indiana Fever's annual "Choices for Champions" program aimed at curbing bullying and encouraging healthy life choices. The event takes place on May 29 at the Indiana Farmers Coliseum. More than 3,000 students in grades 3 through 8 will attend the event that begins at 9:45 a.m., prior to the Fever pre-season game vs. the Washington Mystics at noon.

"One of the ways we can fight teen suicide is to talk about it early and provide children with the tools they need to live healthy lives," said Suzanne Clifford, executive vice-president of behavioral health at Community Health Network. "Children need positive role models like members of the Indiana Fever, who share their insight and experience to help students make good choices in their own lives. This year, Community Health Network is sponsoring this event and integrating our Behavioral Health services, specifically the Zero Suicides Initiative."
A program begins at 9:45 a.m. with the following speakers:

- **Kim Walton, MSN, APRN, Chief Clinical Officer for Behavioral Health Services at Community Health Network**
  Walton will speak about Community's Zero Suicides Initiative and the text-for-help technology made possible from a grant offered by The Glick Fund, a fund of Central Indiana Community Foundation. Community Health Network will also have adolescent counselors on site during the event to talk with students and teachers.
- **Camishe Nunley, Licensed Mental Health Counselor and Certified Trauma Specialist, owner Healing Your Hidden Hurts (HYHH)**
  The HYHH program, Building Resiliency in Children (B.R.I.C.) is based on empowering children, adolescents and young adults. Nunley will speak about the B.R.I.C. program which teaches schools how to implement procedures and programming to help create a safe and positive atmosphere that doesn't tolerate bullying.
- **UFC Legend Chris "Lights Out" Lytle Rise Up Against Bullying**
  Lytle is a fourteen-year member of IFD and a retired American Mixed Martial artist, boxer and veteran UFC Champion. Lytle will talk about the importance of strength, discipline and resilience in battling bullies. He has released his book, "Lights Out on Bullying" to help others.
- **Indiana Fever players, including: Tamika Catchings, Layshia Clarendon, and Jeanette Pohlen, as well as the Indiana Pacers' Shayne Whittington,** will take questions from the children and talk about healthy eating, exercise and education. During a lunch break that begins at 11:00 a.m., counselors from Community Behavioral Health will be on hand to talk to the students.

University of Indianapolis, Community Health Network to launch innovative partnership at new campus clinic

For release: 6/2/2015

Facility in university Health Pavilion will serve campus and network patients while creating new opportunities for education, internships and research.

Community Health Network and the University of Indianapolis are joining forces to establish a clinical facility on campus where students and faculty will work alongside health and wellness professionals to serve patients and clients, transforming the educational experience and bringing important resources to an underserved part of the city.

The partnership is central to the philosophy behind Ulndy's four-story, $30 million Health Pavilion on Hanna Avenue, which will open in August as the new home for nationally respected academic programs in nursing, physical therapy, occupational therapy, psychology, gerontology, kinesiology, athletic training and social work.

"Our vision is to close the gap between education and practice in a way that benefits our students, our partners and the broader community," Ulndy President Robert Manuel said. "With our friends at Community Health Network sharing that vision, we have an amazing opportunity for innovation in the preparation of new health professionals and the delivery of health and wellness services in our city and beyond."

Under a renewable five-year lease, more than 10,000 square feet of the Ulndy Health Pavilion's first floor will operate as a department of Community Hospital South. The space will include a 7,000-square-foot physical therapy and rehab center with private treatment rooms and a therapy gym that includes a walking track and therapy equipment.

Adjacent will be a 3,700-square-foot primary care clinic that will provide health and wellness services to Ulndy employees, Community Health Network clients and other patients, with examination rooms where students can gain hands-on experience in their chosen fields under the supervision of professionals and faculty. Also on the first floor will be Ulndy's own Psychological Services Center, a training and research facility where faculty and graduate students from the School of Psychological Sciences provide evaluation and therapy services to the public.

Although Community Health Network has partnerships with other colleges and universities throughout Indiana, the partnership with Ulndy is the first comprehensive one that includes employer health, sports medicine and physical therapy services, nursing education, clinical internships and research.

"Our goal is to provide exceptional healthcare at as many access points as possible in Indiana," said Bryan Mills, president and CEO of Community Health Network. "In addition to providing quality care to the Ulndy family, this partnership will be a model for the future of healthcare education, pairing students and new innovations with the network's outstanding caregivers."

Under the agreement, Community Health Network will gradually increase the number of internships and clinical and field experiences provided at its various facilities for students in Ulndy's allied health programs, which account for approximately half of the university's total enrollment of 5,400 undergrad and graduate students. The

partnership also opens the door to joint faculty appointments, interdisciplinary training opportunities and the joint pursuit of research and grant opportunities.
Aside from the lease agreement, Community Health Network has pledged additional financial support to the university for activities related to the Health Pavilion, including scholarships, internships, research, interdisciplinary study and the cultivation of innovative programs.
The 160,000-square-foot Ulndy Health Pavilion, designed by local firm CSO Architects, is itself a partnership between the university and local developer Strategic Capital Partners. The ongoing construction at Hanna and State avenues is overseen by Pepper Construction Group.

Community Hospital North celebrates 30th anniversary

For release: 6/9/2015

Indianapolis, IN—Thirty years ago on June 12, 1985, Community Health Network embarked on a journey to provide greater access to healthcare for northeast side residents by opening Community Hospital North. It took significant vision and the spirit of innovation on the part of network leaders, who acquired the farmland on which the hospital was built, while Castleton was in its early stages of development and Fishers was just a small rural town. It was this vision that established Community Health Network as the most prominent healthcare provider in what has become one of the nation's fastest-growing suburban areas.
"Community's leaders in the early eighties gambled on an area of Indianapolis that seemed destined for growth," said Jason Fahrlander, president of acute care services at Community Health Network. "It was a smart move. Community Hospital North has grown into the largest campus in the network, and as the northeast corridor continues to expand and flourish, we are making plans to serve the needs of the growing area by providing increased access points and exceptional patient experiences."

Community Hospital North grew into a full-service hospital, and the North campus expanded to include multiple medical office buildings, Community's Behavioral Health Pavilion, a cancer center and one of the world's first all-digital hospitals, Community Heart and Vascular Hospital, formerly The Indiana Heart Hospital.

In 2007, a $170 million expansion at Community North took place with the construction of ultra-modern surgical suites, 60 private maternity guest suites (the largest of its kind in the nation), specialty women's and children's services, developmentally-friendly neonatal intensive care suites and a dedicated pediatric unit with a treasure hunt

theme. Growth will continue this fall on the campus, when ground is broken on a 104,000 square foot cancer center.

In celebration of the hospital's 30th anniversary on June 12, employees and hospital visitors can enjoy an ice cream social in the main lobby from noon to 4:00 p.m. Health screenings will also be offered, including body mass index (BMI) and blood pressure screenings. Informational booths will offer emergency medical services (EMS), heart health and women's health education.
Four hospital volunteers who worked at Community North when the original hospital opened, are still volunteering today, and have put in nearly 19,000 hours of service time.

Community Health Network sponsors INShape Black & Minority Health Fair

For release: 7/15/2015

Health fair will offer free medical consultations and screenings July 16-19

Indianapolis, IN---Community Health Network is tripling its presence at this year's INShape Black & Minority Health Fair at the Indiana Convention Center July 16-19. An increased focus on healthcare at this year's Indiana Black Expo has led to the expansion of health services offered and a move to Hall "F" for the event. More than 250 Community employees and 25 physicians will offer health services such as free medical consultations, health screenings and medical education for an expected crowd of nearly 2,000.

"Community Health Network believes that easy access to healthcare and health information can have a positive impact on the citizens of Indiana," said Deborah Whitfield, director of network diversity and inclusion at Community. "This event is a way for the network to reach a large number of people and get them started on the path to living healthier lives."

Free health screenings will be available to check cholesterol, blood pressure, diabetes, sickle cell anemia and BMI. Community physicians will also be performing clinical breast exams in private screening booths. Participants will have access to physicians for medical consultations and information on behavioral health, Touchpoint senior services, stroke and heart disease.
"For those attendees who do not have a relationship with a primary care doctor, this event provides an opportunity to get connected," continued Whitfield. "Having regular visits with a physician is another important step to overall good health."

Community Health Network names new president for its North Region

For release: 7/16/2015

Healthcare administrator with more than 25 years of experience will take the reins August 17

Indianapolis, IN—Community Health Network has hired an experienced healthcare administrator as the new president of Community's North Region, home to Community Hospital North and Community Heart and Vascular Hospital. Kathleen R. Krusie will start this position August 17, replacing the role of Jason Fahrlander, who was promoted to president of acute care services for the network.

"Kathleen is a proven healthcare leader, who can help guide the future of Community's fast-growing North Region," said Fahrlander. "As the network continues its focus on delivering exceptional care and the best possible patient experience, she brings a successful background in those areas to our North campus."

Krusie, who has more than 25 years of healthcare experience, left St. Joseph Regional Health Center in Bryan/College Station, Texas, where she served as chief executive officer since 2010. While at St. Joseph, she led major quality initiatives to improve patient satisfaction scores and implemented cost reduction and productivity processes that positively impacted the organization.

Prior to her position at St. Joseph Regional Health Center, Krusie held several leadership roles with Mercy Medical Center in Cedar Rapids, Iowa. She is a graduate of the University of Iowa, where she received her M.A. in hospital and health administration. Krusie has been involved in a number of professional organizations, including the American College of Healthcare Executives, the University of Iowa Department of Health Management & Policy Alumni Board and the MHA Professional Advisory Committee at Texas A&M Health Science Center's School of Public Health.

Krusie, who was named a Woman of Influence by the Corridor (Iowa) Business Journal in 2009, has also served as a member of the Bryan Rotary Club and as director and president of Daybreak Rotary Club in Cedar Rapids. She has served on the board of directors for the Greater Cedar Rapids Community Foundation, United Way of East Central Iowa and Goodwill Industries of SE Iowa.

Community Health Network named 2015 Most Wired

For release: 7/20/2015

Most Wired hospitals focus on security and patient engagement

Indianapolis, IN---Health data security and patient engagement are top priorities for the nation's hospitals, according to results of the 17th annual HealthCare's Most Wired™ survey, released by the American Hospital Association's Health Forum and the College of Healthcare Information Management Executives (CHIME). Community Health Network in Indianapolis is among the Most Wired health systems in the nation, according to the survey.

The 2015 Most Wired™ survey and benchmarking study, in partnership with CHIME and sponsored by VMware, is a leading industry barometer measuring information technology (IT) use and adoption among hospitals nationwide. The survey of more than 741 participants, representing more than 2,213 hospitals, examined how organizations are leveraging IT to improve performance for value-based healthcare in the areas of infrastructure, business and administrative management, quality and safety, and clinical integration.

"Community Health Network has been recognized for the 15th time as a national leader in adopting information technology for the benefit of our patients and their families," said Ron Thieme, Ph.D., chief knowledge & information officer at Community. "But the best is still to come, as we invent new ways of engaging with our patients wherever and whenever it is convenient for them. The innovative use of technology is one way that we continue to live our mission—to simply deliver an exceptional experience with every life we touch."

According to the survey, hospitals are taking more aggressive privacy and security measures to protect and safeguard patient data. Top growth areas in security among this year's Most Wired organizations include privacy audit systems, provisioning systems, data loss prevention, single sign-on and identity management. The survey also found:

- 96 percent of Most Wired organizations use intrusion detection systems compared to 85 percent of the all respondents. Privacy audit systems (94 percent) and security incident event management (93 percent) are also widely used.

- 79 percent of Most Wired organizations conduct incident response exercises or tabletop tests annually, a high-level estimate of the current potential for success of a cybersecurity incident response plan, compared to 37 percent of all responding hospitals.

- 83 percent of Most Wired organizations report that hospital board oversight of risk management and reduction includes cybersecurity risk.

"With the rising number of patient data breaches and cybersecurity attacks threatening the healthcare industry, protecting patient health information is a top priority for hospital customers," said Frank Nydam, Senior Director of Healthcare at VMware.

"Coupled with the incredible technology innovation taking place today, healthcare organizations need to have security as a foundational component of their mobility, cloud and networking strategy and incorporated into the very fabric of the organization."

As hospitals and health systems begin to transition away from volume-based care to more integrated, value-based care delivery, hospitals are utilizing IT to better facilitate information exchange across the care settings. This includes greater alignment between hospitals and physicians. According to the survey, the physician portal is a key factor in strengthening physician-hospital alignment:

- In 84 percent of Most Wired organizations, physicians can view and exchange other facilities' results in the portal compared with 63 percent of hospitals surveyed.
- 76 percent use the portal and electronic health record (EHR) to exchange results with other EHRs and health information exchanges compared to 56 percent of those surveyed.
- 81 percent can communicate with patients via email or alerts in contrast to 63 percent of all respondents.

Driven beyond the requirements of Meaningful Use Stage 2, this year's Most Wired hospitals are utilizing the benefits of a patient portal to get patients actively involved in their health and healthcare. For instance, 89 percent of Most Wired organizations offer access to the patient portal through a mobile application. Other key findings include:

- 67 percent of Most Wired hospitals offer the ability to incorporate patient-generated data.
- 63 percent offer self-management tools for chronic conditions.
- 60 percent offer patient-specific education in multiple languages.

"We commend and congratulate this year's Most Wired hospitals and their CIOs for improving care delivery and outcomes in our nation's hospitals through their creative and revolutionary uses of technology," said CHIME CEO and President Russell P.

Branzell, FCHIME CHCIO. “These Most Wired organizations represent excellence in IT leadership on the frontlines of healthcare transformation.”

“Congratulations to our nation’s Most Wired hospitals for harnessing the potential of information technology to improve quality care and patient safety and lower health care costs,” said Rich Umbdenstock, president and CEO of the AHA. “At the forefront of the field, these hospitals are setting the bar for protection of patient data through discerning security measures.”

HealthCare’s Most Wired™ Survey, conducted between Jan. 15 and March 15, 2015, is published annually by Health & Hospitals Network. Respondents completed 741 surveys, representing more than 39 percent of all U.S. hospitals. Last October, the AHA/Health Forum and CHIME announced the formation of a Most Wired partnership to enhance collaboration between the two organizations in the development and sustainability of the survey, and to collectively help meet the growing demand for useful data on health IT integration.

Detailed results of the survey and study can be found in the July issue of H&HN. For a full list of winners visit www.hhnmag.com.

Community Health Network breaks ground on $175 million hospital campus on eastside

For release: 8/19/2015

Mayor Ballard and other elected officials celebrate the rebirth of Community Hospital East

Indianapolis, IN---Since 1956, Community Health Network’s mission has been to serve the hard working people of the eastside by utilizing its medical expertise and heartfelt care to provide an exceptional patient experience. Today, a new chapter begins as the network breaks ground on a brand new Community Hospital East. The $175 million dollar investment in the neighborhood sends a message of commitment to those who live there.

“Community has a rich heritage on the eastside of Indianapolis,” said Bryan Mills, president and CEO of Community Health Network. “This new hospital means we will remain firmly rooted where our story began nearly 60 years ago. The changes coming to the Community East campus reflect the need to focus on patient well-being, while providing economic stability and community benefits to local neighborhoods.”

The groundbreaking begins the second phase of the $175 million project: the construction of a new hospital tower, housing inpatient and outpatient procedure rooms, and a new emergency department. Community is also moving its Family Medicine Center to the East campus and demolishing four antiquated buildings. Follow the construction updates here.

"This project will accomplish a number of key objectives," said Scott Teffeteller, president of Community's East Region. "It will improve the patient experience, refigure the campus to accommodate more patients and modernize existing facilities. The end result is a campus that can create innovative strategies and handle the ever-changing trends in healthcare."

The anticipated completion of the new hospital project is 2019.

Community Hospital South unveils new electrophysiology and interventional radiology labs

For release: 8/20/2015
$5.1 million investment brings innovative cardiovascular technology to the hospital

Indianapolis, IN --- Community Hospital South has taken a major step in bringing state-of-the-art heart care to South Central Indiana, with the opening of a cutting-edge electrophysiology (EP) lab and interventional radiology (IR) lab. The new labs will give patients access to the most minimally-invasive techniques available to diagnose and treat cardiovascular conditions, including irregular heartbeats or arrhythmias. **A media availability with tours of the new labs is scheduled for Wednesday, August 19, at 2:30 p.m.** A complementary ice cream social and open house to showcase the new space will be held from 4 p.m. to 7 p.m.

"The new labs will enhance our physicians' ability to treat heart arrhythmias and other cardiac conditions, while allowing us to continue to provide the most comprehensive heart care available," said Tony Lennen, president of Community Health Network's South Region. "It's truly a testament for what a community-based hospital can achieve when it commits to delivering the highest-quality patient care."

The EP lab and the IR lab occupy 3,800 square feet of space and are equipped with state-of-the-art technology. The EP lab is equipped with the Philips FD10 EP Cockpit System digital imaging x-ray system. This technology provides sharper images and the ability to better visualize a patient's anatomy during a procedure. In addition, it offers enhanced safety by significantly reducing radiation doses to both the patient and staff. Its flat panel technology also brings new capabilities to Community, by allowing physicians to perform electrophysiology procedures in a dedicated space. Both labs are located in a common area next to the existing catheterization lab, thereby centralizing the cardiovascular labs into one space for better patient treatment.

"Cardiac electrophysiology is the evaluation and treatment of patients with heart rhythm disorders," said Vincent Keating, M.D., electrophysiologist with Community Physician Network. The use of high- quality imaging is of vital importance to the success of any cardiac electrophysiology procedure. This new lab ensures access to that high-quality imaging for our patients on the south side."

Building upon its tradition of innovative cardiovascular care, Community Hospital South offers a full range of services including cardiac diagnosis, treatment, rehabilitation, holter monitoring, research and vascular surgery.

Dr. Tim Kelly to serve on Governor's Task Force

For release: 9/1/2015

Dr. Tim Kelly, internist and addictions specialist with Community Behavioral Health, has been tapped to serve on the newly-created Governor's Task Force on Drug Enforcement, Treatment and Prevention.
Below is the official press release from Governor Pence's office.

Governor Pence Announces Governor's Task Force on Drug Enforcement, Treatment, and Prevention
Indianapolis –Governor Mike Pence today announced the creation of the Governor's Task Force on Drug Enforcement, Treatment, and Prevention (Task Force), an effort by his Administration to combat drug abuse in Indiana.
"We've created the Governor's Task Force on Drug Enforcement, Treatment, and Prevention because it is time to take a holistic and collaborative approach to addressing substance abuse and its many heartbreaking repercussions in our state," said Governor Pence. "Drug abuse problems are not unique to Indiana, and while multiple entities are doing their part to combat drug abuse, we must work together as a state identify gaps that hinder us from preventing drug abuse, treating drug abuse, and effectively enforcing drug laws. An effort of this magnitude requires the insight and involvement of all three branches of government, multiple state agencies, local municipalities, experts in the fields of drug treatment and youth intervention, community outreach, medical authorities and I welcome the input of all of those who will be involved in this critical undertaking. Together is the best way to reduce, prevent, and treat drug addiction in Indiana."

Established by Executive Order, the Task Force will bring together Indiana experts from a variety of specialties to evaluate the growing national drug problem here in Indiana. Specifically, the Task Force is charged with:

· Statewide assessment: Evaluate the existing resources across all areas, identify gaps in enforcement, treatment and prevention and provide recommendations for improvement.
· Enforcement: Identify effective strategies so federal, state, and local law enforcement can partner together to combat drug abuse
· Treatment: Analyze available resources for treatment and identify best practices for treating drug addiction
· Prevention: Identify programs and/or policies which are effective in preventing drug abuse, including early youth intervention programs

The Task Force will meet monthly for the next three months –on September 16th, October 15th, and November 19th. The meetings will take place in the north, south, and central regions and will include testimony from local experts and families impacted by the epidemic. TheTask Force will provide recommendations to the Governor throughout the process of meetings, and will prepare a final report of all findings and recommendations.

From 1999 to 2009, Indiana saw a 500 percent increase in the rate of drug overdose deaths, and in 2013, Indiana ranked 16th in highest overdose rate in the nation.

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Community Health Network announces $8.6 million project in Anderson

For release: 9/1/2015

New health pavilion will improve healthcare access and promote economic development

Anderson, IN---Community Health Network will host a groundbreaking ceremony on Tuesday, September 1, at 11 a.m., as construction begins for the new Community Health Pavilion Anderson. The $8.6 million project will improve access to healthcare and support economic development in Madison County. The groundbreaking will take place at 32nd and Scatterfield Road.

Located on 3.8 acres of land, Community Health Pavilion Anderson will be a three-story, 68,000 square- foot medical building that will house a variety of health care services.

“The development of the Community Health Pavilion Anderson will serve as an important addition to the health services available to residents in Madison County,” said Beth Tharp, president and CEO of Community Hospital Anderson.

When completed in late 2016, the new pavilion will offer convenient access to outpatient services, including MedCheck; behavioral health; primary care physicians;

specialty care; physical therapy; rehab and sports medicine; a lab; and other health-related services. It will also house a community room dedicated to patient education and health screenings.

"Our medical pavilion concept has been extremely popular with patients and families, and our new facility in Anderson will provide a wide variety of services in a great location," said Jon Fohrer, vice president Community Health Network's ambulatory division.
Alderson Commercial Group, Inc. has been named the pavilion's developer.
Community manages a total of twelve health pavilions conveniently located throughout Central Indiana.

Community Health Network partners with VillageMD to form new company and deliver innovative primary care model in Indiana

For release: 9/2/2015

Focus is on keeping people healthy and managing chronic disease, while increasing quality and reducing healthcare costs

Indianapolis, IN---In a bold move that will positively impact Indiana primary care providers and patients, Community Health Network is partnering with Chicago-based VillageMD to create a new model of healthcare delivery that will improve the quality of patient care and significantly reduce healthcare costs, while providing primary care physicians the tools to focus on their patients. The joint venture is called Primaria Health LLC and is the first of its kind in the state. Doug Stratton—a longtime healthcare executive who previously served as the CEO of Principal Healthcare of Indiana and president and CEO of Cigna of Kansas and Missouri—is the CEO of Primaria, effective September 1.
"Community Health Network has long recognized that the status quo in healthcare is not sustainable," said Bryan Mills, president and CEO of Community. "The current fee-for-service model, a system in which people seek care when they are sick, not only is costly, it frequently does not yield the best outcomes for patients. Our strategy is a value-based model of care for patients, which will improve their outcomes and drive down healthcare costs."
Primaria Health LLC will provide services to Community and independent providers across a 38-county area of Central Indiana, managing the population health process so that physician time is focused on patient care and engagement with other physicians. Physicians will have access to proven processes and technology that have demonstrated significant clinical improvements in patients dealing with diabetes, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), coronary artery disease (CAD), and other complicated health conditions. These

resources include sophisticated data analysis to identify patients most at risk for a variety of health conditions and complications, as well as those living with chronic conditions; behavioral health management; and resources addressing medication management challenges that require improved coordination of services. Primaria will begin providing services to Community primary care physicians on October 1, 2015.
"VillageMD prides itself on the ability to partner with forward-thinking primary care providers, who are aligned around a clinical care model that improves not only the health of those patients living with chronic and debilitating illness, but also focuses on wellness and prevention," said VillageMD CEO Tim Barry. "The result of this proactive approach is a reduction in avoidable admissions and readmissions. With its vibrant primary care base, and leadership conviction toward a better model of care delivery, Community is the ideal partner for this venture. Community's doctors, along with independent primary care physicians across Central Indiana, will serve as the foundation for a physician-led network that drives quality and cost improvements."
"Community Health Network has been on the forefront of finding new care models that improve patients' health and outcomes," said Stratton. "This new model places a priority on primary care, early intervention and disease prevention. We believe that with the help of targeted care teams, data infrastructure and analysis, we can keep people at their optimum health and avoid unnecessary services. Being able to address problems before they require emergency care is at the heart of the new model developed by Primaria."

Community Health Network enters into new contract with Anthem Blue Cross and Blue Shield to improve patient health, lower costs

For release: 9/29/2015

Anthem is first insurer to sign contract with Community Health Network since its formation of Primaria Health, the company created recently to improve coordination of care and enhance patient experience

Indianapolis, IN---Community Health Network announced today that it has reached an agreement with the state's largest health insurer on a value-based contract that will benefit patients, primary care providers and employers across Central Indiana.
"This contract with the largest payer in the state of Indiana is an important step on the path to a value-based system, where the emphasis is placed on better health outcomes at lower healthcare costs," said Bryan Mills, president and CEO of Community. "We are now transitioning to a new healthcare future that helps patients prevent illness and stay healthier longer."

With this agreement, Anthem becomes the first health benefits company in Indiana to contract with Community Health Network since the formation of Primaria Health LLC Sept. 1. Primaria Health is a management services organization formed by Community, in a joint venture with VillageMD, to help Community and independent primary care physicians across 38 counties in Central Indiana manage the health of their patients.

Approximately 70,000 of Anthem's policyholders who receive healthcare services from a Community primary care physician will be supported by Primaria, which provides the tools and resources enabling physicians to focus on their patients, delivering quality care that will keep them healthy.

"Community physicians, using the resources of the newly established Primaria, will proactively reach out to Anthem members to help them manage chronic disease, coordinate their care and improve their health," said Robert W. Hillman, president of Anthem Blue Cross and Blue Shield in Indiana. "Our members will be pleased to see more emphasis on preventive health and wellness and efforts to prevent costly hospital readmissions. This contract continues Anthem's productive relationship with Community Health Network. We believe that their efforts to improve health and control health care costs will benefit Anthem's customers throughout Central Indiana."

Primaria Health will begin providing services to Community primary care physicians October 1.

"Patients will now live in an age where they can expect improved health through prevention, early identification, and improved methods of treating chronic diseases," said Doug Stratton, CEO of Primaria Health. "Primaria will help physicians with proven processes and sophisticated data analysis that will show them who's most at risk for complicated health conditions, and provide additional resources to help manage their conditions."

Community Health Network breaks ground on $60 million cancer center

For release: 10/6/2015

Community Cancer Center North to bring expanded oncology services to the North Region

Indianapolis, IN---Community Health Network today broke ground on a new $60 million cancer center, Community Cancer Center North, which will provide state-of-the art expanded oncology services to Community's North Region. An increasing demand for cancer care is the driving force behind the new facility, which will focus on the entire experience of cancer patients. The new center, to be located on the Community Hospital North campus along Shadeland Avenue and just south of Community Heart and Vascular Hospital, will replace the existing decades-old cancer center. It will be connected by a walkway to Community Hospital North.

“Our cancer volumes have significantly increased across the network over the past several years, outpacing our growth projections,” said Bryan Mills, president and CEO of Community Health Network. “The need for this new facility couldn’t be greater. We have outgrown the space in our current cancer center on the Community North campus, and this new building will not only provide the kind of exceptional cancer care our patients already expect and receive, but also a host of new services that take cancer care well into the future.”

Community Cancer Center North will be a three-story, 104,000-square foot facility that offers a calming and supportive environment for cancer patients and their families. The new center will treat medical, radiation and surgical oncology patients. Amenities and benefits include expansive private guest suites with family areas; natural lighting; a garden, courtyard and entry built to lessen anxiety; work space areas; a wellness facility; a labyrinth for walking and meditation; and short-wait treatment times.

The new center will incorporate an integrative healthcare model, which provides such services as spaces devoted to cancer support groups, physical therapy, art therapy, music therapy, tai chi and massage. In addition, some rooms will be equipped with exercise equipment. Computers will be available in each exam room, so that patient may continue work plans or conduct research about their disease.

“Our new cancer facility was designed completely around our patients and their personal needs during the treatment process,” said Jianan Graybill, MD, radiation oncologist and lead physician on the project. “We are building this with direct design input from our patients, physicians and staff. The result will be enhanced patient care, as well as efficient use of treatment space that also improves the experience for physicians and staff.

Community Health Network is affiliated with MD Anderson Cancer Network®, a program of The University of Texas MD Anderson Cancer Center. The University of Texas MD Anderson Cancer Center is currently the No. 1 cancer hospital according to U.S. News and World Report’s “Best Hospitals” survey. Thirty-four Community Health Network oncology specialists are certified physicians by MD Anderson Cancer Network®.

Construction on the new Community Cancer Center North is expected to be complete in early 2017.

Community Health Network launches suicide prevention website for teens, parents, educators

For release: 10/7/2015

New resource offered thanks to grants received by Community Health Network Foundation

Indianapolis, IN—Community Health Network recently launched a new website, www.HaveHope.com, which provides resources for teenagers, parents and educators to learn the warning signs and risk factors associated with suicide among youth in Indiana. The website is part of Community's Zero Suicide initiative, which supports our aspirational goal to achieve a zero percent suicide incident rate for people in our care in the next ten years.

From what to say for teenagers worried about a friend to personal accounts from parents and educators who have intervened and prevented suicide, the Have Hope website offers tools to combat the ever-rising rate of death by suicide in our community.

In Indiana, one in five youth contemplate suicide, and the state has the nation's second highest rate of high school students attempting suicide. Statewide, more than twice as many Hoosiers die by suicide than homicide.

"Suicide is a leading cause of death among children and teens in Indiana, and it is imperative that our community have resources like the Have Hope website to combat the issue," said Suzanne Clifford, Senior Vice President of Integrated Primary Care at Community. "This tool will play a powerful role in starting much-needed conversations about suicide prevention in homes and schools across Indiana. Whether a friend, parent or teacher, you can help make a difference in preventing suicide and the heartbreak that comes with it."

Community's new online resource is made possible by a grant Community Health Network Foundation received late in 2014 from The Glick Fund, a fund of Central Indiana Community Foundation, and in part from a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) under the U.S. Department of Health and Human Services.

Community Health Network is Indiana's most comprehensive provider of youth behavioral health services, and last year announced its commitment to becoming one of the first health care systems in the United States to fully implement the Zero Suicide model, developed by the National Action Alliance for Suicide Prevention and other partners. At the same time, the Indiana Division of Mental Health and Addiction and Community Health Network have partnered to spearhead the state's suicide prevention movement to save young lives.

If you are concerned someone you know is contemplating suicide, call Community Health Network's crisis hotline at 800-662-3445 or text "HELPNOW" to 20121.

Community Health Network Foundation kicks off year-end effort for youth suicide prevention

For release: 11/18/2015

Will be focus on Giving Tuesday, includes Matching Challenge from Eli Lilly and Company Foundation

Indianapolis, IN - Community Health Network Foundation recently launched its end-of-year effort geared toward suicide prevention among Hoosier youth and teenagers. The campaign will support Community's Zero Suicide Initiative, the non-profit health system's bold and aspirational goal to achieve a zero percent suicide incident rate among patients in the next ten years.

Indiana has the second highest rate of high school students attempting suicide. Suicide is the second leading cause of death for youth ages 15 to 24, and the third leading cause for youth ages 10 to 14.
As part of the end-of-year campaign, which will include the Foundation's Giving Tuesday efforts on December 1, the Eli Lilly and Company Foundation has offered a $100,000 Matching Challenge, meaning that every dollar donated on the way to reaching $100,000 will double.

"From now until the end of December, Community Health Network Foundation will focus on supporting the Zero Suicide Initiative and doing all we can to raise awareness of this important cause," said Bente Weitekamp, Vice President of Development for the Foundation. "With the generosity of Eli Lilly and Company Foundation's Matching Challenge, the support of Hoosiers and the expertise of Community's behavioral health team, this effort will help to change and save lives."

Support received for the Foundation's year-end effort will further Community's behavioral health services for youth and teens in the community including:

- Providing mental health and substance abuse services to students in the school environment in more than 80 sites for Indianapolis Public Schools and the Metropolitan School Districts of Lawrence, Warren, Washington and Wayne townships;
- Implementing and expanding Community's suicide prevention and early intervention programs, including its 24-hour toll-free Crisis Line;
- Training staff and volunteers to detect and assist youth who are at risk; and

- Continuing the "Text to Help" program, available by texting "HELPNOW" to 20121, so a teen in trouble can communicate with a health services professional who knows how to help.

The announcement was made in the form of a video featuring Kimble Richardson, a licensed mental health counselor at Community Health Network.

"Suicide is a real threat to our kids and teens," says Richardson in the video. "This is a problem that goes beyond racial, ethnic or religious groups. This is a problem for all of us. And this is what Community's Zero Suicide Initiative is all about. It's about every one of us doing everything we can to understand this threat, to create awareness in our schools, communities and families, and to create the tools and programs that will help our kids and teens, as well as everyone around them, know that there is always a better option, and that they are worth every effort we can make."

The full video is available at http://whatcommunitymeansto.me/2015/zero-suicide/video.php. Visitors to the web page are able to select whether they are a teen, parent or educator and then take a demographic-specific suicide prevention quiz aimed at increasing awareness of this statewide health crisis. Individuals interested in making a donation are encouraged to visithttps://give.ecommunity.org/support, call 317-355-GIVE or email give@eCommunity.com.
Community is Central Indiana's largest provider of behavioral health services. This announcement follows the recent launch of Community's web resource, www.HaveHope.com, which provides suicide prevention resources for teens, parents and teachers.

3. **Environmental improvements:**

   Although no activities were listed in this category as far as dollars spent it is far from illustrating our impact on the environmental issues in the community. From energy efficiency initiatives to community gardens all can be documented in several categories. This categorization is driven by the funds reported in each area rather than our interest and support.

4. **Leadership development and training for community members:**

   Although no activities were listed in this category as far as dollars spent it is far from illustrating our impact on leadership development for community leaders. We are integral in many neighborhood groups and have initiated and maintained a relationship with over five "Healthy Communities" initiatives. They include the

original Partnership for a Healthier Johnson County, Binford Redevelopment and Growth, Eastside Redevelopment Committee, Healthier Hamilton County and Irvington Development Organization.

5. **Coalition building:**

Although no activities were listed in this category as far as dollars spent it is far from illustrating our impact on coalition building. In each hospital services area we have coalitions built to give us constant community input and a tool to disperse important health information to the community at large. Each coalition is unique to the social climate of the community and reflects the mission of Community Health Network to "enhance health and well being". These coalitions assist with the Implementation Strategy and provide us with realistically looking at the ability to change a culture. The coalitions in each service area include:

- Community Hospital East: Eastside Redevelopment Committee
- Community Hospital North: Partnership for Healthy Hamilton County
- Community Hospital South: Partnership for a Healthier Johnson County
- Community Hospital Anderson: Madison County Health Coalition (United Way)
- Community Hospital Howard: United Way Partnership

6. **Community health improvement advocacy:**

School Based Health Services

Community Health Network will be recognized as the premier healthcare provider for customizing unique school partnerships within Central Indiana. The partnerships and services meet the needs of each school district and their local community and help ensure timely access to coordinated care while enhancing the health and well-being of students, staff and families.

Seven Principles of School Health

I. *The school health services should be built upon mutual respect and collaboration between the school and the health provider to promote the health and educational success of students.*
II. *School Health Services will be responsive to community needs.*
III. *School Health Services will have a primary focus on the student.*
IV. *School Health Services will deliver comprehensive care.*
V. *All school health services will advance health promotion activities.*

VI. *The school health services will implement effective administrative and clinical systems.*

VII. *The school health services will provide leadership in adolescent and child health.*

The following illustrates the array of services that Community Health Network provides to schools

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

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

As a response to federal, state and local initiatives that address the needs for families to receive basic primary healthcare, Community Health Network (CHN) has successfully partnered with schools, churches, community associations, local businesses and funding sources to bring health education and health services to various communities while respecting their unique cultural situations. The School District in Indianapolis and surrounding counties are rife with adverse social indicators and all have used many initiatives to address these needs in their students, families and community. The many needs and risk factors of its students led CHN to form partnerships with school systems. These partnerships led to the creation of the first school based clinic 12 years ago. The partnerships chose locations for a full time school based health clinic which provides health care and medical education for not only its students but for their families and the surrounding community. As we quickly discovered, the students and their families faced many obstacles to health, treatment, and academic achievement.

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

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

and fewer missed school days, but they also performed better than other schools on the standardized ISTEP exams.

School-based wellness clinics

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

The clinics provide such wellness services as immunizations, and also see children with minor illnesses or injuries. Sometimes another family member—sibling or parent—will also receive health care services at the clinics. The clinics help families connect with other health services as well. For example, parents without insurance are offered help in enrolling their kids in the Hoosier Healthwise program that insures children. School officials believe that the easy availability of health care services is one of the factors behind their students' success. For example, the students at clinic host site Hawthorne Elementary have made significant academic achievement throughout the clinics 12 year tenure at the school. Hawthorne third-graders recently had Warren Township's best ISTEP scores and the school received national recognition as a "Title I" School.

The following chart list the school districts and key information for each school in regards to student health.

Name	% FRL *	# School Nurse Clinics	#CHNw Nursing Staff	# School District Staff	# Students	# School Nurse Clinic Visits	% RTC **
Beech Grove	66%	5	8	251	2,986	39,503	95.4%
Decatur	66%	9	10	671	6,202	42,335	96.6%
Franklin	36%	11	16	743	8,748	71,735	96.6%
Greenwood	46%	6	6	375	3,757	39,503	96%
Lawrence	59%	21	27	2,175	15,164	151,058	95.6%
Warren	73%	18	19	1,450	12,100	113,279	96.5%
Charter Schools	95%	17	17	379	5863	8050	89%
TOTALS	**63%**	**87**	**103**	**6,044**	**54,820**	**460,384**	**94.9%**

Behavioral Care School-based program

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

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

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

School crisis response

Community Hospital's behavioral care staff participates with several mental health organizations in Marion County on a school crisis response team. This team is composed of trained volunteers from various participating agencies, and services are provided at no cost to the schools served upon their request. Volunteers provide crisis debriefing, education and consultation to school-age children and adolescents, teachers and school administrators. Services are provided at the school or another pre-arranged site such as a church or community center. The following chart list the school districts and key information for each school in regards to student behavioral health services.

Name	# Behavioral Health Clinics	# Students Receiving BHS *	# CHNw Therapists**	# Behavioral Health Clinic Visits
Lawrence	19	521	21	33,534
Warren	18	715	23	42,175
Washington	4	131	5	4,124
Charter Schools	11	198	11	2,157
IPS	29	780	43	59,638
TOTALS	**81**	**2,345**	**103**	**141,628**

Jane Pauley Community Health Center

What are the Jane Pauley Community Health Centers?

The Jane Pauley Community Health Centers offer comprehensive health care to the communities we serve, regardless of someone's ability to pay. The health centers offer primary health care, dental, and behavioral health services for adults and children. Our services include preventive care and annual exams, well-child checks, acute care, and certain procedures. The health centers also focus on the management of chronic diseases, such as diabetes, cardiac disease, and depression. The Jane Pauley Community Health Center was established in 2009 with generous support from the Metropolitan School District of Warren Township, Community Health Network and the Community Health Network Foundation. It is named after Jane Pauley, a 1968 Warren Central High School graduate who grew up in the area and is well known as the former anchor of NBC-TV's Today and Dateline programs. The Community Health Network continues its support through financial contributions and collaborative practices. Jane Pauley has been one of the most respected figures in American broadcast journalism for more than thirty years, with a television career that spanned morning, daytime, and primetime.

In 1972, Pauley began her journalism career as a "temporary, probationary employee for 90 days" at WISH-TV her hometown in Indianapolis, but within three years became the first woman to anchor a weekday evening newscast in Chicago at NBC's WMAQ-TV. Only one year later, Pauley vaulted to the top of network news as co-host of NBC's Today—she was 25.

For the next thirteen years she interviewed thousands of newsmakers from every walk of life and in locations all over the world—from the Vatican to the Great Wall of China. First teamed with Tom Brokaw and later with Bryant Gumbel, Pauley was on the scene of a dozen presidential nominating conventions. She covered both the royal wedding and the funeral of Princess Diana.

Pauley also anchored the Weekend Edition of NBC News; appeared as a regular substitute for Tom Brokaw on Nightly News; hosted Time and Again, a retrospective news program on MSNBC; and contributed to a weekly newsmagazine, Real Life with Jane Pauley. For more than a decade, Pauley anchored Dateline NBC with co-host Stone Phillips, appearing as many as four nights a week on the NBC primetime schedule. Pauley's Dateline farewell, "Jane Pauley: Signing Off," attracted record ratings. In 2004, she returned to television with The Jane Pauley Show.

A member of the Broadcast and Cable Hall of Fame, Pauley has been honored with multiple Emmy Awards, the Edward R. Murrow Award for outstanding achievement, the Radio and Television News Directors Association's Paul White Award for lifetime contribution to electronic journalism, the Gracie Allen Award for outstanding achievement by an individual from American Women in Radio and Television, and the first

international Matrix Award from the Association for Women in Communication. In 2007, Pauley received the Walter Cronkite Award for Excellence in Journalism from Arizona State University and, in 2009 she was inducted into the Indiana Journalism Hall of Fame on the campus of DePauw University. Pauley was also honored with another Gracie Award, this time for her work as host of AARP's nationally acclaimed television documentary, Picking Up the Pieces.

Pauley is a former trustee of the Radio and Television News Directors Foundation, and a Fellow of the Society for Professional Journalists, under the guidance of which she funded the Pauley Task Force on Mass Communication Education, a comprehensive assessment of college journalism curriculums.

Pauley is a former member of the advisory board of Pencil, an organization which fosters civic involvement in public education. She is also a member of the advisory board of the International Council of Freedom from Hunger, as well as chairman of the advisory board of The Children's Health Fund.

Pauley is recognized as a powerful advocate in the field of mental health. In her memoir, the New York Times bestseller Skywriting: a Life out of the Blue, Pauley wrote candidly about being diagnosed with mental illness at the age of 50, after medical treatment for hives triggered a previously unrecognized vulnerability to bipolar depression. In 2008, the National Alliance on Mental Illness presented Jane with their highest honor, The Rona and Ken Purdy Award, for her national contribution to the fight against discrimination and stigma. Pauley is a member of the Leadership Board of the McGovern Institute for Brain Research at MIT. A graduate of Indiana University, Pauley has been married since 1980 to Doonesbury cartoonist Garry Trudeau. They have three children and reside in New York City.

Jane Pauley Community Health Center

Primary care offices

JPCHC at 16th Street
5317 E. 16th St.
Indianapolis, IN 46218
Located behind Community Hospital East
View a map/Get directions
Phone: 317-355-3700
Fax: 317-355-9319
Hours: Monday through Friday, 8 a.m. to 7 p.m.

JPCHC at Post Road
8931 E. 30th Street
Indianapolis, IN 46219
The Center is located in the Renaissance School
View a map/Get directions
Phone: 317-355-9320

Fax: 317-355-9319
Hours: Monday through Friday, 8 a.m. to 5 p.m.

JPCHC at Shadeland Avenue
Community Health Pavilion Shadeland
2040 N. Shadeland Avenue, Suite 300
Indianapolis, IN 46219
View a map/Get directions
Phone: 317-355-3232
Fax: 317-355-7851
Hours: Monday through Friday, 8 a.m. to 5 p.m.

JPCHC at Anderson
1210B Medical Arts Blvd. Suite 300
Anderson, IN 46011
View a map/Get directions
Phone: 765-298-5263
Hours: Monday through Friday, 8 a.m. to 5 p.m.

JPCHC at Greenfield
1107 N. State St.
Greenfield, IN 46140
View a map/Get directions
Phone: 317-477-5263
Hours: Monday through Friday, 8 a.m. to 5 p.m.

JPCHC at Brook Park Elementary School
5259 David Street, Indianapolis, IN 46226
Phone: 317-355-3904
Hours: Monday through Friday, 8 a.m. to 5 p.m.

JPCHC at Hawthorne Elementary School
8301 Rawles Ave, Indianapolis, IN 46219
Phone: 317-355-3905
Hours: Monday through Friday, 8 a.m. to 5 p.m.

JPCHC at Howe High School
4900 Julian Ave, Indianapolis, IN 46201
Phone: 317-355-3906
Hours: Monday through Friday, 8 a.m. to 5 p.m.

JPCHC at Shelbyville Middle School
1200 W. McKay Rd, Shelbyville, IN 46176

Phone: 317-395-5059
Hours: Monday through Friday, 8 a.m. to 5 p.m.

Dental office

Jane Pauley Community Health Center Dental Clinic
Located inside the Walker Career Center at Warren Central High School
9651 E. 21st Street
Indianapolis, IN 46229
View a map/Get directions
Phone: 317-355-2123
Hours: Tuesday, Thursday, Friday 7 a.m. to 4 p.m.; Wednesday 7 to 11 a.m.

7. **Workforce development**

Project SEARCH / Indiana

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

- State of Indiana, Family & Social Services Administration/Office of Vocational Rehabilitation • Role = Fiscal Support
- Community Health Network • Role = Training Site and Employer
- Easter Seals Crossroads • Role = Job Coaching and Job Accommodations Provider
- Indianapolis Public Schools • Role = Educational Provider
- Indiana University / Indiana Institute on Disability and Community • Role = Technical Assistance Provider

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

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

How

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

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

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

Healthcare Career Mentoring and Job Shadowing Program

Program Description

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

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

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

Students that successfully complete the second semester two-week orientation will participate in a six-week job shadowing across various front-office and back-office medical disciplines within the Community Health Network organization. Student job shadowing placement opportunities exist primarily in clinical out-patient health services and non-clinical healthcare fields.

Students completing both semesters of the program will take the Indiana State Department of Health's CNA examination. Students who successfully pass the CNA examination and who graduate from each of the respective Career Centers with a high school diploma or GED in addition to being listed in good standing as a CNA on the Indiana State Nurse Aide Registry will be afforded a prioritized opportunity for CNA employment within the Community Health Network organization. Also, program

graduates will receive prioritized opportunity for CNA employment with Bethany Village Nursing Home. Program graduates who prefer to continue with their postsecondary educational opportunities rather than initial employment will remain in the program tracking database regarding educational progress.

Goal & Objectives

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

The main objectives include:

- Ensure that 75% of graduating program participants will be attending an accredited postsecondary institution and/or be employed by a healthcare provider no later than six months after graduating from high school and passing the nurse aide competency evaluation test.

- Provide appropriate and varied learning experiences for program participants in accordance to each respective Career Center's educational goals and objectives.

- Enable student participants increased access to professional networking and employment opportunities through job shadowing and career mentoring externships.

8. **Other: NA**

Part V: Supplemental Information:

Figure 6. Part V Schedule H

Part V **Facility Information** *(continued)*

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a State as a hospital facility in the current tax year or the immediately preceding tax year?	1		✔
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		✔
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	✔	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The significant health needs of the community			
f	☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☑ Information gaps that limit the hospital facility's ability to assess the community's health needs			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 12			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	✔	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	✔	
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b		✔
7	Did the hospital facility make its CHNA report widely available to the public?	7	✔	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	☑ Hospital facility's website (list url): www.ecommunity.com			
b	☑ Other website (list url): www.ecommunityanderson.com			
c	☑ Made a paper copy available for public inspection without charge at the hospital facility			
d	☐ Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	✔	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 13			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	✔	
a	If "Yes," (list url): www.ecommunity.com/aboutus/care.aspx			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	✔	
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12 a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		✔
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Schedule H (Form 990) 2014

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group Community Health Network, Inc.

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	13	✔	
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 % and FPG family income limit for eligibility for discounted care of 300 %			
b	☐ Income level other than FPG (describe in Section C)			
c	☐ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☑ Underinsurance status			
g	☑ Residency			
h	☑ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	✔	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	15	✔	
a	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Included measures to publicize the policy within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	16	✔	
a	☑ The FAP was widely available on a website (list url): www.ecommunity.com/s/financial-assitance/			
b	☐ The FAP application form was widely available on a website (list url):			
c	☑ A plain language summary of the FAP was widely available on a website (list url): Same as above			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	☑ Notice of availability of the FAP was conspicuously displayed throughout the hospital facility			
h	☐ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☐ Other (describe in Section C)			
Billing and Collections				
17	Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon non-payment?	17	✔	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:			
a	☐ Reporting to credit agency(ies)			
b	☐ Selling an individual's debt to another party			
c	☐ Actions that require a legal or judicial process			
d	☐ Other similar actions (describe in Section C)			
e	☐ None of these actions or other similar actions were permitted			

Part V Facility Information *(continued)*

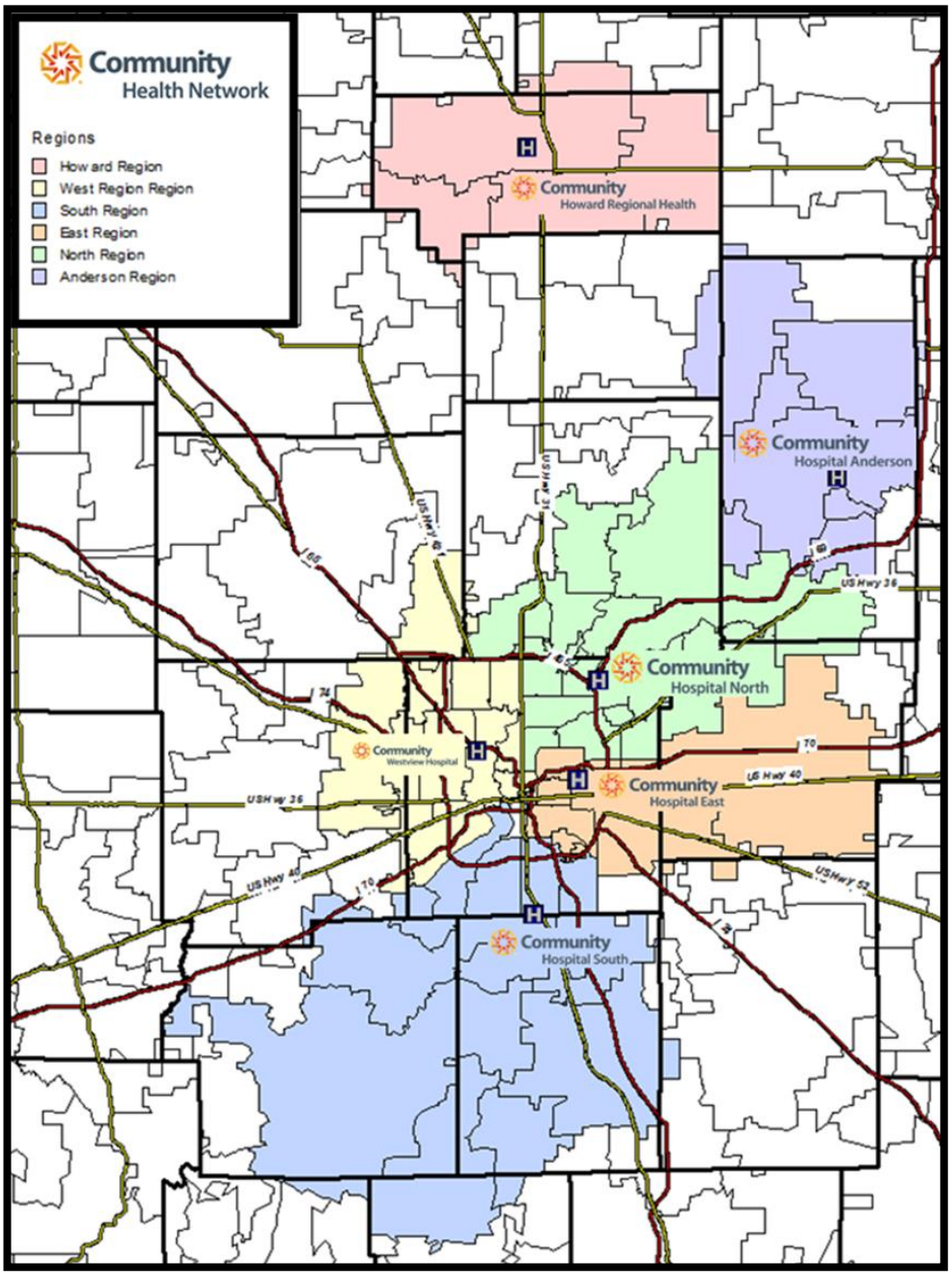
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16i, 18d, 19d, 20e, 21c, 21d, 22d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

Community Health Needs Assessment:

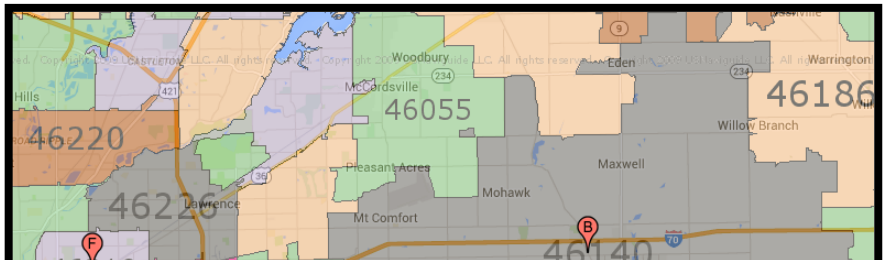
3a: A definition of the community served by the hospital facility:

Each hospital facility has a defined services area. What follows are several maps which provide examples of the individual service areas of each market with associated zip codes. Each provides us with different information depending on the audience we are trying to reach and the level of detail given their geography.

Figure 6. Part V Schedule H



Community Hospital East
Service Area Zip Codes

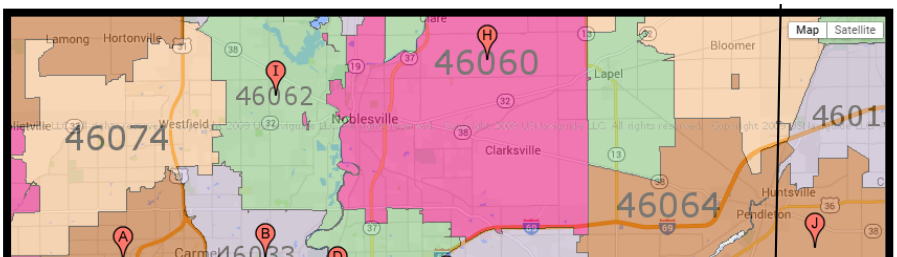


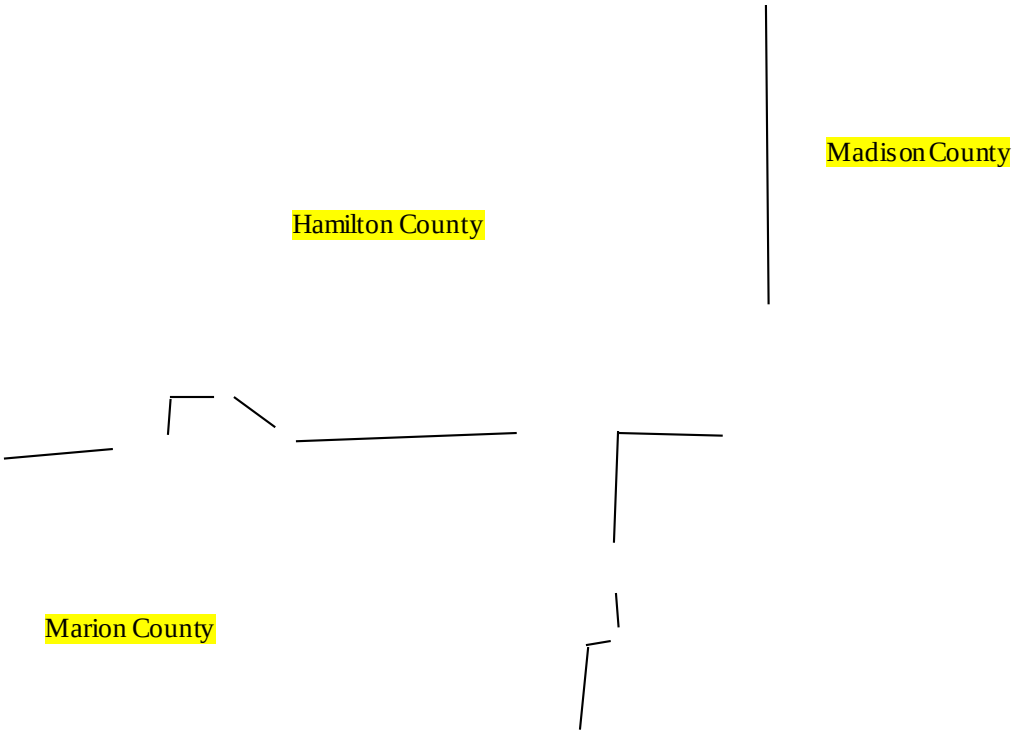
Marion County

Hancock County

A	46107 Beech Grove, IN
B	46140 Greenfield, IN
C	46163 New Palestine, IN
D	46201 Indianapolis, IN
E	46203 Indianapolis, IN
F	46218 Indianapolis, IN
G	46219 Indianapolis, IN = CHE LOCATION
H	46229 Indianapolis, IN
I	46239 Indianapolis, IN

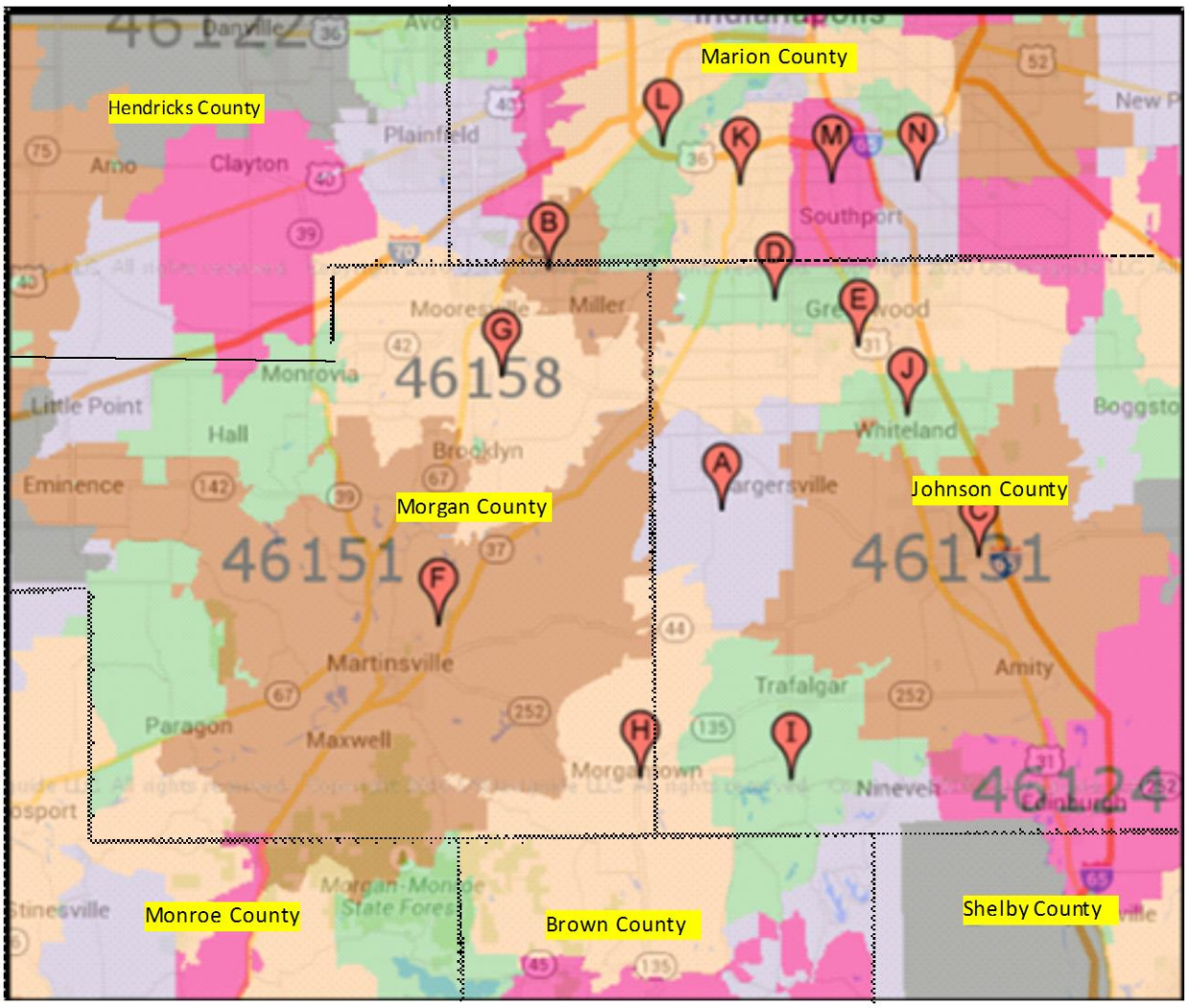
Community Hospital North
Service Area Zip Codes





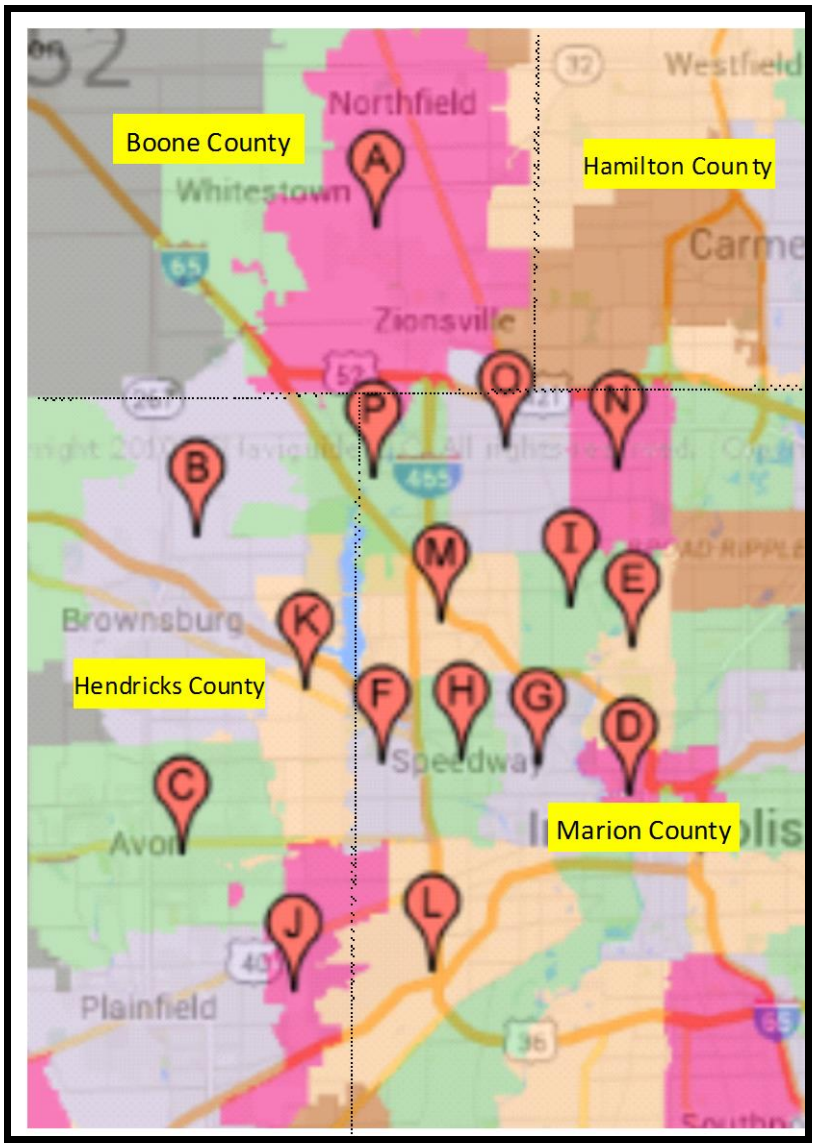
A	46032 Carmel, IN	**K**	46205 Indianapolis, IN
B	46033 Carmel, IN	**L**	46216 Indianapolis, IN
C	46037 Fishers, IN	**M**	46220 Indianapolis, IN
D	46038 Fishers, IN	**N**	46226 Indianapolis, IN
E	46040 Fortville, IN	**O**	46235 Indianapolis, IN
F	46048 Ingalls, IN	**P**	46236 Indianapolis, IN
G	46055 McCordsville, IN	**Q**	46240 Indianapolis, IN
H	46060 Noblesville, IN	**R**	46250 Indianapolis, IN
I	46062 Noblesville, IN	**S**	46256 Indianapolis, IN = CHN LOCATION
J	46064 Pendleton, IN	**T**	46280 Indianapolis, IN

Community Hospital South
Service Area Zip Codes



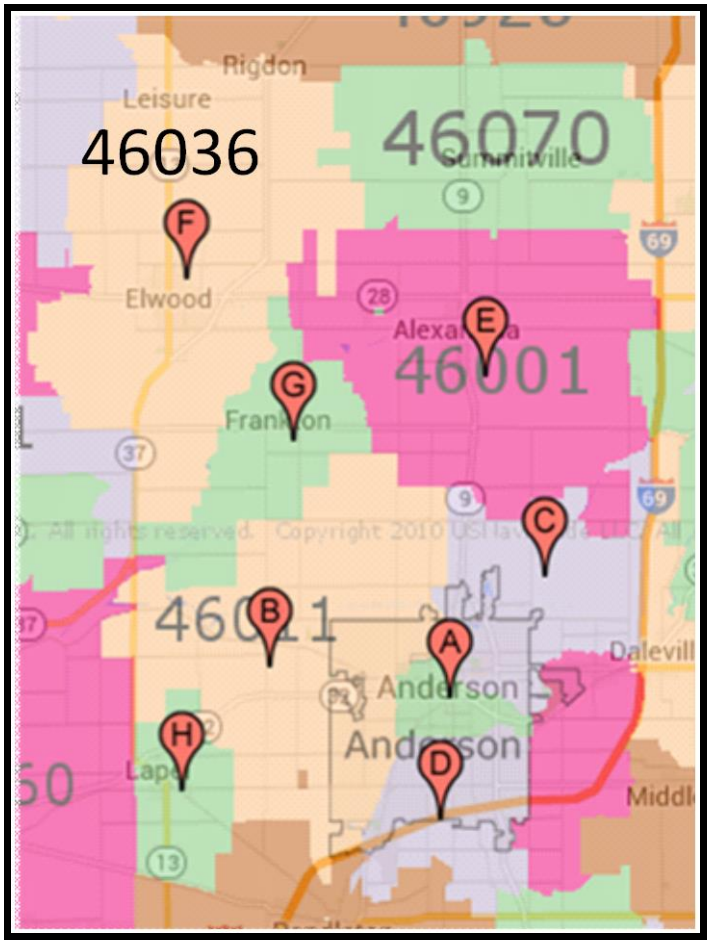
A	46106 Bargersville, IN	H	46160 Morgantown, IN
B	46113 Camby, IN	I	46181 Trafalgar, IN
C	46131 Franklin, IN	J	46184 Whiteland, IN
D	46142 Greenwood, IN	K	46217 Indianapolis, IN
E	46143 Greenwood, IN	L	46221 Indianapolis, IN
F	46151 Martinsville, IN	M	46227 Indianapolis, IN = CHS LOCATION
G	46158 Mooresville, IN	N	46237 Indianapolis, IN

Community Westview Hospital
Service Area Zip Codes



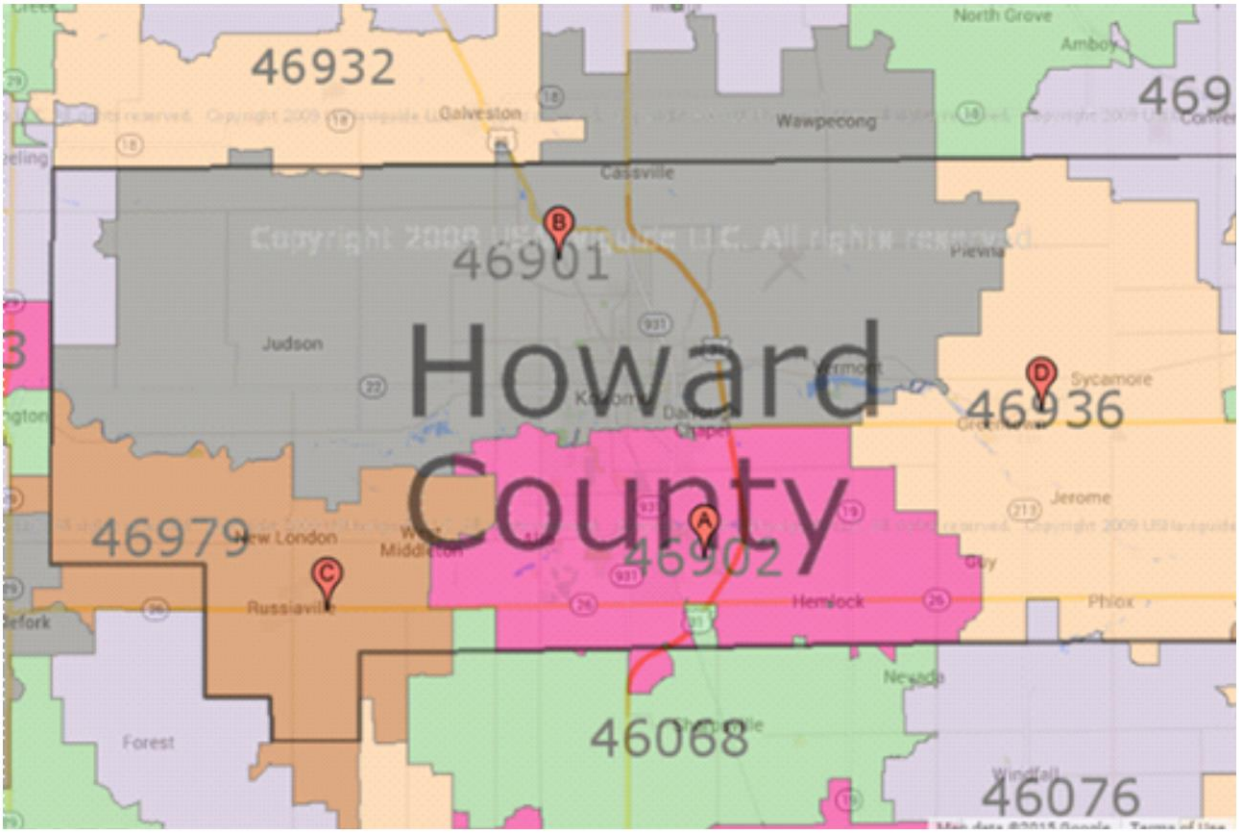
A	46077 Zionsville, IN	I	46228 Indianapolis, IN
B	46112 Brownsburg, IN	J	46231 Indianapolis, IN
C	46123 Avon, IN	K	46234 Indianapolis, IN
D	46202 Indianapolis, IN	L	46241 Indianapolis, IN
E	46208 Indianapolis, IN	M	46254 Indianapolis, IN
F	46214 Indianapolis, IN	N	46260 Indianapolis, IN
G	46222 Indianapolis, IN = WESTVIEW LOCATION	O	46268 Indianapolis, IN
H	46224 Indianapolis, IN	P	46278 Indianapolis, IN

Community Hospital Anderson
Service Area Zip Codes



A	46016 Anderson, IN
B	46011 Anderson, IN = CHA LOCATION
C	46012 Anderson, IN
D	46013 Anderson, IN
E	46001 Alexandria, IN
F	46036 Elwood, IN
G	46044 Frankton, IN
H	46051 Lapel, IN

Howard Regional Health
Health Districts



A	46902 Kokomo, IN = HRH LOCATION
B	46901 Kokomo, IN
C	46979 Russiaville, IN
D	46936 Greentown, IN

3b. Demographics of the community.

Although the initial community health needs assessment was conducted three years ago we continue to collect data to monitor any changes. We are able to do this with our vendor Health Communities Institute. The following are the demographics for our service areas in 2015. They are listed alphabetically by county.

Figure 7: Part V Schedule H

Hamilton		Hancock	
2015 Population	312,157	2015 Population	72,939
2015 Households	113,797	2015 Households	27,476
2015 Housing Units	120,931	2015 Housing Units	29,435
2015 Families	85,345	2015 Families	20,691
2015 Population by Single Race and Sex		**2015 Population by Single Race and Sex**	
White	269,649 (86.38%)	White	68,883 (94.44%)
Black/Af Amer	12,979 (4.16%)	Black/Af Amer	1,643 (2.25%)
Am Ind/AK Native	568 (0.18%)	Am Ind/AK Native	201 (0.28%)
Asian	17,776 (5.69%)	Asian	688 (0.94%)
Native HI/PI	150 (0.05%)	Native HI/PI	28 (0.04%)
Some Other Race	4,235 (1.36%)	Some Other Race	389 (0.53%)
2+ Races	6,800 (2.18%)	2+ Races	1,107 (1.52%)
2015 Pop by Ethnicity and Single Race		**2015 Pop by Ethnicity and Single Race**	
Hisp/Lat	12,550 (4.02%)	Hisp/Lat	1,631 (2.24%)
Not Hisp/Lat	299,607 (95.98%)	Not Hisp/Lat	71,308 (97.76%)
2015 Population by Age		**2015 Population by Age**	
2015 Population by Age	312,157	2015 Population by Age	72,939
2015 Pop, Age <18	87,027 (27.88%)	2015 Pop, Age <18	17,158 (23.52%)
2015 Pop, Age 18+	225,130 (72.12%)	2015 Pop, Age 18+	55,781 (76.48%)
2015 Pop, Age 25+	198,373 (63.55%)	2015 Pop, Age 25+	49,286 (67.57%)
2015 Pop, Age 65+	33,894 (10.86%)	2015 Pop, Age 65+	11,400 (15.63%)
2015 Median Age	36.7	2015 Median Age	40.4
2015 Population by Sex and Age		**2015 Population by Sex and Age**	
2015 Male Population by Age	152,420	2015 Male Population by Age	35,844
2015 Pop, Male: Age <18	44,333 (29.09%)	2015 Pop, Male: Age <18	8,752 (24.42%)
2015 Pop, Male: Age 18+	108,087 (70.91%)	2015 Pop, Male: Age 18+	27,092 (75.58%)
2015 Pop, Male: Age 65+	15,080 (9.89%)	2015 Pop, Male: Age 65+	5,211 (14.54%)
2015 Median Age Male	35.8	2015 Median Age Male	39.3
2015 Female Population by Age	159,737	2015 Female Population by Age	37,095
2015 Pop, Female: Age <18	42,694 (26.73%)	2015 Pop, Female: Age <18	8,406 (22.66%)
2015 Pop, Female: Age 18+	117,043 (73.27%)	2015 Pop, Female: Age 18+	28,689 (77.34%)
2015 Pop, Female: Age 65+	18,814 (11.78%)	2015 Pop, Female: Age 65+	6,189 (16.68%)
2015 Median Age Female	37.5	2015 Median Age Female	41.4
2015 Owner-Occ Housing Units by Value		**2015 Owner-Occ Housing Units by Value**	
2015 Own Occ HUs Median Value	$250,070	2015 Own Occ HUs Median Value	$168,139
2015 Own Occ HUs Avg Value	$305,217	2015 Own Occ HUs Avg Value	$202,541
2015 Households	113,797	2015 Households	27,476
2015 Average Household Size	2.73	2015 Average Household Size	2.63
2015 Households by Presence of People Under 18		**2015 Households by Presence of People Under 18**	
2015 Households, People < 18	49,615 (43.60%)	2015 Households, People < 18	10,284 (37.43%)
2015 Occupied Housing Units by Vehicles Available		**2015 Occupied Housing Units by Vehicles**	
2015 Avg Number Vehicles Available	2	2015 Avg Number Vehicles Available	2.1
No Vehicle	3,002 (2.64%)	No Vehicle	647 (2.35%)
1 Vehicle	29,269 (25.72%)	1 Vehicle	7,147 (26.01%)
2 Vehicles	55,868 (49.09%)	2 Vehicles	12,602 (45.87%)
2015 Households by Household Income		**2015 Households by Household Income**	
2015 Households by Income	113,797	2015 Households by Income	27,476
2015 Median Household Income	$86,200	2015 Median Household Income	$66,348
2015 Average Household Income	$111,057	2015 Average Household Income	$77,568
2015 Households by Ethnicity and Household Income		**2015 Households by Ethnicity and Household**	
2015 Median HH Inc, Hisp/Lat	$58,767	2015 Median HH Inc, Hisp/Lat	$65,625
2015 Avg HH Inc, Hisp/Lat	$83,219	2015 Avg HH Inc, Hisp/Lat	$72,983
2015 Median HH Inc, Not Hisp/Lat	$86,872	2015 Median HH Inc, Not Hisp/Lat	$66,365
2015 Avg HH Inc, Not Hisp/Lat	$111,870	2015 Avg HH Inc, Not Hisp/Lat	$77,644
2015 Families by Poverty Status		**2015 Families by Poverty Status**	
2015 Families Below Poverty	3,305 (3.87%)	2015 Families Below Poverty	1,061 (5.13%)
2015 Families Below Poverty with Children	2,721 (3.19%)	2015 Families Below Poverty with Children	812 (3.92%)
2015 Population by Sex and Educational Attainment		2015 Population by Sex and Educational	
2015 Population 25+ with Less Than High School Graduation	7,677 (3.87%)	2015 Population 25+ with Less Than High School Graduation	3,413 (6.92%)
2015 Population 25+, Male, with Less Than High School Graduation	4,106 (4.35%)	2015 Population 25+, Male, with Less Than High School Graduation	1,547 (6.51%)
2015 Population 25+, Female, with Less Than High School Graduation	3,571 (3.43%)	2015 Population 25+, Female, with Less Than High School Graduation	1,866 (7.31%)

Hendricks		Howard	
2015 Population	159,840	2015 Population	83,026
2015 Households	57,308	2015 Households	34,598
2015 Housing Units	60,515	2015 Housing Units	39,277
2015 Families	43,510	2015 Families	22,765
2015 Population by Single Race and Sex		**2015 Population by Single Race and Sex**	
White	139,991 (87.58%)	White	72,350 (87.14%)
Black/Af Amer	10,040 (6.28%)	Black/Af Amer	6,078 (7.32%)
Am Ind/AK Native	376 (0.24%)	Am Ind/AK Native	289 (0.35%)
Asian	4,026 (2.52%)	Asian	899 (1.08%)
Native HI/PI	73 (0.05%)	Native HI/PI	27 (0.03%)
Some Other Race	2,111 (1.32%)	Some Other Race	828 (1.00%)
2+ Races	3,223 (2.02%)	2+ Races	2,555 (3.08%)
2015 Pop by Ethnicity and Single Race		2015 Pop by Ethnicity and Single Race	
Hisp/Lat	6,161 (3.85%)	Hisp/Lat	2,710 (3.26%)
Not Hisp/Lat	153,679 (96.15%)	Not Hisp/Lat	80,316 (96.74%)
2015 Population by Age		**2015 Population by Age**	
2015 Population by Age	159,840	2015 Population by Age	83,026
2015 Pop, Age <18	40,253 (25.18%)	2015 Pop, Age <18	18,661 (22.48%)
2015 Pop, Age 18+	119,587 (74.82%)	2015 Pop, Age 18+	64,365 (77.52%)
2015 Pop, Age 25+	105,198 (65.81%)	2015 Pop, Age 25+	57,262 (68.97%)
2015 Pop, Age 65+	20,652 (12.92%)	2015 Pop, Age 65+	15,567 (18.75%)
2015 Median Age	37.8	2015 Median Age	41.6
2015 Population by Sex and Age		**2015 Population by Sex and Age**	
2015 Male Population by Age	79,845	2015 Male Population by Age	40,021
2015 Pop, Male: Age <18	20,502 (25.68%)	2015 Pop, Male: Age <18	9,473 (23.67%)
2015 Pop, Male: Age 18+	59,343 (74.32%)	2015 Pop, Male: Age 18+	30,548 (76.33%)
2015 Pop, Male: Age 65+	9,124 (11.43%)	2015 Pop, Male: Age 65+	6,777 (16.93%)
2015 Median Age Male	36.8	2015 Median Age Male	40.1
2015 Female Population by Age	79,995	2015 Female Population by Age	43,005
2015 Pop, Female: Age <18	19,751 (24.69%)	2015 Pop, Female: Age <18	9,188 (21.36%)
2015 Pop, Female: Age 18+	60,244 (75.31%)	2015 Pop, Female: Age 18+	33,817 (78.64%)
2015 Pop, Female: Age 65+	11,528 (14.41%)	2015 Pop, Female: Age 65+	8,790 (20.44%)
2015 Median Age Female	38.8	2015 Median Age Female	43
2015 Owner-Occ Housing Units by Value		**2015 Owner-Occ Housing Units by Value**	
2015 Own Occ HUs Median Value	$174,291	2015 Own Occ HUs Median Value	$103,683
2015 Own Occ HUs Avg Value	$203,535	2015 Own Occ HUs Avg Value	$122,952
2015 Occupied Housing Units by Vehicles Available		**2015 Occupied Housing Units by Vehicles Available**	
2015 Avg Number Vehicles Available	2.1	2015 Avg Number Vehicles Available	1.8
No Vehicle	1,026 (1.79%)	No Vehicle	2,582 (7.46%)
1 Vehicle	14,353 (25.05%)	1 Vehicle	11,667 (33.72%)
2 Vehicles	27,080 (47.25%)	2 Vehicles	13,649 (39.45%)
2015 Median HH Inc, Hisp/Lat	$54,464	2015 Median HH Inc, Hisp/Lat	$43,600
2015 Avg HH Inc, Hisp/Lat	$68,107	2015 Avg HH Inc, Hisp/Lat	$55,641
2015 Median HH Inc, Not Hisp/Lat	$70,183	2015 Median HH Inc, Not Hisp/Lat	$46,451
2015 Avg HH Inc, Not Hisp/Lat	$84,628	2015 Avg HH Inc, Not Hisp/Lat	$59,765
2015 Families by Poverty Status		**2015 Families by Poverty Status**	
2015 Families Below Poverty	1,335 (3.07%)	2015 Families Below Poverty	2,528 (11.10%)
2015 Families Below Poverty with Children	1,032 (2.37%)	2015 Families Below Poverty with Children	2,210 (9.71%)
2015 Population by Sex and Educational Attainment		**2015 Population by Sex and Educational Attainment**	
2015 Population 25+ with Less Than High School Graduation	6,668 (6.34%)	2015 Population 25+ with Less Than High School Graduation	6,911 (12.07%)
2015 Population 25+, Male, with Less Than High School Graduation	3,176 (6.14%)	2015 Population 25+, Male, with Less Than High School Graduation	3,400 (12.62%)
2015 Population 25+, Female, with Less Than High School Graduation	3,492 (6.53%)	2015 Population 25+, Female, with Less Than High School Graduation	3,511 (11.58%)

Johnson		Marion	
2015 Population	150,338	2015 Population	945,096
2015 Households	56,228	2015 Households	381,322
2015 Housing Units	60,778	2015 Housing Units	434,743
2015 Families	40,620	2015 Families	226,922
2015 Population by Single Race and Sex		**2015 Population by Single Race and Sex**	
White	138,346 (92.02%)	White	572,938 (60.62%)
Black/Af Amer	2,984 (1.98%)	Black/Af Amer	258,876 (27.39%)
Am Ind/AK Native	378 (0.25%)	Am Ind/AK Native	3,022 (0.32%)
Asian	3,613 (2.40%)	Asian	24,797 (2.62%)
Native HI/PI	60 (0.04%)	Native HI/PI	375 (0.04%)
Some Other Race	2,219 (1.48%)	Some Other Race	54,680 (5.79%)
2+ Races	2,738 (1.82%)	2+ Races	30,408 (3.22%)
2015 Pop by Ethnicity and Single Race		**2015 Pop by Ethnicity and Single Race**	
Hisp/Lat	5,699 (3.79%)	Hisp/Lat	95,748 (10.13%)
Not Hisp/Lat	144,639 (96.21%)	Not Hisp/Lat	849,348 (89.87%)
2015 Population by Age		**2015 Population by Age**	
2015 Population by Age	150,338	2015 Population by Age	945,096
2015 Pop, Age <18	37,584 (25.00%)	2015 Pop, Age <18	236,852 (25.06%)
2015 Pop, Age 18+	112,754 (75.00%)	2015 Pop, Age 18+	708,244 (74.94%)
2015 Pop, Age 25+	98,833 (65.74%)	2015 Pop, Age 25+	620,282 (65.63%)
2015 Pop, Age 65+	21,506 (14.31%)	2015 Pop, Age 65+	113,184 (11.98%)
2015 Median Age	37.7	2015 Median Age	34.9
2015 Population by Sex and Age		**2015 Population by Sex and Age**	
2015 Male Population by Age	74,070	2015 Male Population by Age	456,648
2015 Pop, Male: Age <18	19,358 (26.13%)	2015 Pop, Male: Age <18	120,917 (26.48%)
2015 Pop, Male: Age 18+	54,712 (73.87%)	2015 Pop, Male: Age 18+	335,731 (73.52%)
2015 Pop, Male: Age 65+	9,388 (12.67%)	2015 Pop, Male: Age 65+	47,235 (10.34%)
2015 Median Age Male	36.5	2015 Median Age Male	33.9
2015 Female Population by Age	76,268	2015 Female Population by Age	488,448
2015 Pop, Female: Age <18	18,226 (23.90%)	2015 Pop, Female: Age <18	115,935 (23.74%)
2015 Pop, Female: Age 18+	58,042 (76.10%)	2015 Pop, Female: Age 18+	372,513 (76.26%)
2015 Pop, Female: Age 65+	12,118 (15.89%)	2015 Pop, Female: Age 65+	65,949 (13.50%)
2015 Median Age Female	38.8	2015 Median Age Female	36
2015 Owner-Occ Housing Units by Value		**2015 Owner-Occ Housing Units by Value**	
2015 Own Occ HUs Median Value	$155,857	2015 Own Occ HUs Median Value	$130,084
2015 Own Occ HUs Avg Value	$197,291	2015 Own Occ HUs Avg Value	$161,799
2015 Households by Number of People in Household		**2015 Households by Number of People in Household**	
2015 Households	56,228	2015 Households	381,322
2015 Average Household Size	2.63	2015 Average Household Size	2.43
2015 Occupied Housing Units by Vehicles Available		**2015 Occupied Housing Units by Vehicles Available**	
2015 Avg Number Vehicles Available	2	2015 Avg Number Vehicles Available	1.6
No Vehicle	2,668 (4.74%)	No Vehicle	36,653 (9.61%)
1 Vehicle	15,819 (28.13%)	1 Vehicle	151,614 (39.76%)
2 Vehicles	23,838 (42.40%)	2 Vehicles	134,945 (35.39%)
2015 Households by Household Income		**2015 Households by Household Income**	
2015 Households by Income	56,228	2015 Households by Income	381,322
2015 Median Household Income	$60,451	2015 Median Household Income	$43,047
2015 Average Household Income	$76,705	2015 Average Household Income	$58,698
2015 Households by Race and Household Income		**2015 Households by Race and Household Income**	
2015 Median HH Inc, White	$61,536	2015 Median HH Inc, White	$50,108
2015 Avg HH Inc, White	$74,819	2015 Avg HH Inc, White	$64,780
2015 Median HH Inc, Black/Af Amer	$48,537	2015 Median HH Inc, Black/Af Amer	$30,527
2015 Avg HH Inc, Black/Af Amer	$63,207	2015 Avg HH Inc, Black/Af Amer	$41,260
2015 Median HH Inc, Am Ind/AK Native	$25,946	2015 Median HH Inc, Am Ind/AK Native	$34,917
2015 Avg HH Inc, Am Ind/AK Native	$29,569	2015 Avg HH Inc, Am Ind/AK Native	$50,964
2015 Median HH Inc, Asian	$68,722	2015 Median HH Inc, Asian	$50,319
2015 Avg HH Inc, Asian	$91,367	2015 Avg HH Inc, Asian	$58,741
2015 Median HH Inc, Native HI/PI	$200,001	2015 Median HH Inc, Native HI/PI	$26,525
2015 Avg HH Inc, Native HI/PI	$250,000	2015 Avg HH Inc, Native HI/PI	$33,787
2015 Median HH Inc, Some Other Race	$43,282	2015 Median HH Inc, Some Other Race	$29,344
2015 Avg HH Inc, Some Other Race	$44,082	2015 Avg HH Inc, Some Other Race	$35,216
2015 Median HH Inc, 2+ Races	$39,522	2015 Median HH Inc, 2+ Races	$38,196
2015 Avg HH Inc, 2+ Races	$43,018	2015 Avg HH Inc, 2+ Races	$47,226
2015 Households by Ethnicity and Household Income		**2015 Households by Ethnicity and Household Income**	
2015 Median HH Inc, Hisp/Lat	$41,214	2015 Median HH Inc, Hisp/Lat	$29,496
2015 Avg HH Inc, Hisp/Lat	$60,824	2015 Avg HH Inc, Hisp/Lat	$40,360
2015 Median HH Inc, Not Hisp/Lat	$61,218	2015 Median HH Inc, Not Hisp/Lat	$44,280
2015 Avg HH Inc, Not Hisp/Lat	$77,133	2015 Avg HH Inc, Not Hisp/Lat	$60,018
2015 Families by Poverty Status		**2015 Families by Poverty Status**	
2015 Families Below Poverty	4,270 (10.51%)	2015 Families Below Poverty	39,074 (17.22%)
2015 Families Below Poverty with Children	3,805 (9.37%)	2015 Families Below Poverty with Children	30,597 (13.48%)
2015 Population by Sex and Educational Attainment		**2015 Population by Sex and Educational Attainment**	
2015 Population 25+ with Less Than High School Graduation	8,281 (8.38%)	2015 Population 25+ with Less Than High School Graduation	91,303 (14.72%)
2015 Population 25+, Male, with Less Than High School Graduation	4,188 (8.80%)	2015 Population 25+, Male, with Less Than High School Graduation	46,119 (15.78%)
2015 Population 25+, Female, with Less Than High School Graduation	4,093 (7.98%)	2015 Population 25+, Female, with Less Than High School Graduation	45,184 (13.77%)
2015 Population Age 16+ by Employment Status		**2015 Population Age 16+ by Employment Status**	
2015 Percent Civ Labor Force Unemployed	6.17%	2015 Percent Civ Labor Force Unemployed	10.52%
2015 Percent Civ Labor Force Unemployed Male	6.19%	2015 Percent Civ Labor Force Unemployed Male	10.61%
2015 Percent Civ Labor Force Unemployed Fem	6.14%	2015 Percent Civ Labor Force Unemployed Fem	10.42%

Morgan		Shelby	
2015 Population	70,002	2015 Population	44,692
2015 Households	26,376	2015 Households	17,547
2015 Housing Units	28,525	2015 Housing Units	19,442
2015 Families	19,841	2015 Families	12,383
2015 Population by Single Race and Sex		**2015 Population by Single Race and Sex**	
White	67,656 (96.65%)	White	42,177 (94.37%)
Black/Af Amer	540 (0.77%)	Black/Af Amer	531 (1.19%)
Am Ind/AK Native	208 (0.30%)	Am Ind/AK Native	102 (0.23%)
Asian	444 (0.63%)	Asian	359 (0.80%)
Native HI/PI	25 (0.04%)	Native HI/PI	111 (0.25%)
Some Other Race	315 (0.45%)	Some Other Race	820 (1.83%)
2+ Races	814 (1.16%)	2+ Races	592 (1.32%)
2015 Pop by Ethnicity and Single Race		**2015 Pop by Ethnicity and Single Race**	
Hisp/Lat	1,155 (1.65%)	Hisp/Lat	1,899 (4.25%)
Not Hisp/Lat	68,847 (98.35%)	Not Hisp/Lat	42,793 (95.75%)
2015 Population by Age		**2015 Population by Age**	
2015 Population by Age	70,002	2015 Population by Age	44,692
2015 Pop, Age <18	16,277 (23.25%)	2015 Pop, Age <18	10,354 (23.17%)
2015 Pop, Age 18+	53,725 (76.75%)	2015 Pop, Age 18+	34,338 (76.83%)
2015 Pop, Age 25+	47,499 (67.85%)	2015 Pop, Age 25+	30,456 (68.15%)
2015 Pop, Age 65+	11,064 (15.81%)	2015 Pop, Age 65+	7,182 (16.07%)
2015 Median Age	41	2015 Median Age	40.6
2015 Population by Sex and Age		**2015 Population by Sex and Age**	
2015 Male Population by Age	34,657	2015 Male Population by Age	22,182
2015 Pop, Male: Age <18	8,379 (24.18%)	2015 Pop, Male: Age <18	5,362 (24.17%)
2015 Pop, Male: Age 18+	26,278 (75.82%)	2015 Pop, Male: Age 18+	16,820 (75.83%)
2015 Pop, Male: Age 65+	5,053 (14.58%)	2015 Pop, Male: Age 65+	3,168 (14.28%)
2015 Median Age Male	40	2015 Median Age Male	39.3
2015 Female Population by Age	35,345	2015 Female Population by Age	22,510
2015 Pop, Female: Age <18	7,898 (22.35%)	2015 Pop, Female: Age <18	4,992 (22.18%)
2015 Pop, Female: Age 18+	27,447 (77.65%)	2015 Pop, Female: Age 18+	17,518 (77.82%)
2015 Pop, Female: Age 65+	6,011 (17.01%)	2015 Pop, Female: Age 65+	4,014 (17.83%)
2015 Median Age Female	41.9	2015 Median Age Female	42
2015 Owner-Occ Housing Units by Value		**2015 Owner-Occ Housing Units by Value**	
2015 Own Occ HUs Median Value	$149,612	2015 Own Occ HUs Median Value	$137,050
2015 Own Occ HUs Avg Value	$182,734	2015 Own Occ HUs Avg Value	$162,192
2015 Occupied Housing Units by Vehicles Available		**2015 Occupied Housing Units by Vehicles Available**	
2015 Avg Number Vehicles Available	2.1	2015 Avg Number Vehicles Available	2
No Vehicle	1,295 (4.91%)	No Vehicle	1,103 (6.29%)
1 Vehicle	6,336 (24.02%)	1 Vehicle	5,186 (29.55%)
2 Vehicles	11,329 (42.95%)	2 Vehicles	6,941 (39.56%)
2015 Households by Household Income		**2015 Households by Household Income**	
2015 Households by Income	26,376	2015 Households by Income	17,547
2015 Median Household Income	$58,431	2015 Median Household Income	$52,615
2015 Average Household Income	$70,700	2015 Average Household Income	$63,361
2015 Households by Race and Household Income		**2015 Households by Race and Household Income**	
2015 Median HH Inc, White	$59,235	2015 Median HH Inc, White	$53,217
2015 Avg HH Inc, White	$70,156	2015 Avg HH Inc, White	$62,610
2015 Median HH Inc, Black/Af Amer	$14,999	2015 Median HH Inc, Black/Af Amer	$22,027
2015 Avg HH Inc, Black/Af Amer	$25,429	2015 Avg HH Inc, Black/Af Amer	$30,913
2015 Median HH Inc, Am Ind/AK Native	$20,870	2015 Median HH Inc, Am Ind/AK Native	$44,569
2015 Avg HH Inc, Am Ind/AK Native	$26,944	2015 Avg HH Inc, Am Ind/AK Native	$51,863
2015 Median HH Inc, Asian	$40,625	2015 Median HH Inc, Asian	$78,947
2015 Avg HH Inc, Asian	$48,180	2015 Avg HH Inc, Asian	$86,964
2015 Median HH Inc, Native HI/PI	$35,000	2015 Median HH Inc, Native HI/PI	$47,000
2015 Avg HH Inc, Native HI/PI	$32,500	2015 Avg HH Inc, Native HI/PI	$67,457
2015 Median HH Inc, Some Other Race	$20,897	2015 Median HH Inc, Some Other Race	$33,387
2015 Avg HH Inc, Some Other Race	$41,382	2015 Avg HH Inc, Some Other Race	$38,993
2015 Median HH Inc, 2+ Races	$39,397	2015 Median HH Inc, 2+ Races	$82,237
2015 Avg HH Inc, 2+ Races	$47,879	2015 Avg HH Inc, 2+ Races	$87,345
2015 Households by Ethnicity and Household Income		**2015 Households by Ethnicity and Household Income**	
2015 Median HH Inc, Hisp/Lat	$44,423	2015 Median HH Inc, Hisp/Lat	$37,845
2015 Avg HH Inc, Hisp/Lat	$55,492	2015 Avg HH Inc, Hisp/Lat	$47,061
2015 Median HH Inc, Not Hisp/Lat	$58,611	2015 Median HH Inc, Not Hisp/Lat	$53,299
2015 Avg HH Inc, Not Hisp/Lat	$70,865	2015 Avg HH Inc, Not Hisp/Lat	$63,798
2015 Families by Poverty Status		2015 Families by Poverty Status	
2015 Families Below Poverty	1,696 (8.55%)	2015 Families Below Poverty	1,177 (9.50%)
2015 Families Below Poverty with Children	1,496 (7.54%)	2015 Families Below Poverty with Children	945 (7.63%)
2015 Population by Sex and Educational Attainment		**2015 Population by Sex and Educational Attainment**	
2015 Population 25+ with Less Than High School Graduation	5,727 (12.06%)	2015 Population 25+ with Less Than High School Graduation	4,307 (14.14%)
2015 Population 25+, Male, with Less Than High School Graduation	3,400 (14.72%)	2015 Population 25+, Male, with Less Than High School Graduation	2,132 (14.40%)
2015 Population 25+, Female, with Less Than High School Graduation	2,327 (9.54%)	2015 Population 25+, Female, with Less Than High School Graduation	2,175 (13.89%)
2015 Population Age 16+ by Employment Status		**2015 Population Age 16+ by Employment Status**	
2015 Percent Civ Labor Force Unemployed	5.93%	2015 Percent Civ Labor Force Unemployed	9.62%
2015 Percent Civ Labor Force Unemployed Male	5.04%	2015 Percent Civ Labor Force Unemployed Male	8.70%
2015 Percent Civ Labor Force Unemployed Fem	6.96%	2015 Percent Civ Labor Force Unemployed Fem	10.67%

Madison	
2015 Population	129,666
2015 Households	51,172
2015 Housing Units	59,006
2015 Families	33,882
2015 Population by Sex and Ethnicity	
2015 Population by Sex	129,666
2015 Population by Ethnicity	129,666
2015 Population by Single Race and Sex	
White	112,826 (87.01%)
Black/Af Amer	10,801 (8.33%)
Am Ind/AK Native	386 (0.30%)
Asian	665 (0.51%)
Native HI/PI	62 (0.05%)
Some Other Race	2,384 (1.84%)
2+ Races	2,542 (1.96%)
2015 Pop by Ethnicity and Single Race	
Hisp/Lat	5,158 (3.98%)
Not Hisp/Lat	124,508 (96.02%)
2015 Population by Age	
2015 Population by Age	129,666
2015 Pop, Age <18	28,486 (21.97%)
2015 Pop, Age 18+	101,180 (78.03%)
2015 Pop, Age 25+	89,203 (68.79%)
2015 Pop, Age 65+	22,796 (17.58%)
2015 Median Age	40.3
2015 Population by Sex and Age	
2015 Male Population by Age	64,725
2015 Pop, Male: Age <18	14,686 (22.69%)
2015 Pop, Male: Age 18+	50,039 (77.31%)
2015 Pop, Male: Age 65+	9,979 (15.42%)
2015 Median Age Male	38.7
2015 Female Population by Age	64,941
2015 Pop, Female: Age <18	13,800 (21.25%)
2015 Pop, Female: Age 18+	51,141 (78.75%)
2015 Pop, Female: Age 65+	12,817 (19.74%)
2015 Median Age Female	42
2015 Pop 5+ by Language Spoken at Home	
Speak Only English at Home	118,166 (96.73%)
Speak Spanish at Home	2,697 (2.21%)
Speak Asian/PI Lang at Home	347 (0.28%)
Speak Indo-European Lang at Home	879 (0.72%)
Speak Other Lang at Home	73 (0.06%)
2015 Owner-Occ Housing Units by Value	
2015 Own Occ HUs Median Value	$103,651
2015 Own Occ HUs Avg Value	$126,538
2015 Households by Number of People in Household	
2015 Households	51,172
2015 Average Household Size	2.41
2015 Occupied Housing Units by Vehicles Available	
2015 Avg Number Vehicles Available	1.8
No Vehicle	4,434 (8.66%)
1 Vehicle	16,781 (32.79%)
2 Vehicles	18,412 (35.98%)
2015 Households by Household Income	
2015 Households by Income	51,172
2015 Median Household Income	$42,515
2015 Average Household Income	$53,851
2015 Households by Race and Household Income	
2015 Median HH Inc, White	$43,933
2015 Avg HH Inc, White	$54,676
2015 Median HH Inc, Black/Af Amer	$27,739
2015 Avg HH Inc, Black/Af Amer	$38,423
2015 Median HH Inc, Am Ind/AK Native	$14,999
2015 Avg HH Inc, Am Ind/AK Native	$30,461
2015 Median HH Inc, Asian	$55,183
2015 Avg HH Inc, Asian	$74,229
2015 Median HH Inc, Native HI/PI	$41,429
2015 Avg HH Inc, Native HI/PI	$68,942
2015 Median HH Inc, Some Other Race	$23,462
2015 Avg HH Inc, Some Other Race	$39,430
2015 Median HH Inc, 2+ Races	$30,093
2015 Avg HH Inc, 2+ Races	$40,503
2015 Households by Ethnicity and Household Income	
2015 Median HH Inc, Hisp/Lat	$28,750
2015 Avg HH Inc, Hisp/Lat	$41,909
2015 Median HH Inc, Not Hisp/Lat	$42,847
2015 Avg HH Inc, Not Hisp/Lat	$54,143
2015 Families by Poverty Status	
2015 Families Below Poverty	4,820 (14.23%)
2015 Families Below Poverty with Children	3,466 (10.23%)
2015 Population by Sex and Educational Attainment	
2015 Population 25+ with Less Than High School Graduation	11,645 (13.05%)
2015 Population 25+, Male, with Less Than High School Graduation	6,071 (13.86%)
2015 Population 25+, Female, with Less Than High School Graduation	5,574 (12.28%)
2015 Percent Civ Labor Force Unemployed	9.33%
2015 Percent Civ Labor Force Unemployed Male	10.02%
2015 Percent Civ Labor Force Unemployed Fem	8.59%

3c. Existing health care facilities and resources within the community that are available to respond to the health needs of the community

Community Health Network Hospital Facilities and Other Hospital Competition

Figure 7. Part V Schedule H

Community Health Network Hospital Facilities	
CHN	Community Hospital Anderson
CHN	Community Hospital East
CHN	Community Hospital North
CHN	Community Hospital South
CHN	The Indiana Heart Hospital

Clarian Health Partners Hospital Facilities	
1	Clarian North Medical Center
2	Indiana University Medical Center
3	Methodist
4	Riley Hospital for Children
5	Clarian West Medical Center

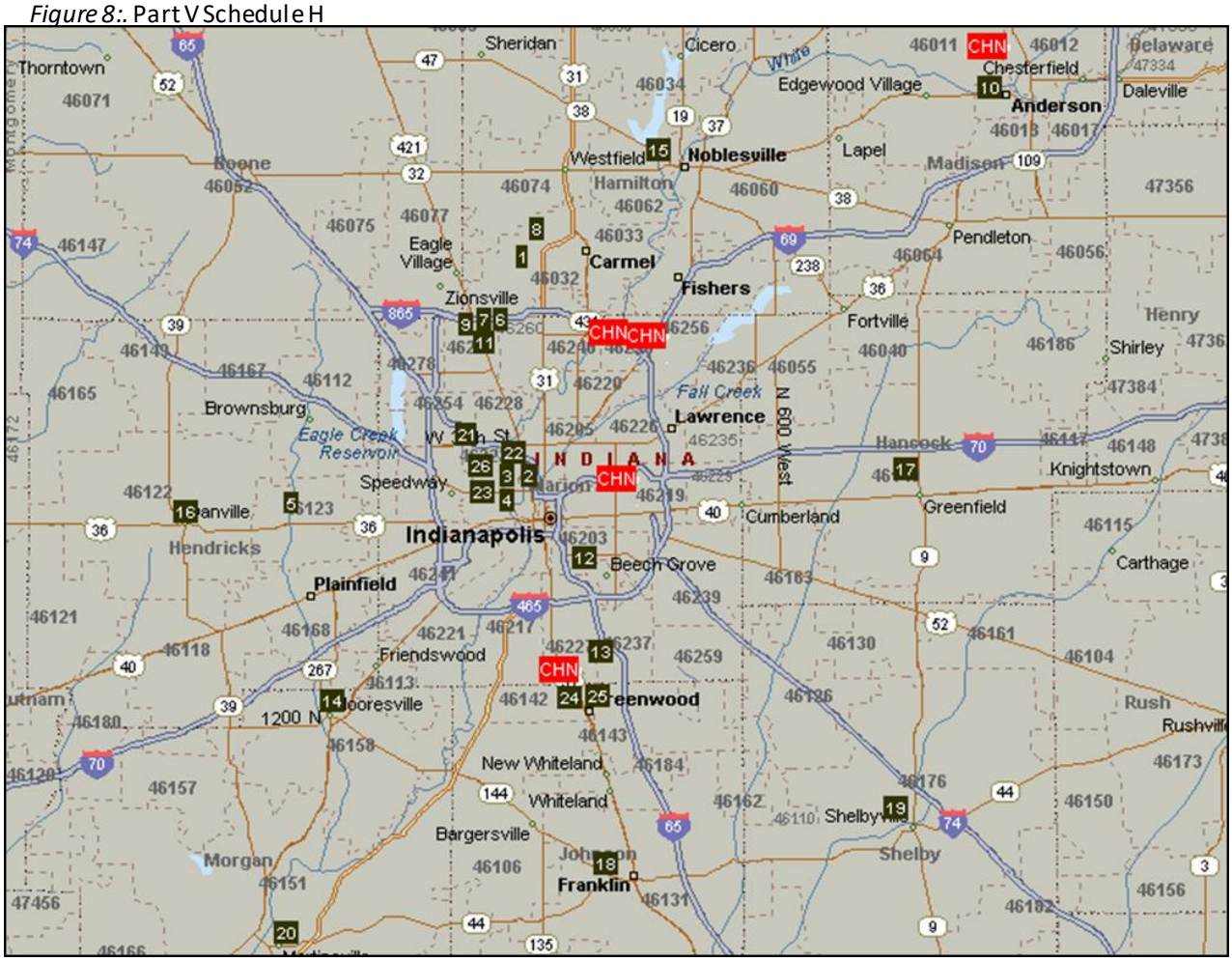
St. Vincent Hospital Facilities	
6	St.Vincent Children's Hospital
7	St.Vincent - 86th Street
8	St.Vincent Carmel
9	St.Vincent Women's
10	St.Vincent St.John's
11	St.Vincent Seton Specialty Hospital (LTC)

St. Francis Hospital Facilities		
12	~~St.Francis Beech Grove~~	CLOSED
13	St.Francis Indianapolis	
14	St.Francis Mooresville	

Surburban Hospital Facilities	
15	Riverview Hospital
16	Hendricks Community
17	Hancock Memorial
18	Johnson Memorial
19	Major
20	Morgan County

Other Hospital Facilities	
21	Westview
22	Wishard
23	Kindred Hospital Indianapolis
24	Kindred Hospital South
25	Valle Vista Health System
26	Select Specialty Hospital-Indianapolis (LTC)

Figure 8:. Part V Schedule H



3d. How data was obtained

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

The 2015 community health needs assessments was completed with all the competing hospitals in the area. In determining to do the needs assessment in the area collaboratively were over 25 focus groups that were conducted in all counties served by the hospitals. We also agreed to provide a survey online and a paper version with translation into Spanish, the results follow.

Secondary Data

The zip code you live is a better determinant of your health expectancy than your genetic code. Since 1996, we have participated in the local and surrounding counties' Community Health Needs Assessments. These assessments have been the springboard to understanding and implementing strategies and programs that have targeted populations in need with specific outcomes driving the strategy for change. A very important lesson was learned in the first assessment:

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

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

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

In 2009 another significant assessment was provided to the Fishers community. The network marketing department collaborated with the Fishers community, bringing interested organizations together to provide an assessment of the Fishers area. The results are summarized and clearly defined how successful we have been in living up to the IRS requirements for assessment.

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

Beginning in 2010 we started to develop interest in the Healthy Communities Institute and brought local and state leaders together to review their product and process for implementation. This tool included a mapping feature that Health Landscapes had offered but more importantly the most up to date secondary data available in the community. Although the fees were minimal compared to other products the groups could not agree on one standard product to assist in the development of the community health needs assessments for the five to seven counties we serve. With all of the assessments we have conducted to date we have never fulfilled all of the findings within these documents. The documents that are generated often are visions of the future rather than specific action

steps for the current reality, in fact, as noted before - health is not often seen on quality of life plans generated by a community – rather the interpretation may be personal safety and clean streets as an indicator of a healthy community.

Summary of Assessments:

1996: Building Healthier Neighborhoods, Marion County,
1996: Partnership for a Healthier Johnson County
2001-ongoing: Minority Health Coalition of Marion County
2001-ongoing: Kids Count in Indiana, The Indiana Youth Institute
2002: Quality of Life in Marion County, A Community Snapshot
2005-ongoing: The SAVI Community Information System
2008: Community Needs Assessment—Windsor Village, Marion County, Indiana
2009: Fishers Community Assessment
2010: Jane Pauley Community Health Center FQHC Application requirements
2011 – 2014 Healthy Communities Institute –Community Health Needs Assessments – All Counties in Community Health Network Service Areas
2015 – All Hospital Systems in Indianapolis Area Particpated in CHNA

We will continue to generate data and information to guide our communities through health needs assessments with the hope of finding issues, addressing them and measuring the positive and negative outcomes of our initiatives. We are encouraged by the product that has been made available through our website and the Health Communities Institute. We believe that the breadth of the data and ease of obtaining this data from our website can enable an eighth grade student to access our information for a school project on health as well as support a professional in a not for profit agency with critical data for writing grants to serve the most vulnerable people in our communities.

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

3e. The health needs of the community.

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

Figure 9. Part V Schedule H

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

Primary data

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

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

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

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

3f. Primary and chronic diseases needs and other issues of uninsured persons low income persons and minority groups.

Areas of need –Implementation Strategy

#1 Access to Care

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

 # 2 Asthma and #3 Diabetes

There were several factors that helped us select asthma and diabetes as the two priority health issues to be addressed. Although access can help address many critical health

issues both asthma and diabetes rank high in the preventable hospital stays for ambulatory-care sensitive conditions, can usually be addressed in an outpatient setting, and do not normally require hospitalization if the condition is well-managed. The most striking difference between these two diseases is that a diagnosis of asthma has immediate short and long-term consequences of hospitalizations while diabetic hospitalizations are the result of longer term complications.

In 2015 baseline information has been gathered and display below. The first set is for asthma and related indicatiors and the second set for diabetes. It will be the indicators that we will use to measure impact on our startegies.

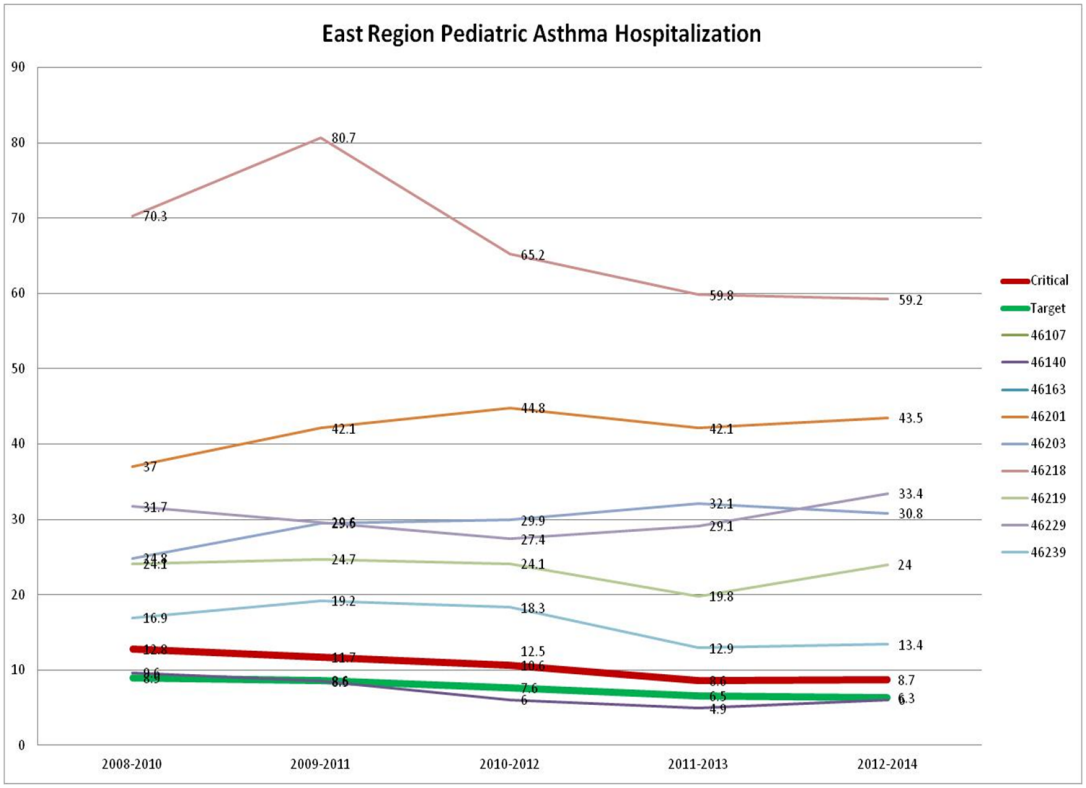
The green line represents that the condition is within the normal range for number of hospitalizations. The red line indicates that it is in a critical range and anything above the red line is even more critical. All these indicators were chosen because of the critical nature and incidences in our service areas. In the Community Hospital Anderson graphs we can only display by county as opposed to zip code and the green line is eliminated for ease of viewing. The red lines that represent a critical condition is also shown as a straight line on the bottom of the graph because the number display is much higher than critical and would make visual display difficult.

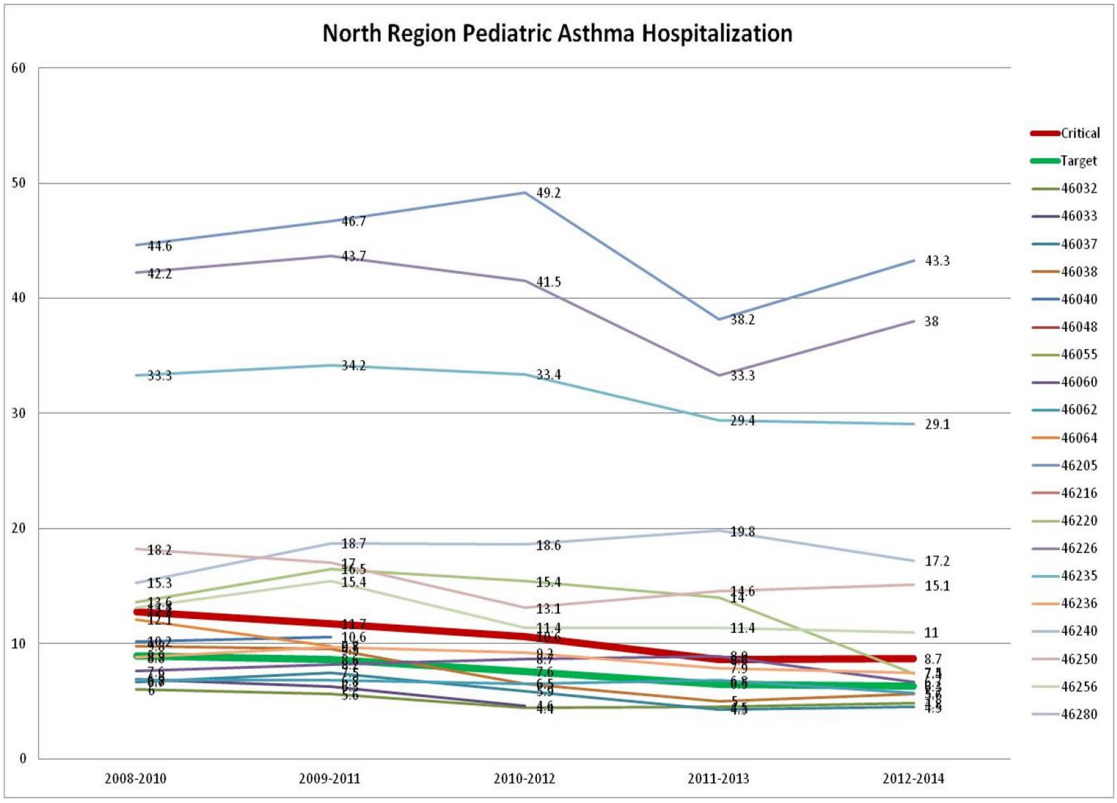
Other Conditions

Other hospitalization rates are noted in our needs assessment however they drop futher down the list due to the gap in critical data sets. They include age adjusted rates for congestive health failure, alcohol abuse, COPD, bacterial pneumonia, and dehydration. The rate and occurence of these chronic conditions are tracked and measured the same as the top two diseases however they are not displayed in this narrative.

Figure 10. Part V Schedule H

Pediatric Asthma Hospitalizations




North Region Pediatric Asthma Hospitalization
60
50
40
30
20
10
0
2008-2010
2009-2011
2010-2012
2011-2013
2012-2014
Critical
Target
46032
46033
46037
46038
46040
46048
46055
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46062
46064
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46220
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46235
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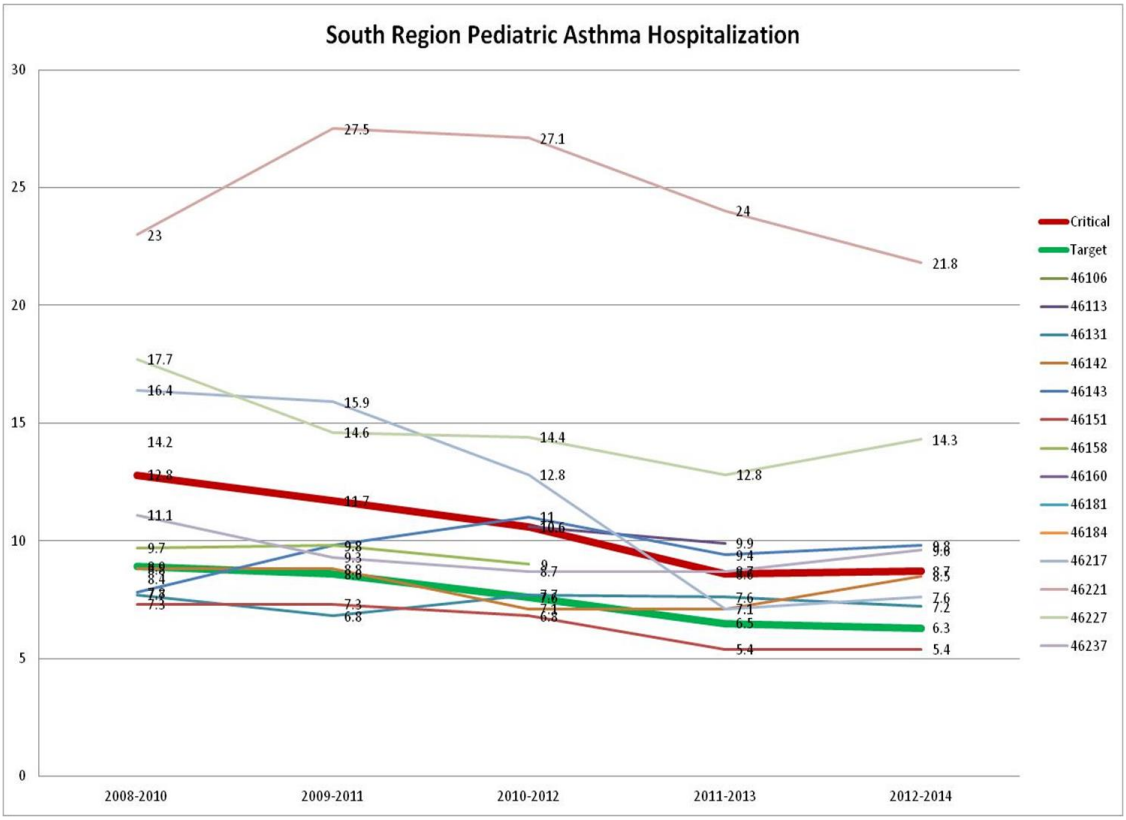
46250
46256
46280


South Region Pediatric Asthma Hospitalization
30
25
20
15
10
5
0
2008-2010
2009-2011
2010-2012
2011-2013
2012-2014
Critical
Target
46106
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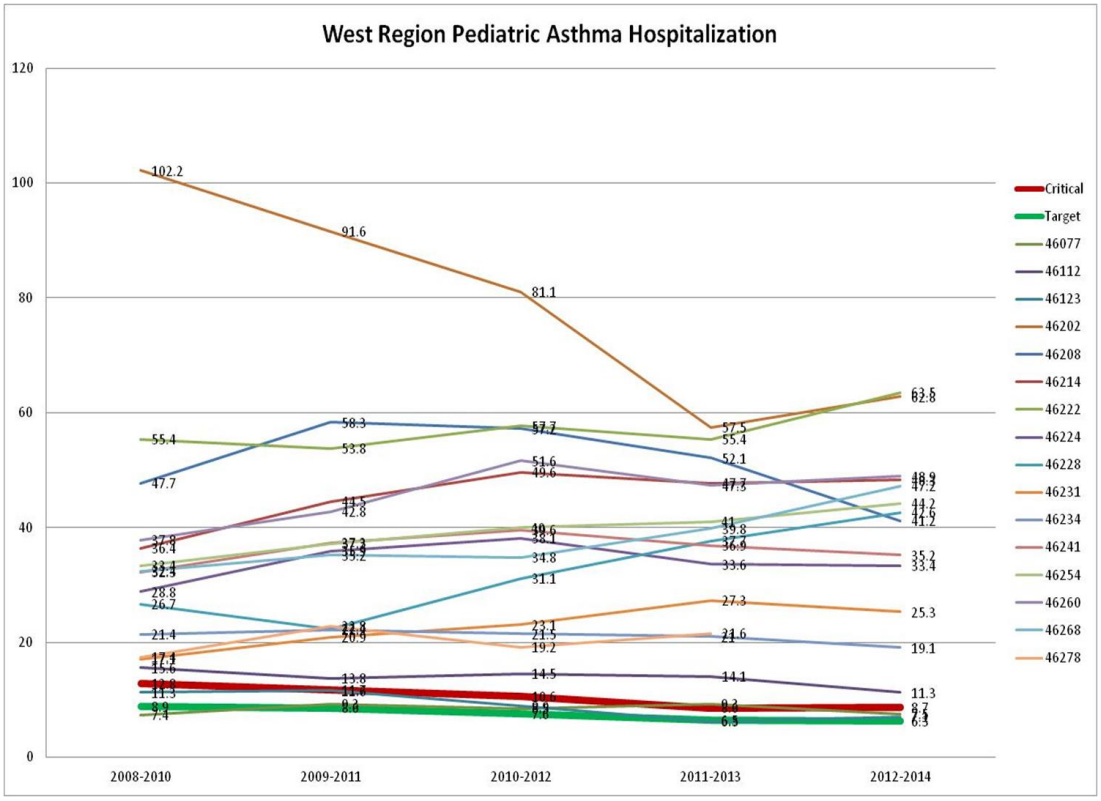
46221
46227
46237


West Region Pediatric Asthma Hospitalization
120
100
80
60
40
20
0
2008-2010
2009-2011
2010-2012
2011-2013
2012-2014
Critical
Target
46077
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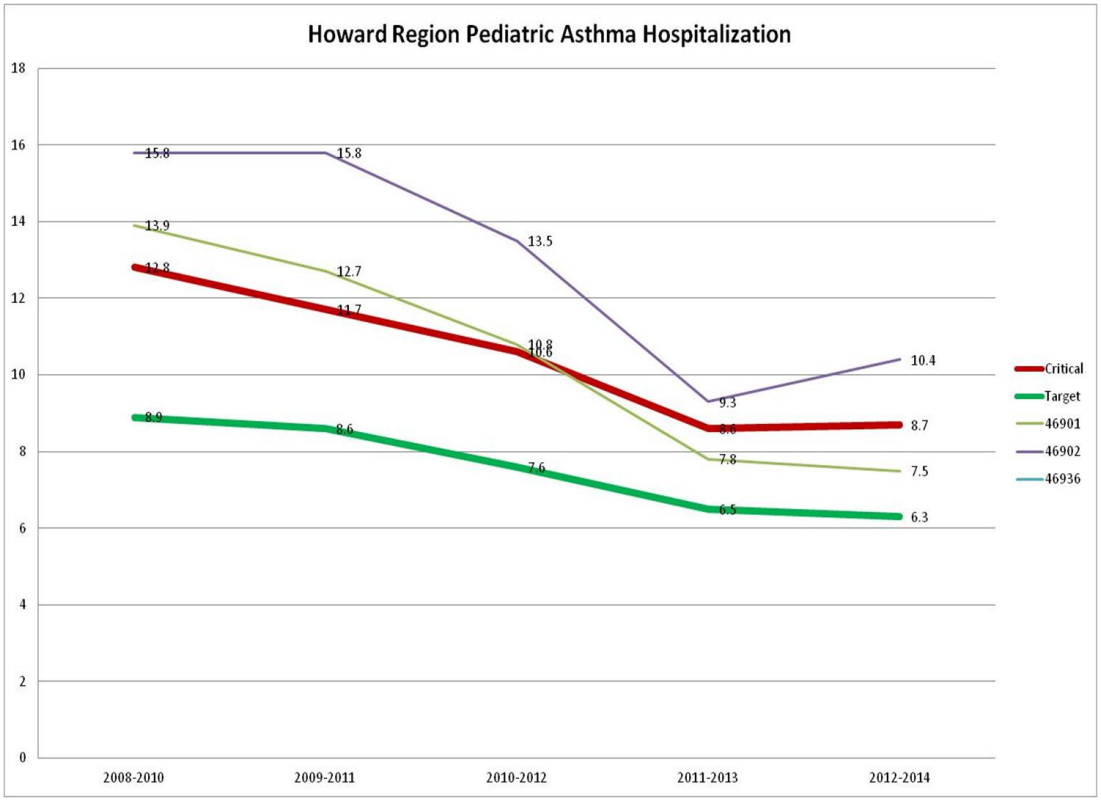
46222
46224
46228
46231
46234
46241
46254
46260
46268
46278


Howard Region Pediatric Asthma Hospitalization
18
16
14
12
10
8
6
4
2
0
2008-2010
2009-2011
2010-2012
2011-2013
2012-2014
15.8
15.8
13.5
13.9
12.7
12.8
11.7
10.8
10.6
10.4
9.3
8.9
8.6
8.7
7.8
7.5
7.6
6.5
6.3
Critical
Target
46901
46902
46936

Asthma Data for Community Hospital Anderson is only available by county not zip code.

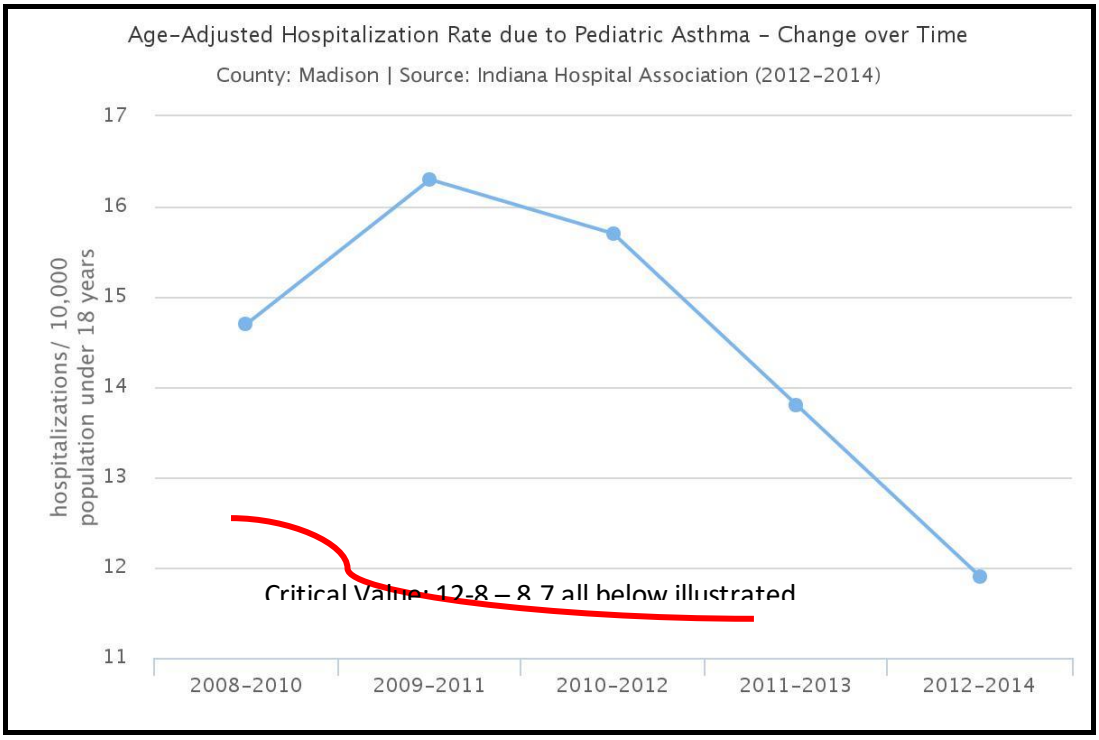
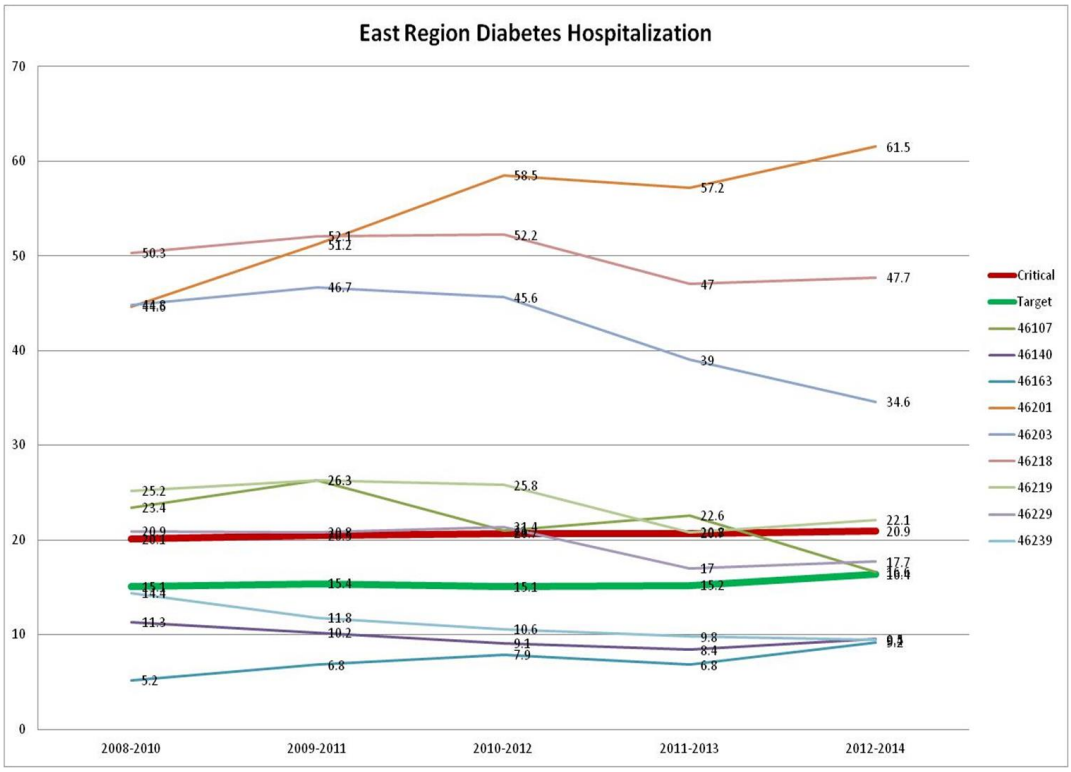
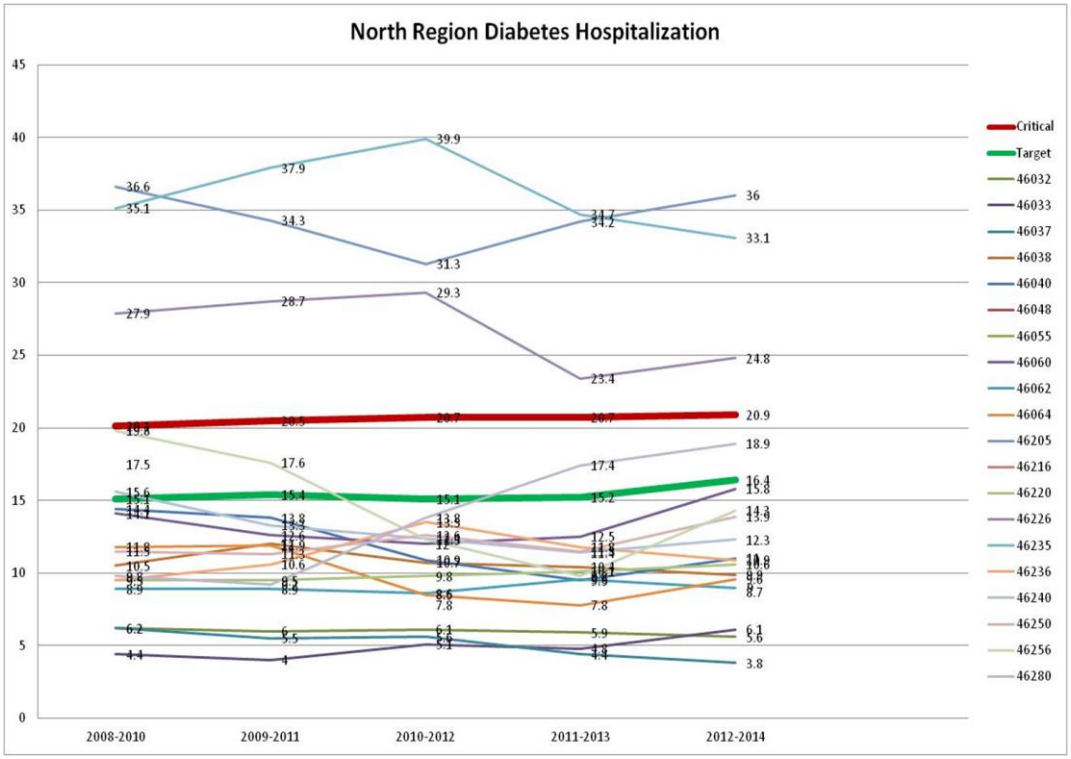


Figure 11. Part V Schedule H

Diabetes:




North Region Diabetes Hospitalization
2008-2010
2009-2011
2010-2012
2011-2013
2012-2014
Critical
Target
46032
46033
46037
46038
46040
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46205
46216
46220
46226
46235
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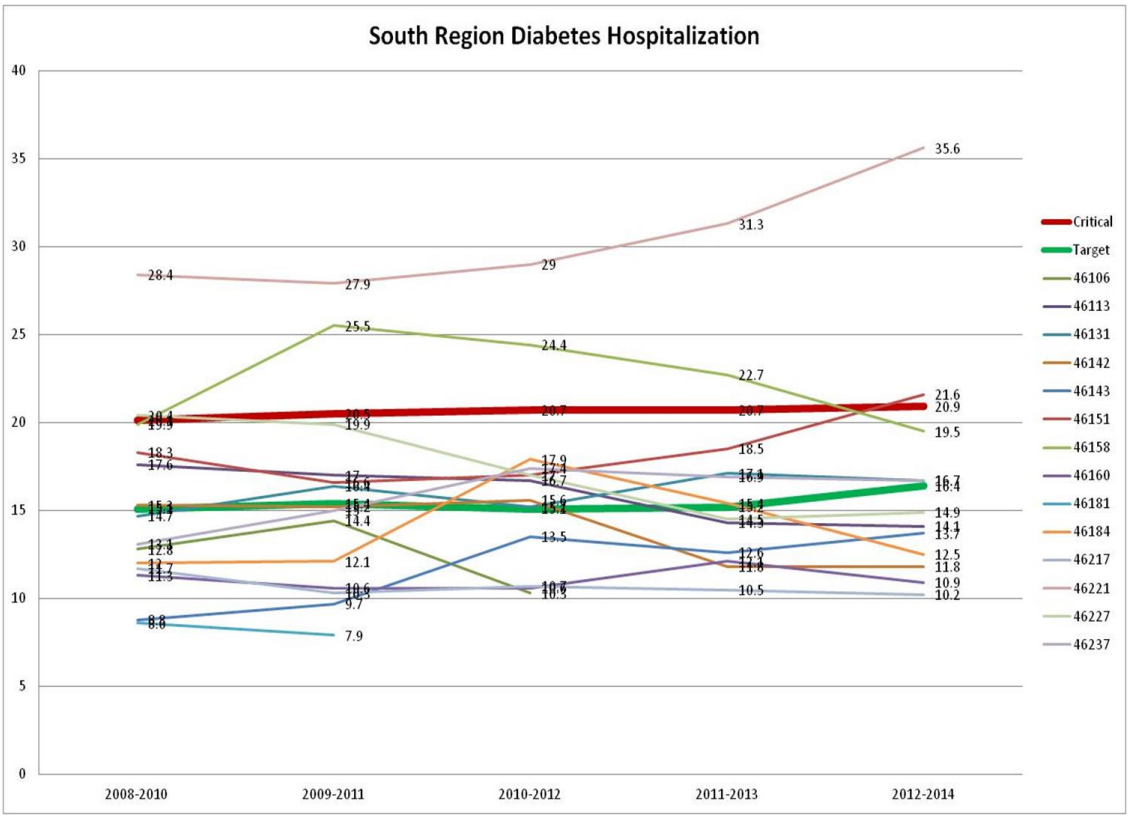
South Region Diabetes Hospitalization
2008-2010
2009-2011
2010-2012
2011-2013
2012-2014
Critical
Target
46106
46113
46131
46142
46143
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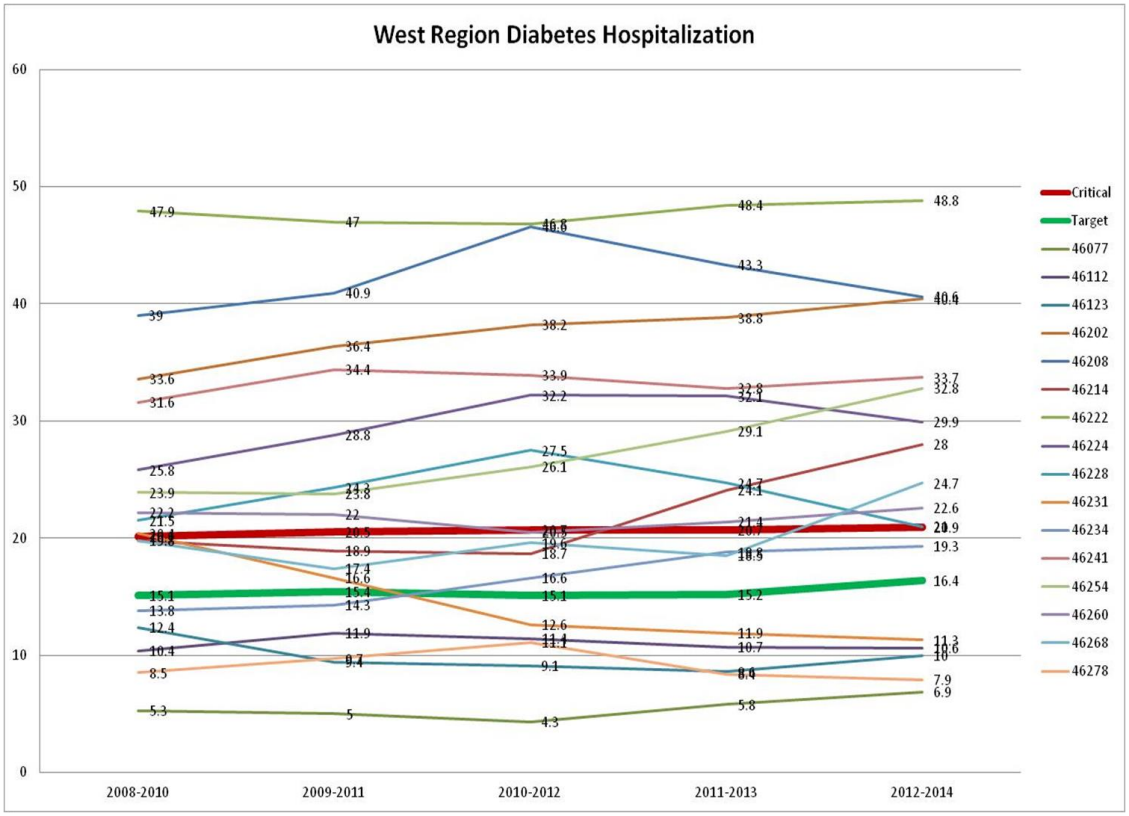
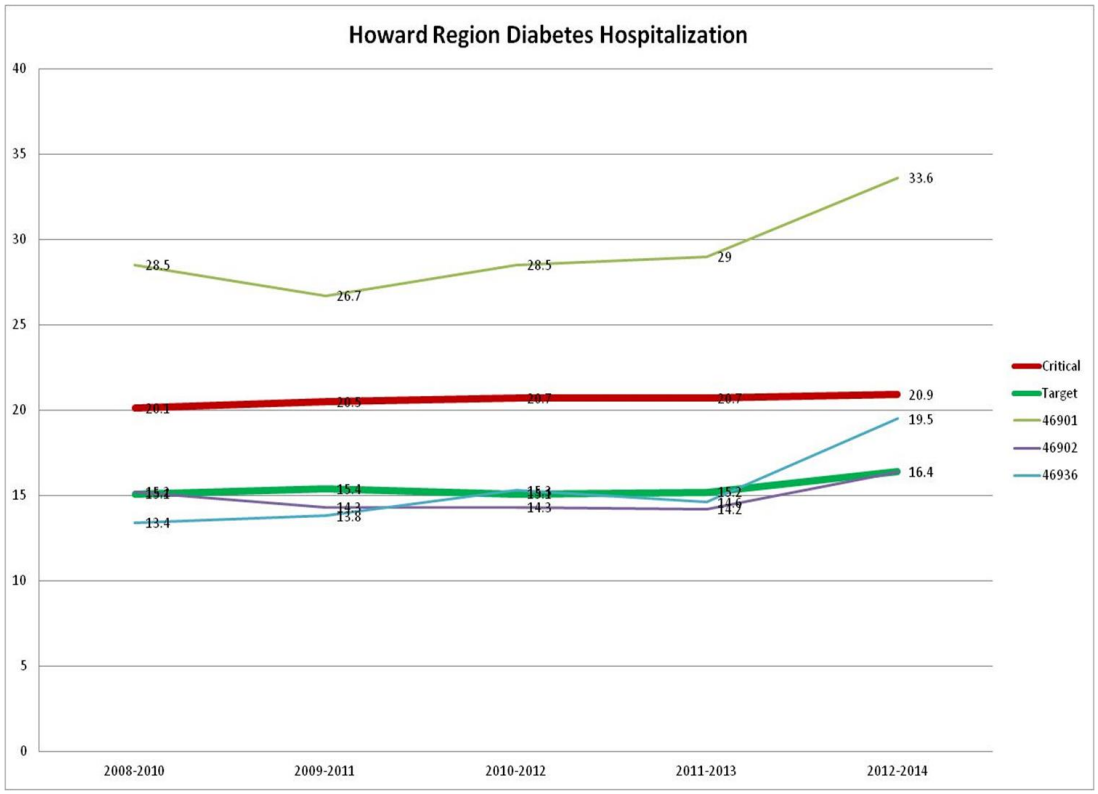
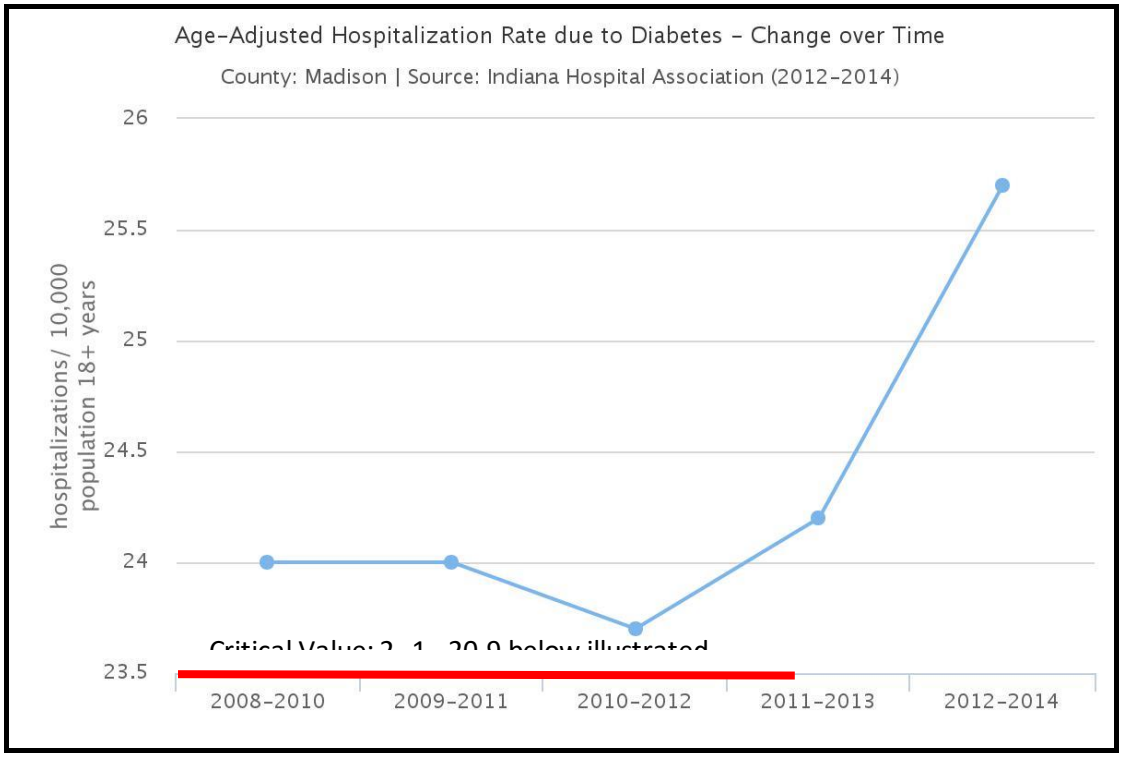
46158
46160
46181
46184
46217
46221
46227
46237





Diabeties Data for Community Hospital Anderson is only available by county not zip code



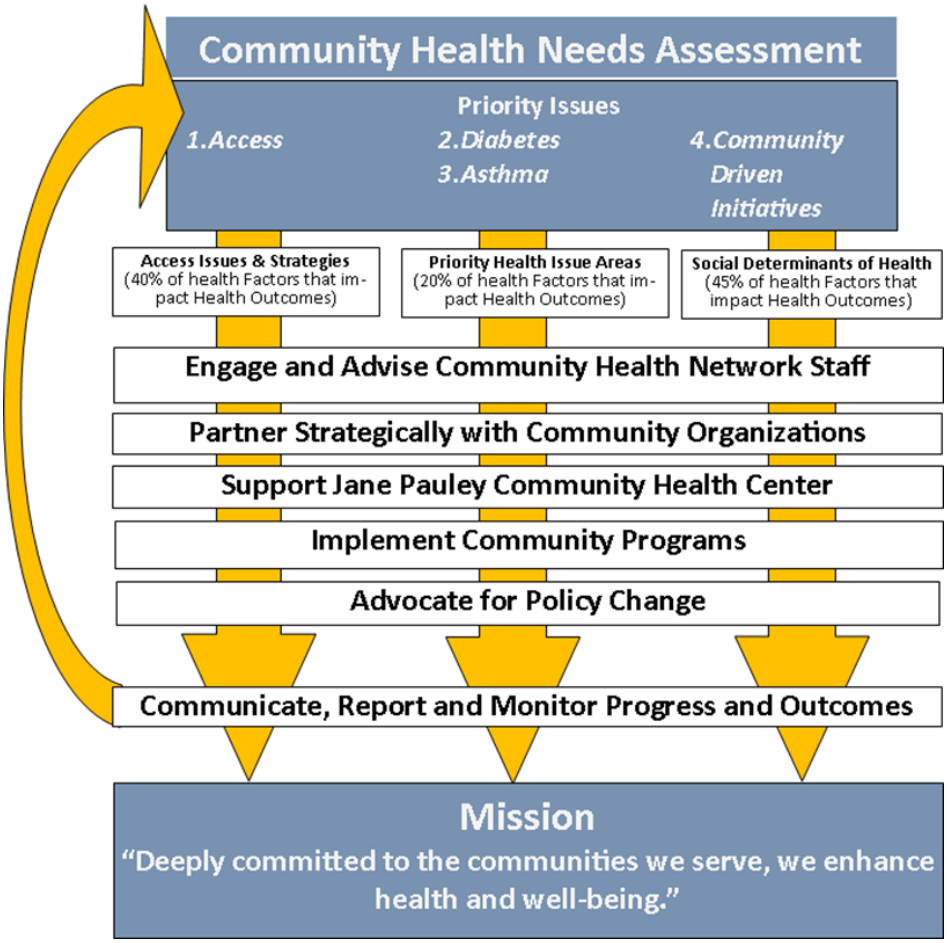
#4 Community-Driven Initiatives that Address the Social Determinants of Health

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

3g. The process for identifying and prioritizing community health needs and services to meet the community health needs.

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

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



3h. Process for consulting with persons representing the community's interests.

In 2011, the network began conducting town hall meetings as a process for consulting with persons representing the communities' interests. There are several other forums

for gaining the community and their expert's opinion and feedback on the communities' interests including neighborhood meetings, coalitions formed to assist in generating public health interests like Partnership for a Healthier Johnson County and Pioneering Healthy Communities. We continue to conduct online surveys, focus groups and soliciting comments for the communities, their consultants and agents. We currently have active committees in the health network to gain community knowledge. They include organizations such as:

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

3i. Information gaps that limit the hospital facility's ability to assess the community's health needs

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

3 j. Other (describe in Section C)

N/A

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

2015

5. In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted.

In conducting its most recent CHNA the hospital facility took into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health. Their input was collected in surveys and focus groups as well as routine community meetings. The following is a partial list of all those who have been involved in the community health needs assessment.

Below is a partial list of those who have participated however it is not an exhaustive list. The process used to receive feedack from the community is ongoing. Through our partnerships in the communities we serve, we are continually receiving information that assists us in shaping the interventions we deploy to improve or change situations that are ameliorated by delving onto the social determinants of health – often the purview of our partners not of our health institutions.

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

6a. Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C.

Yes: We included all facilities in the Community Health Network which includes Community Hospital East with Community Hospital North. It includes Community Hospital South, Community Hospital Anderson, Indianapolis Osteopathic Hospital, Inc. as well as St Vincent, St Francis and IU Health.

6b. Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C.

Yes. Healthy Communities Institute.

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

a) ☒ ***Hospital facility website (list url):*** ecommunity.com
b) ☒ ***Other Website (list url):***ecommunityanderson.com
c) ☒ ***Made a paper copy available for public inspection without charge at the hospital facilityupon request from hospital facility*** (yes)
d) ☐ ***Other (describe in Section C)*** NA

8. Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA?

Yes.

9*. Indicate the tax years the hospital facility last adopted and implementation strategy*

2015

10. Is the hospital facility's most recent adopted implementation strategy posted on the website?

Yes.

10a. If "Yes" (list url)

http://webapp.ecommunity.com/aboutus/

Implementation Strategy included with CHNA and a separate hyperlink

10b. If "No" is the hospital facility's most recently adopted implementation strategy attached to this return

11. Describe in Section C how the facility is addressing the significant needs identified in its most recently conducted CHNA and any such

needs that are not being addressed together with the reasons why such needs are not being addressed.

The Community Health Network is addressing the significant needs identified in its most recent conducted CHNA through the implementation startegy that follows. Just as Nobel Prize winner Elinor Ostrom's academic habits emphasized collaboration and cooperation, so did the content of her study and so does our community benefit plan. To address all of the needs identified in the community health needs assessment would be to achieve what no community has been able to do which is maintain optimal health. However we do believe that our plan and execution will weave together a resilient web that can address many needs identified by the communities we serve.

As we move into a new century with a host of ecological health pressures the answer to "What is healthcare for?" becomes important. We need a paradigm shift to transfer the institution led paradigm to a community led one that accounts for the future of society and the environment and is informed by decision making with patients and their communities. A place based community driven approach. Healthcare begins in the community not in the institution. We need to extend the health outside the hospital walls for the benefit of all. We need to see health as owned by the community and as a "commons", a "Health Commons" –encompassing all of the physical, financial, human, and social capital resources relevant to the delivery of health care and/or the promotion of population health in a geographic region.

Traditionally, economics taught that common ownership of resources results in excessive exploitation, as when fishermen overfish a common pond. This is the so-called tragedy of the commons, and it suggests that common resources must be managed either through privatization or government regulation, in the form of taxes, say, or limits on use. Professor Ostrom studied cases around the world in which communities successfully regulated resource use through cooperation. Her work has important applications for climate change policy today. Professor Ostrom inspired the Data Governance Council with her work demonstrating that people could effectively self-organize to govern common resources, such as fields, fish, lakes, rivers, and data. Her inspiration came not from text-books and formulas, but from field work with real people working together to govern the use of these common resources without government intervention or regulation. Self-Organization and Self-Governance are not just nice theories. They are solutions to common human problems that have existed for a millenium. These ideas are the foundation for our community benefit plan and implementation strategies.

Community Benefit Plan 2016

Community Health Needs Assessment 2016 – 2019 Implementation Strategy

Daniel E Hodgkins, M.Ed.

08/21/2015

The Community Health Network's Community Benefit Plan has developed from the strategic objectives and practices of our founding organization, as well as those of the neighborhoods and businesses surrounding Community Hospital East. Our principles and practices are echoed in the teachings of Dr. Elinor Ostrum, a Nobel Prize winner in Economics, the "Triple Aim" of Dr. Don Berwick, and the Institute for Healthcare Improvement. These innovative and efficacious community development and data driven approaches have been thoroughly consulted and applied in the CHNW Community Benefit Plan.

Introduction

In December 2014, the Internal Revenue Service and the Treasury Department published final rules implementing the Affordable Care Act's requirements for tax-exempt hospitals. The rules state that these tax-exempt hospitals must aim to "…prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community."

The Community Health Network has subscribed to these objectives since its inception. In the1950's, the desire to improve upon community health led Indianapolis' Eastside citizens to raise funds to build a hospital. Today, this Eastside hospital has grown and expanded into the Community Health Network, the second largest not-for-profit health system in Indiana. The Community Health Network's purpose and goals remain based on commitment and compassion in serving the community. Such commitment extends to neighborhoods, schools, businesses and churches. Like our founding community members, The Community Health Network views community organizations as pillars and core strengths. We believe that any lasting cultural change in community health status will be driven by local communities themselves—that they are the key towards identifying and addressing needs. As such, we remain committed to working with them to ensure a thriving population of healthy individuals through myriad ambitious, sustainable initiatives.

The 2015 Community Health Needs Assessment (CHNA) and this 2016 Implementation Strategy (IS) were undertaken by the health network to understand and address community health needs, and in accordance with proposed Internal Revenue Service (IRS) regulations pursuant to the Patient Protection and Affordable Care Act of 2010.

Our implementation strategy identifies the significant community health needs described in the CHNA that the hospital plans to address in whole or in part. The hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and merit enhancements to the described strategic initiatives. Alternately, other organizations in the community may decide to address certain community health needs, and the hospital may amend its strategies and refocus on other significant health needs. Beyond the initiatives and programs described herein, the hospital is addressing some of these needs simply by providing health care to the community, regardless of ability to pay.

About Community Health Network

Community Benefit Plan / Implementation Strategy

The board of our network plays an integral role in our community benefit plan and is involved in setting strategy—communicating within the organization and the community at large. Our leadership team members, the network board, and numerous physician leaders have developed this strategic plan and vision for our network. Our plan will serve as our roadmap from 2016 through 2020.

Mission

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

Values

Our values can be encapsulated as follows:

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

Vision

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

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

History

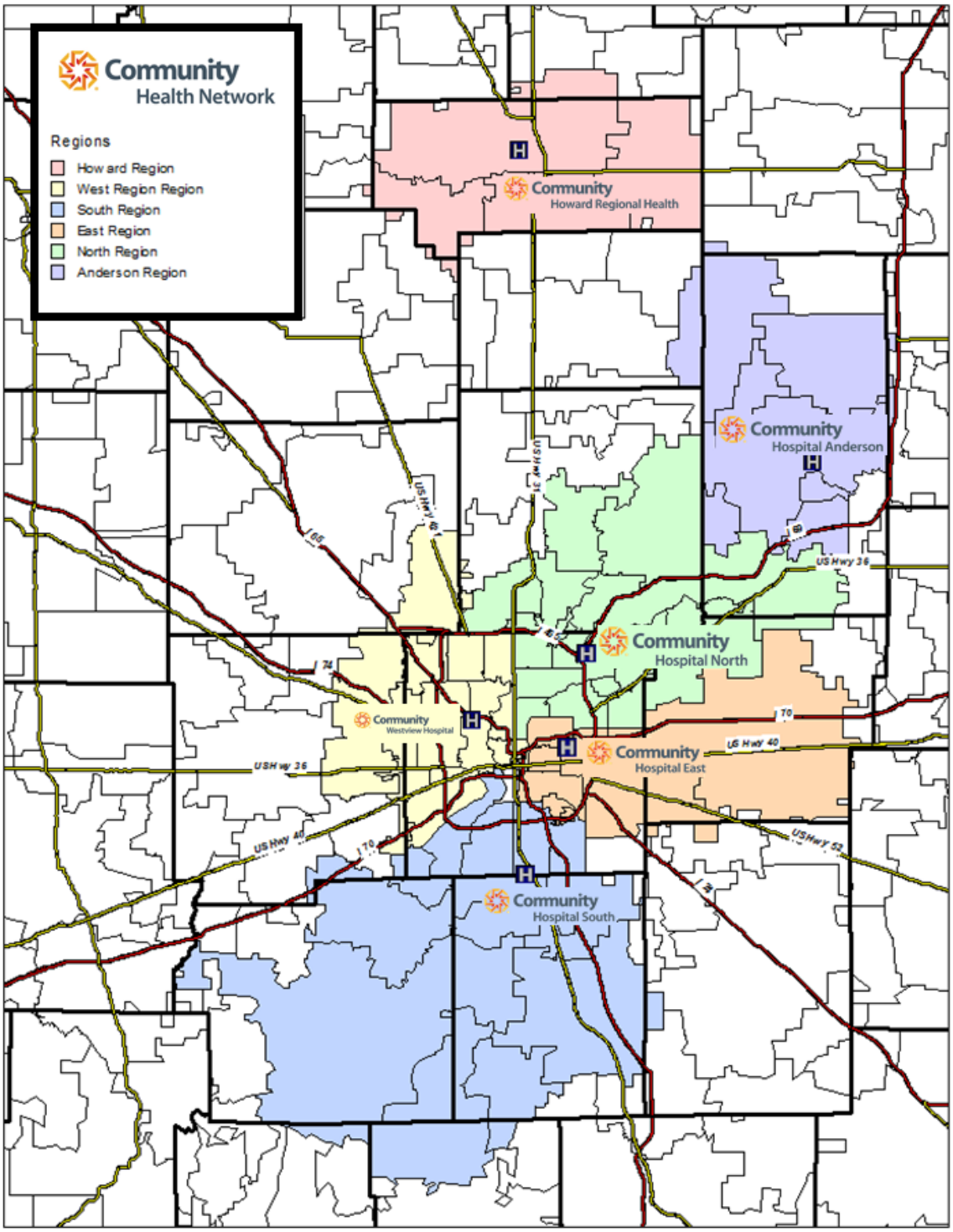
In 1954 the citizens on Indianapolis' east side decided to raise funds and build a hospital to serve the community. They did not have a name for the collective trust, action, cooperation or stewardship necessary in dealing with such a complex health and social dilemma. Nor did they understand that their transformation in 1954 would inform the leadership of the organization they initiated more than half a century later, to continuously progress health care on the Indianapolis Eastside into a better and more sustainable system in 2015. It wasn't until 2009 that the term for this collective care for the community and its resources was coined "care for the commons" by Indiana University Professor Elinor Ostrum. Her research has validated what we have known and experienced since 1954—that a community can manage its own resources successfully. Her theory was considered so significant she won the Nobel Prize in Economics.

Today Community Health Network is ranked among the nation's most integrated healthcare systems. Community Health Network is Central Indiana's leader in providing convenient access to exceptional healthcare services, where and when patients need them. This includes providing services and support in hospitals, health pavilions and doctor's offices, or within workplaces, schools, and homes. As a non-profit health system with over 200 affiliated care sites throughout Central Indiana, Community Health

Network's full continuum of care integrates hundreds of physicians, specialty and acute care hospitals, surgery centers, home care services, MedChecks, behavioral health, and employer health services.

Overview of Communities Served by Community Health Network

Figure I: Map of Service Regions:



The above map illustrates our service area, which reaches into 11 Indiana Counties.

Demographics of the community:

Each hospital facility has a defined services area as illustrated in the map above. What follows is an example of the demographics for an individual zip code in the East service area. Each service area has its own set of data that is reviewed for the implementation strategy. Below is a comprehensive analysis of the demographics compiled by searching our online database. Anyone with a computer can access this data. Our hope is that such access allows the community health needs assessment to be in "real time," so that data updated and collected at the beginning of a project can be compared to real-time data throughout a project's lifespan, encouraging continual feedback and improvement. For example, the same chart can be constructed by anyone, and the results can be found online at: http://webapp.ecommunity.com/aboutus/

Demographics

Location Type: Zip Code **Location:** 46219

2015 Base Counts			
2015 Population	34,672	940,939	6,613,067
2015 Households	15,021	379,925	2,556,127
2015 Housing Units	17,379	432,898	2,868,109
2015 Families	8,482	226,236	1,710,950
Percent Pop Growth 2010 to 2015	1.58%	4.16%	1.99%
Percent Household Growth 2010 to 2015	2.93%	3.75%	2.16%
Percent Housing Unit Growth 2010 to 2015	2.72%	3.60%	2.60%
Percent Family Growth 2010 to 2015	2.89%	3.62%	2.20%
2015 Population by Sex and Ethnicity			
2015 Population by Sex	34,672	940,939	6,613,067
2015 Population by Ethnicity	34,672	940,939	6,613,067
2015 Population by Single Race and Sex			
White	24,794 (71.51%)	575,031 (61.11%)	5,503,824 (83.23%)
Black/Af Amer	6,564 (18.93%)	255,376 (27.14%)	617,304 (9.33%)
Am Ind/AK Native	95 (0.27%)	2,842 (0.30%)	19,883 (0.30%)
Asian	345 (1.00%)	22,374 (2.38%)	124,521 (1.88%)
Native HI/PI	6 (0.02%)	464 (0.05%)	2,736 (0.04%)
Some Other Race	1,842 (5.31%)	55,135 (5.86%)	196,379 (2.97%)
2+ Races	1,026 (2.96%)	29,717 (3.16%)	148,420 (2.24%)
2015 Pop by Ethnicity and Single Race			

Hisp/Lat	3,051 (8.80%)	96,606 (10.27%)	445,227 (6.73%)
Not Hisp/Lat	31,621 (91.20%)	844,333 (89.73%)	6,167,840 (93.27%)
2015 Population by Age			
2015 Population by Age	34,672	940,939	6,613,067
2015 Pop, Age <18	7,962 (22.96%)	238,412 (25.34%)	1,584,011 (23.95%)
2015 Pop, Age 18+	26,710 (77.04%)	702,527 (74.66%)	5,029,056 (76.05%)
2015 Pop, Age 25+	24,102 (69.51%)	613,522 (65.20%)	4,342,468 (65.66%)
2015 Pop, Age 65+	5,654 (16.31%)	110,031 (11.69%)	960,459 (14.52%)
2015 Median Age	40.30	34.70	37.60
2015 Population by Sex and Age			
2015 Male Population by Age	16,783	454,758	3,257,585
2015 Pop, Male: Age <18	4,148 (24.72%)	121,713 (26.76%)	809,954 (24.86%)
2015 Pop, Male: Age 18+	12,635 (75.28%)	333,045 (73.24%)	2,447,631 (75.14%)
2015 Pop, Male: Age 65+	2,252 (13.42%)	45,605 (10.03%)	417,754 (12.82%)
2015 Median Age Male	38.20	33.60	36.30
2015 Female Population by Age	17,889	486,181	3,355,482
2015 Pop, Female: Age <18	3,814 (21.32%)	116,699 (24.00%)	774,057 (23.07%)
2015 Pop, Female: Age 18+	14,075 (78.68%)	369,482 (76.00%)	2,581,425 (76.93%)
2015 Pop, Female: Age 65+	3,402 (19.02%)	64,426 (13.25%)	542,705 (16.17%)
2015 Median Age Female	42.30	35.80	38.80
2015 Pop 5+ by Language Spoken at Home			
Speak Only English at Home	29,500 (91.31%)	760,574 (87.40%)	5,669,554 (91.64%)
Speak Spanish at Home	2,214 (6.85%)	74,089 (8.51%)	284,605 (4.60%)
Speak Asian/PI Lang at Home	137 (0.42%)	10,510 (1.21%)	69,024 (1.12%)
Speak Indo-European Lang at Home	373 (1.15%)	17,196 (1.98%)	139,977 (2.26%)
Speak Other Lang at Home	82 (0.25%)	7,834 (0.90%)	23,431 (0.38%)
2015 Pop 15+ by Sex, Marital Status			
Never Married	9,181 (32.90%)	284,514 (38.49%)	1,592,040 (30.02%)
Married, Spouse present	10,990 (39.39%)	277,084 (37.48%)	2,551,794 (48.11%)

Married, Spouse absent	1,282 (4.59%)	35,059 (4.74%)	174,383 (3.29%)
Divorced	4,496 (16.11%)	103,477 (14.00%)	667,939 (12.59%)
Widowed	1,955 (7.01%)	39,128 (5.29%)	317,877 (5.99%)
2015 Owner-Occ Housing Units by Value			
2015 Own Occ HUs Median Value	$104,664	$127,980	$132,846
2015 Own Occ HUs Avg Value	$114,613	$157,272	$164,793
2015 Households by Number of People in Household			
2015 Households	15,021	379,925	2,556,127
2015 Average Household Size	2.26	2.43	2.51
2015 Households by Presence of People Under 18			
2015 Households, People < 18	4,153 (27.65%)	122,787 (32.32%)	853,189 (33.38%)
2015 Occupied Housing Units by Year Householder Moved In			
2015 Median Length of Residence	10.20	9.30	10.60
2015 Renter Occ Housing Units: Median Length of Residence	6.10	5.80	6.10
2015 Owner Occ Housing Units: Median Length of Residence	13.50	12.40	13.00
2015 Occupied Housing Units by Vehicles Available			
2015 Avg Number Vehicles Available	1.60	1.60	1.80
No Vehicle	1,518 (10.11%)	35,904 (9.45%)	177,024 (6.93%)
1 Vehicle	5,766 (38.39%)	155,710 (40.98%)	839,487 (32.84%)
2 Vehicles	5,699 (37.94%)	134,310 (35.35%)	998,470 (39.06%)
3 Vehicles	1,569 (10.45%)	40,300 (10.61%)	379,801 (14.86%)
4 Vehicles	314 (2.09%)	9,910 (2.61%)	115,921 (4.54%)
5+ Vehicles	155 (1.03%)	3,791 (1.00%)	45,424 (1.78%)
2015 Households by Household Income			
2015 Households by Income	15,021	379,925	2,556,127
2015 Median Household Income	$39,962	$42,577	$49,030
2015 Average Household Income	$52,412	$57,776	$64,249
2015 Households by Race and Household Income			
2015 Median HH Inc, White	$43,561	$49,455	$51,913
2015 Avg HH Inc, White	$55,341	$63,736	$64,991
2015 Median HH Inc, Black/Af Amer	$26,992	$30,246	$30,790
2015 Avg HH Inc, Black/Af Amer	$36,188	$41,377	$42,661
2015 Median HH Inc, Am Ind/AK Native	$34,500	$37,780	$41,337
2015 Avg HH Inc, Am Ind/AK Native	$56,646	$50,491	$56,050
2015 Median HH Inc, Asian	$32,955	$49,992	$56,428

2015 Avg HH Inc, Asian	$53,761	$62,647	$75,253
2015 Median HH Inc, Native HI/PI	$25,000	$21,022	$34,437
2015 Avg HH Inc, Native HI/PI	$25,000	$26,317	$56,046
2015 Median HH Inc, Some Other Race	$39,756	$30,640	$37,053
2015 Avg HH Inc, Some Other Race	$45,851	$34,961	$45,242
2015 Median HH Inc, 2+ Races	$54,049	$34,624	$39,746
2015 Avg HH Inc, 2+ Races	$60,885	$47,919	$52,258
2015 Households by Ethnicity and Household Income			
2015 Median HH Inc, Hisp/Lat	$33,793	$30,144	$38,911
2015 Avg HH Inc, Hisp/Lat	$45,407	$41,493	$52,934
2015 Median HH Inc, Not Hisp/Lat	$40,579	$43,849	$49,574
2015 Avg HH Inc, Not Hisp/Lat	$52,814	$58,965	$64,789
2015 Families by Poverty Status			
2015 Families Below Poverty	1,248 (14.71%)	37,796 (16.71%)	192,651 (11.26%)
2015 Families Below Poverty with Children	1,016 (11.98%)	31,141 (13.76%)	153,783 (8.99%)
2015 Population by Sex and Educational Attainment			
2015 Population 25+ with Less Than High School Graduation	3,987 (16.54%)	93,095 (15.17%)	545,925 (12.57%)
2015 Population 25+, Male, with Less Than High School Graduation	1,952 (17.24%)	45,315 (15.68%)	275,045 (13.12%)
2015 Population 25+, Female, with Less Than High School Graduation	2,035 (15.92%)	47,780 (14.73%)	270,880 (12.06%)
Population 25+ by Educational Attainment	24,102	613,522	4,342,468
Male Population 25+ by Educational Attainment	11,323	289,060	2,095,591
Female Population 25+ by Educational Attainment	12,779	324,462	2,246,877
2015 Population Age 16+ by Employment Status			
2015 Percent Civ Labor Force Unemployed	11.79%	11.39%	9.30%
2015 Percent Civ Labor Force Unemployed Male	11.41%	11.46%	9.62%
2015 Percent Civ Labor Force Unemployed Fem	12.19%	11.31%	8.94%
2015 Workers by Means of Transportation to Work			
Means of Transportation to Work	15,268	433,974	3,021,721
2015 Workers by Travel Time to Work			
Travel Time to Work	15,019	421,397	2,922,428
2015 Avg Commute (minutes) Workers Worked Away	25	25	26
2015 Employed Civilian 16+ Population by Industry			
Accommdtn/Food Svcs	1,120 (7.35%)	39,545 (9.06%)	225,260 (7.42%)
Admin/Spprt/Waste Mgmt	1,006 (6.60%)	24,654 (5.65%)	107,781 (3.55%)
Agriculture/Forest/Fish/Hunt	45 (0.30%)	1,233 (0.28%)	42,911 (1.41%)
Entertainment/Rec Svcs	225 (1.48%)	7,516 (1.72%)	51,804 (1.71%)
Construction	1,215 (7.98%)	22,920 (5.25%)	177,409 (5.85%)

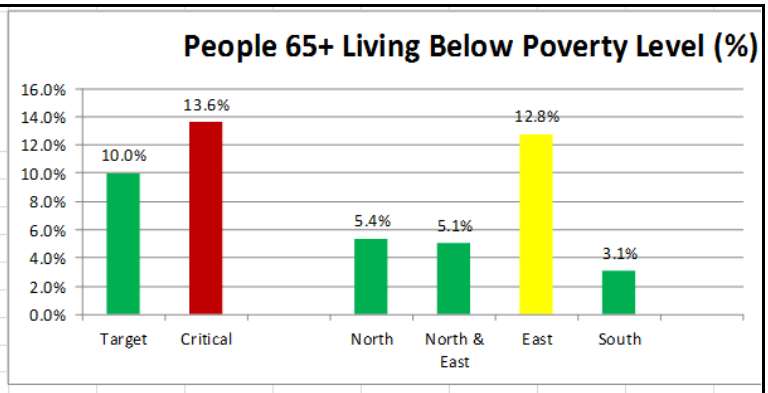
Educational Svcs	870 (5.71%)	32,361 (7.41%)	284,185 (9.36%)
Fin/Insur/RE/Rent/Lse	998 (6.55%)	28,665 (6.57%)	160,480 (5.29%)
Health Care/Soc Asst	2,287 (15.01%)	64,797 (14.84%)	422,495 (13.92%)
Information	297 (1.95%)	6,705 (1.54%)	43,981 (1.45%)
Mgmt of Companies	27 (0.18%)	340 (0.08%)	1,848 (0.06%)
Total Manufacturing	1,789 (11.74%)	49,384 (11.31%)	577,993 (19.05%)
Oth Svcs, Not Pub Admin	784 (5.15%)	20,197 (4.63%)	147,449 (4.86%)
Prof/Sci/Tech/Admin	645 (4.23%)	26,284 (6.02%)	131,860 (4.35%)
Public Administration	887 (5.82%)	19,384 (4.44%)	106,211 (3.50%)
Retail Trade	2,086 (13.69%)	57,368 (13.14%)	358,266 (11.81%)
Transport/Warehse/Utils	781 (5.13%)	27,908 (6.39%)	160,027 (5.27%)
Wholesale Trade	490 (3.22%)	14,668 (3.36%)	78,491 (2.59%)
2015 Employed Civilian 16+ Population by Occupation			
Architect/Engineer	226 (1.48%)	5,811 (1.33%)	53,637 (1.77%)
Arts/Entertain/Sports	188 (1.23%)	6,878 (1.58%)	39,291 (1.29%)
Building Grounds Maint	694 (4.56%)	21,433 (4.91%)	116,688 (3.85%)
Business/Financial Ops	713 (4.68%)	21,832 (5.00%)	117,399 (3.87%)
Community/Soc Svcs	339 (2.23%)	8,744 (2.00%)	47,622 (1.57%)
Computer/Mathematical	350 (2.30%)	10,617 (2.43%)	50,471 (1.66%)
Construction/Extraction	1,015 (6.66%)	18,473 (4.23%)	146,853 (4.84%)
Edu/Training/Library	617 (4.05%)	22,365 (5.12%)	175,701 (5.79%)
Farm/Fish/Forestry	14 (0.09%)	516 (0.12%)	13,138 (0.43%)
Food Prep/Serving	922 (6.05%)	28,341 (6.49%)	189,064 (6.23%)
Health Practitioner/Tec	686 (4.50%)	24,861 (5.69%)	180,259 (5.94%)
Healthcare Support	417 (2.74%)	11,683 (2.68%)	75,249 (2.48%)
Maintenance Repair	561 (3.68%)	12,320 (2.82%)	115,379 (3.80%)
Legal	149 (0.98%)	5,171 (1.18%)	25,440 (0.84%)
Life/Phys/Soc Science	51 (0.33%)	3,137 (0.72%)	19,957 (0.66%)
Management	1,061 (6.96%)	35,136 (8.05%)	261,158 (8.61%)
Office/Admin Support	2,597 (17.05%)	67,723 (15.51%)	414,783 (13.67%)
Production	1,078 (7.08%)	29,674 (6.80%)	327,434 (10.79%)
Protective Svcs	363 (2.38%)	9,247 (2.12%)	53,839 (1.77%)
Sales/Related	1,885 (12.37%)	51,920 (11.89%)	323,318 (10.65%)
Personal Care/Svc	448 (2.94%)	12,573 (2.88%)	94,115 (3.10%)
Transportation/Moving	1,178 (7.73%)	35,474 (8.13%)	237,656 (7.83%)
White Collar	8,862	264,195	1,709,036

	(58.17%)	(60.51%)	(56.32%)
Blue Collar	3,832 (25.15%)	95,941 (21.97%)	827,322 (27.26%)
Service and Farm	2,858 (18.76%)	83,793 (19.19%)	542,093 (17.86%)

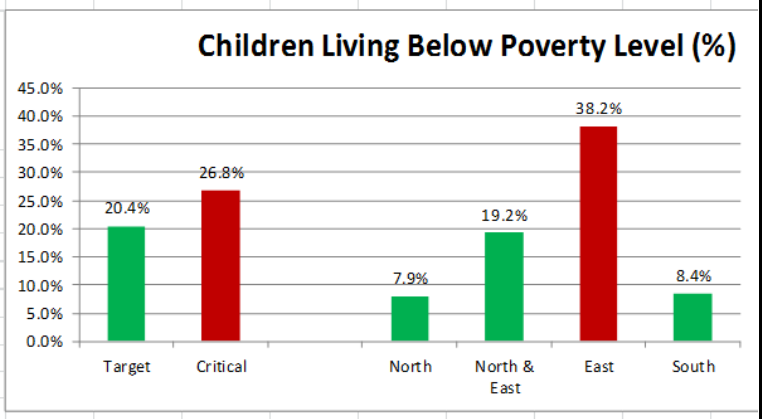
The demographics are broken down by county and zip codes, and when the data is available in census tract it is included. The more "granular" the data (i.e. specific to a geography) in a service area, the easier it is to make disctinctions that can be used to drive improvement strategies, as well as communications and marketing to assist in illustrating what a community looks like and how to "target" messages for interventions. For this reason granular data is invaluable. Less data (county, state) runs the risk of being insufficient or too general to develop strategies for a particular service area.

Below is another example of the demographic data and the overview of our markets. In this case we are comparing three of the markets, North, East and South.

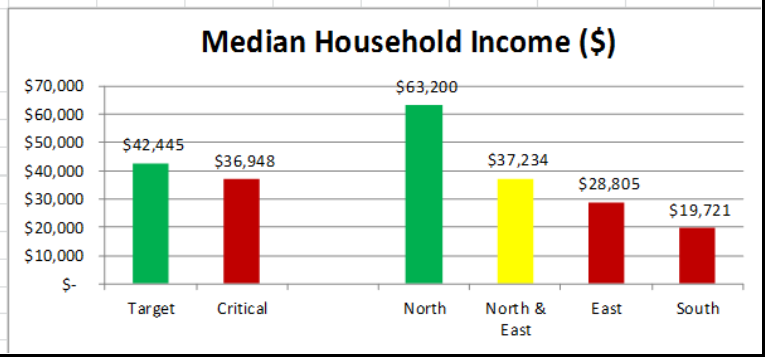
	People 65+ Living Below Poverty Level (%)
Target	10.0%
Critical	13.6%
North	5.4%
North & East	5.1%
East	12.8%
South	3.1%



	Children Living Below Poverty Level (%)
Target	20.4%
Critical	26.8%
North	7.9%
North & East	19.2%
East	38.2%
South	8.4%



	Median Household Income ($)
Target	$ 42,445
Critical	$ 36,948
North	$ 63,200
North & East	$ 37,234
East	$ 28,805
South	$ 19,721



Community Health Needs Assessment

The IRS requires a Community Health Needs Assessment (CHNA) and defines that a CHNA must exist for each hospital service area and "define the community it serves and assess the health needs of that community. In assessing the community's health needs, the hospital facility must take into account input from persons who represent the broad interests of its community, including those with special knowledge of or expertise in public health." Community Health Network began the process of creating a CHNA in 2011, seeking national models and proven practices while attempting to use local resources to

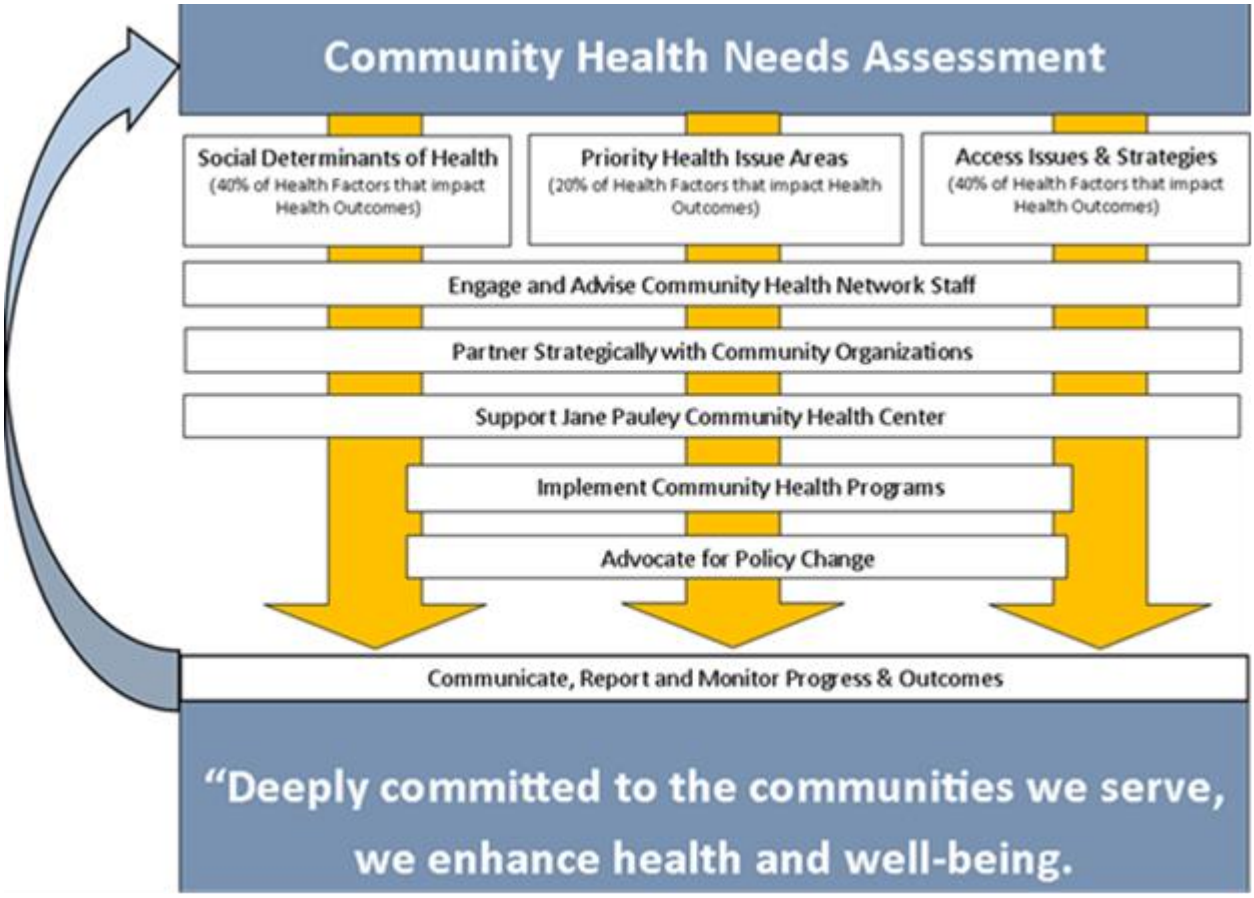
collect the necessary data. The Community Benefit department brought together a group of informed practitioners from hospital and community organizations that would also benefit from the data collected. Although a joint CHNA was not originally able to become a reality, this current CHNA does include efforts of all local health care institutions and some cooperation and planning with the local county public health departments.

Our website, http://www.ecommunity.com/aboutus/care.aspx# displays over 125 health and quality of life indicators updated in real time. It offers hundreds of community-level resources for common community interventions in the "Promising Practices." Just by accessing our website, anyone in the network and the community can know the health needs of any locality. When they reach the CHNA section as a first-time user they are asked to take a survey of what they believe to be the health issues in their community, which is then used as primary data in our own CHNA. The website displays national, state, and county data, including our own institutional medical and data by county, zip code and census tract. Internally we can analyze financial data and incorporate sensitive data like crime statistics, which may not be used in a public display but would be valuable in setting strategies for the network.

Using all of the tools available to us, we went through a process of evaluation and started our community assessments with a list of the top community health issues for each of our IRS compliant service areas. The diagram below illustrates the process we used in interpreting our Community Health needs assessment data and transforming the data into a viable and measurable implementation strategy.

Process for Developing Implementation Strategy

The Community Health Needs Assessment was broken down into three categories based on the approach of "America Health Rankings." These rankings are based on a model of population health that was supported by the Robert Wood Johnson Foundation. It emphasizes many factors that, if improved upon, can make communities healthier places to live, learn, work, and play. The first area needing to be addressed is access issues or strategies. Evidence suggests that access to effective and timely primary care has the potential to improve the overall quality of care and reduce costs. Some populations experience additional barriers in access to preventive health services due to lack of transportation to providers' offices, lack of knowledge about preventive care, long waits to get an appointment, low health literacy, and inability to pay the high-deductible of many insurance plans and/or co-pays. Our first priority therefore is access to quality health services and expand the capacity needed to address health issues in the areas we serve. As Don Berwick describes in the "triple aim" of healthcare improvement, the goal is to improve the health of the population we serve, enhance our patient experience through access, quality, and reliability, which ultimately will reduce the cost of care.



The second area to be addressed is priority health issues. Multiple factors led us to specifically identify asthma and diabetes as two priority health issues in the first CHNA. During the 2016 Implementation strategy we will continue to focus on asthma, but our focus on diabetes will change to a focus on obesity – the root cause for type 2 diabetes. Although access can help address many critical health issues, both asthma and diabetes rank high in the preventable hospital stays for ambulatory-care sensitive conditions and can usually be addressed in an outpatient setting, not normally requiring hospitalization (if the condition is well-managed). The most striking difference between these two diseases is that diagnosis of asthma has immediate consequences regarding hospitalizations short and long-term, while diabetic hospitalizations are typically the result of longer-term complications. The metrics used to determine these two areas are illustrated below. The transition to a focus on obesity is supported by the survey data collected on over 6,000 individuals. When community members were asked to select "the top five health needs in your community," obesity was always on top of others, especially when considering that it made it to at least one of the top three concerns in every survey.

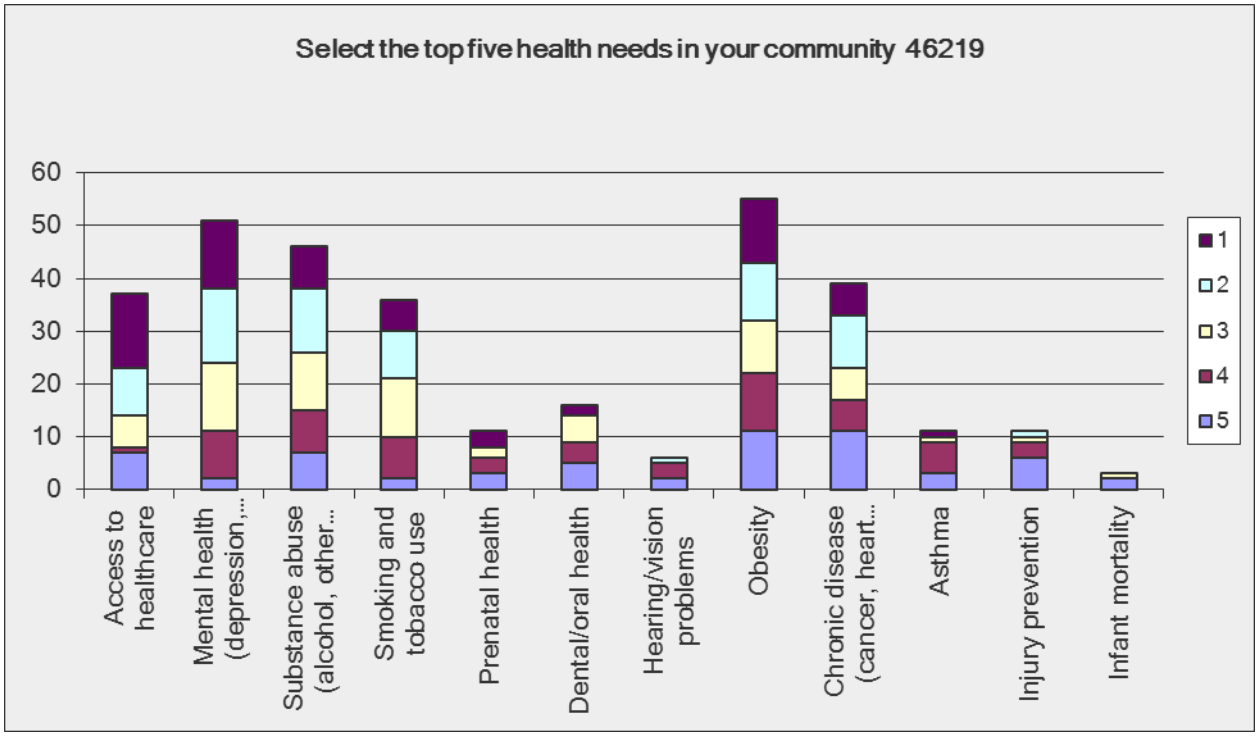
Implementation Strategy 2012 – 2015 Data

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

The chart above illustrates the 13% gap in the hospitalization data and belies the critical rate of 100% incidence in our smaller markets.

Implementation Strategy 2012 – 2015 Data

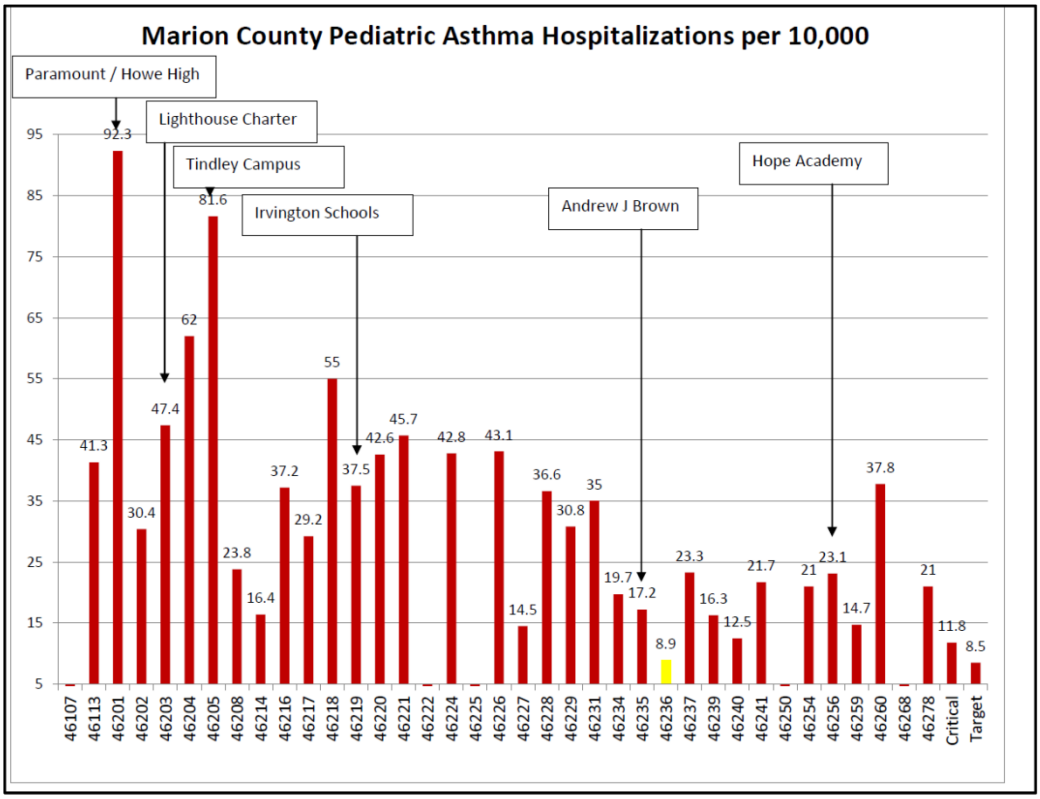
As illustrated above, the surveys justify the transition from a focus on diabetes to obesity. And given that the root cause for diabetes is grounded in living standards related to poverty, food access, and the lack of environmental support for health, the transition is supported by our focus on external community improvements.



While asthma is not often listed in the top five health care needs in the survey, our data from the schools in which we operate has pointed out why our focus on asthma has not changed. In our school based health data respiratory issues make up 9% of all visits to the school health personnel and 11% of the presenting problems. Asthma causes ~10% of all school health-related issues and yet it is an issue that has readily available interventions. By anticipating students' health needs we can send them back to class with minimal impact on behavior and academic performance.

Rank		Highest % of Actual Visits	Rank		Highest % of Presenting Problems
1	Gastrointestinal (7)	19%	1	Gastrointestinal (7)	35%
2	Musculo/ Skeletal (11)	16%	2	Dermatological (4)	31%
3	Eye/ Ears/ Nose/ Throat (5)	15%	3	Eye/ Ears/ Nose/ Throat (5)	31%
4	Dermatological (4)	14%	4	Musculo/ Skeletal (11)	27%
5	Neurological (13)	13%	5	Neurological (13)	27%
6	Respiratory (17)	9%	6	Other/ Miscellaneous (18)	16%
7	Other/ Miscellaneous (18)	7%	7	Respiratory (17)	11%
8	Psychosocial (16)	3%	8	Dental (3)	7%
9	Dental (3)	3%	9	Gynecological/ Obstetrical (9)	4%
10	Gynecological/ Obstetrical (9)	2%	10	Nutrition/ Metabolic (12)	3%
11	Endocrine (6)	2%	11	Psychosocial (16)	2%
12	Nutrition/ Metabolic (12)	1%	12	Genitourinary (8)	2%
13	Genitourinary (8)	1%	13	Parasites/ Infections (14)	1%
14	Parasites/ Infections (14)	0.36%	14	Cardiovascular (2)	1%
15	Cardiovascular (2)	0.28%	15	Immune System (allergies) (10)	1%
16	Immune System (allergies) (10)	0.21%	16	Endocrine (6)	0.37%
17	Disorder from Physical Agents (15)	0.05%	17	Disorder from Physical Agents (15)	0.16%

The illustration below focuses on specific zip codes, and shows asthma hospitalization rates relative to incidences of asthma being treated in the schools we serve. The top three zip codes where the incidences of pediatric asthma hospitalization are highest also represent communities in which we already have the capability to treat asthma through the school health program. The other zip codes with high rates could be served through our school health services.



Our third priority area is related to the social determinants of health. Don Berwick speaks plainly about Elinor Ostrum, the founder of term "micro-commons:"

> "Elinor Ostrom showed that it was possible to safeguard commonly owned resources like water and forests…Her work should inspire us to looks for ways to prevent health care costs from overwhelming another shared resource: the public coffers."

In our community benefit plan, the "public coffers" Berwick refers to are a shared concern and are addressed by our adherence to the IRS guidelines to "relieve or reduce the burden of government or other community efforts."

As was the case in 1954, the Community Health Network in 2015 worked to develop and implement community strategies—in consort with these communities—to improve their

overall health. Ostrums' design principles, echoed by Berwick, provide a functional paradigm through which we view our entire system of health care. Rather than seeing the health system as a conglomerate of organizations, using Ostums' vernacular, we see them as made up of "micro commons" that need to be reinforced and enhanced by local strategic leadership. Only those with local knowledge of existing programs and remaining challenges can knit a strong tapestry of health care delivery. The communities look to us to solve health issues. Their definition of healthy communities goes beyond the diseases we treat in our hospitals and clinics. It is this implementation strategy that will rectify the disparity between perceptions and our abilities.

The Community Benefit Plan was developed from the perspective that health care does not happen exclusively in the institutions—it happens in the community. It is a place-based, community-driven approach, extending health initiatives and wellness outside the hospital walls for the benefit of all. Just as Elinor Ostroms' Nobel Prize-winning research emphasizes collaboration and cooperation, so to does our Community Benefit Plan.

Data Driven

Although most health care providers consider Florence Nightingale the founder of modern nursing, Nightingale was also a celebrated British social reformer and statistician who came to prominence while nursing during the Crimean War. Like Ostrum, Nightingale believed that the problems of a community were most effectively solved when the citizens were educated in order to govern themselves. She supported bills for increased self-government and improved local education. Alongside her stances on social order, Nightingale became a pioneer of data-driven approaches to health care. In fact, she was a master of the visual presentation of statistics. She used methods such as the pie chart, and developed one called "the polar area diagram" that enabled her to illustrate the prevalence of particular diseases and the impacts of their treatments. Today, Nightingale would likely be gratified to see that we are adopting her data-driven approach in our Community Health Needs Assessment. In all likelihood, she would agree that the zip code you live is a better determinant of your health expectancy than your genetic code.

Engaging and Advising Community Health Network Staff

Charity Care Strategy

Our current charity care policy was crafted in response to community need and in relation to available resources. The health network does not always have the resources available to meet every community need identified in every health assessment. We do not always have the resources to offer charity care to anyone who comes to us for care.

Consequently, using a data-driven approach we have developed a strategic Charity Care policy that targets the highest need areas and restricts our charity care resources to those "Health Districts." The process of defining our Health Districts was developed to identify or more precisely illuminate the needs in communities we serve and to target our resources for optimization. Clearly we do not have the funds to offer charity care throughout all counties or even our own service areas. What resources we do have we need to use in a way that will make the biggest difference. And to do so, we need to focus on specific geographic areas. A few points to clarify how we identified "Health Districts:"

- We started with all the zip codes in our service areas (80) and ONLY those zip codes.
- All criteria are judged "worst" by credible organizations—not our own. For example, the Census Bureau has determined through census data and other measures of poverty that a particular zip code is at critical level, or a criteria has been set by Healthy People 2020.
- We did NOT use the highest level of charity care expenditure as an initial screen. However, as would be expected, the highest level of charity care expenditure was contained in these zip codes except in the South market.

The Identifications of Health Districts

We used all 80 service area zip codes and selected all those zip codes identified as having median household incomes that were below the target set by the US Census Bureau (below $43,417 in our geographic area). We came up with a total of 20 zip codes.

To make sure that this one indicator would not stand alone and we would capture or identify other zip codes "in need" or "at risk," we ran several other reports and came up with additional zip codes included in our "Health Districts."

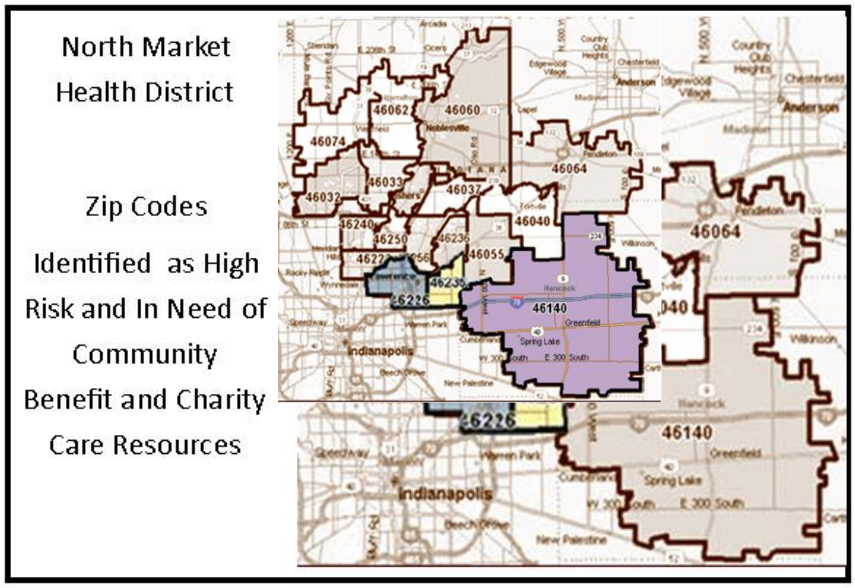
We ran a report to list all those zip codes that identified more than 15% of the zip code population living in poverty in that specific zip code. We captured an additional 3 zip codes.

We ran a report to identify families in a specific zip code that pay more than 30% of the annual income on rent (these families would have limited discretionary funds available). Any zip code that had more than 47% of the total zip code population spending 30% of their annual income on the rent (The critical level as identified by the US Census Bureau), 2 zip codes were added.

We screened the service area zip codes for "Children Living in Poverty." Any zip code that had more than 21% of their children living in poverty, we added 3 zip codes.

The final screen we ran was People 65+ living in poverty. If there were any additional zip codes that had more than 10% of their total population 65+ living in poverty we added those zip codes. No additional zip codes were added because the zip codes at highest risk or "in need" were already identified in previous screens.

Finally three other zip codes (46217, 46142 and 46143) were added to the list in the South Market. The reason for the addition of these zip codes was because of the known immigration population and the fast changes in these zip codes' population. They are the highest at-risk or in-need zip codes for the south market and they had the highest charity care expenditures in that market



Partner Strategically with Community Organizations

Since our founding in 1954, we have established a culture of collaborating in order to optimize community resources. All of our community work is performed in consort with the communities we plan to work with and with the added values of the organizations they respect and trust. For several years the network has taken on the issue of access and that will remain our number one focus in our prioritized issues. The priority health issues that have been identified by the community health needs assessment are the two chronic diseases, diabetes and asthma. Access, asthma, and diabetes will remain top priorities, however other areas of concern may be adopted given that the communities drive the plan. The fourth priority therefore is community-driven initiatives.

We continue to take a collective approach that involves our systematic collection of the knowledge and views of informants on healthcare services and needs. These include

online surveys, focus groups and one-on-one discussions. Valuable information is often available from the data we collect from providers, clinicians, and general practitioners, as well as from users of our services. Although such an approach blurs the distinction between need and demand and between science and vested interest, the intimate, detailed knowledge of interested parties might otherwise be overlooked. Furthermore, this collective approach is essential if policies are to be sensitive to local circumstances. Eliciting local views is not the same as being bound by them. Socioeconomic factors, particularly high poverty rates, are associated with some aspects of health system performance, but not all. There are significant variations within areas with low levels of poverty as well as within areas with high poverty levels. This approach allows sensitivity to local circumstances as local concerns may justifiably attach priorities to particular services. Local experience and involvement will make any needs assessment easier to publicize and defend. Each facility in our network will have prioritized activities and programs determined by the input of the communities they serve which may be different from the overall corporate strategy. As discussed earlier, access to care is a top priority. This access priority is illustrated by our school health strategies in the community benefit budget. Our priority health issues are asthma and diabetes, and both require health care access, which is of course impeded upon by socioeconomic situations defined in the social determinants of health. Both asthma and diabetes are best addressed where children are located—in schools. But to address these health issues the partner schools need to see the impact of success—such as better grades and higher attendance. Keeping both goals and outcomes out in front may slow the timeline down, but in the end it builds a support system that supports a culture of health.

Support Jane Pauley Community Health Center

The Jane Pauley Community Health Center serves the local community regardless of insurance or income, with an emphasis on integrating medical and behavioral health along with access to various other social services. The center offers primary health care services, including preventive and annual exams, well-child care, acute care and certain procedures. The center also focuses on the management of chronic diseases, such as diabetes, cardiac disease, and depression. The Jane Pauley Community Health Center was established in 2009 with generous support from Community Health Network and the Community Health Network Foundation. It is named after Jane Pauley, a 1968 Warren Central High School graduate who grew up in the area and is well known as the former anchor of NBC-TV's "Today" and "Dateline" programs.

Implement Community Health Programs

In Johnson County, one of the most successful community health needs assessments and community benefit plans was initiated over 13 years ago by the collaboration of many organizations in our South market and service area. The Partnership for a Healthier Johnson County has had success while most other initiatives like it have failed. It illustrates the success of our long-term strategy adopted from the beginning and outlined in the introduction of the Partnership website. Our health partners include hospitals, the health department and hundreds of individuals from businesses, schools, social service agencies and civic and faith-based organizations. The mission of Partnership is to plan and implement collaborative, measurable strategies to improve the health of the residents of Johnson County. This strategy developed 13 years ago continues to be our "Best Practice" and sets the stage for who we participate with and how we measure the success of our participation. Each service area (or in many cases, combined service areas) have unique neighborhood and community initiatives that we support.

Advocate for Policy Change

Everyone knows that tobacco use is the number one cause of preventable death, as well as preventable disease in the United States. With all the awareness and educational resources being spent, one of the final efforts was in changing policy. This has been successful. Smoking kills more people in Indiana than alcohol, AIDS, car crashes, illegal drugs, murders, and suicides combined. Cigarette smoking is the number one preventable cause of premature death in Indiana. The United States Surgeon General, in his 1986 report on involuntary smoking concluded that involuntary smoking is a significant cause of diseases, including lung cancer, in otherwise healthy nonsmokers. The Center for Disease Control and Prevention is officially warning people at risk for heart disease to avoid all buildings and gathering places that allow smoking. The agency claims that as little as 30 minutes exposure of secondhand smoke can have serious and lethal effect. And still the state of Indiana has one of the highest incidence rates of smoking and one of the lowest rates of policy changes to help manage preventative strategies.

Community Health Network, as a leader among all of the health care organizations in Indiana, possess the expertise, the tradition of clinical innovation, and the institutional commitment to promote healthy activities and behaviors. In 2005, only a handful of health care organizations in the state of Indiana had a tobacco-free environment and Community Health Network, through the implementation of their policy in 2006, was among the leaders—the first hospital system in Marion County to go smoke free. It was changing policy that made the big difference. We often use policy change as a last intervention, but sometimes it is the only intervention that will shift our culture to a community that values health.

Communicate, Report and Monitor Progress and Outcomes

Each service area of each network entity will be reviewed and evaluated for the CHNA. The results will be displayed in all upcoming Community Benefit Reports with outcomes of any interventions. This data will give us a baseline and an opportunity to measure our interventions in a way that has never, to this point, been possible.

Our community benefit plan re-examines the social contract that began in 1954 with the community and citizens of the Eastside. Now we ask ourselves whether twentieth century assumptions, programs, and services are adequate and appropriate for twenty-first century problems and issues. The winning strategy that has been adopted by our health system—one that is a key driver in innovation around the Affordable Care Act and the adoption of its tenants—is the "Triple Aim." Developed by Berwick and executed by many health organizations, it sums up what our community benefit plan hopes to do: to improve the health of the population we serve, enhance our patient experience through access, quality, reliability, and ultimately reduce the cost of care.

Priority Issue / Significant Health Need	Intervention	Tracking / Outcomes
Access	Outreach and interventions that improve the access to health care for the underserved and vulnerable populations	Increase to 100% the number of Primary Care Physicians in the Community Health Network accepting Medicaid patients Increase volume of patients referred to and treated at the Jane Pauley Community Health Center for uninsured and Medicaid services. Focus Charity Care in Health Districts that have the highest need.
Asthma	Provide outreach, education and intervention in the community that ultimately decreases the number of hospital admissions in our service area and Health Districts for pediatric asthma and overall increases the health of children.	Tracked through comparative county and state of Indiana hospitalization data and nationally through Healthy Community Institute.
Obesity/Diabetes	Provide outreach, education and intervention in the community that ultimately decreases the number of hospital admissions in our service area and Health Districts for long term and short term complications of diabetes in the adult population	Tracked through comparative county and state of Indiana hospitalization data and nationally through Healthy Community Institute.

Community Driven Initiatives		
Priority Issue / Significant Health Need	**Intervention**	**Tracking / Outcomes**
CHE	Eastside Economic Development Committee (Wellness Opportunity Zone)	Complete Emerson Ave. Corridor Project. Support community driven projects and encourage data driven measurement approach to drive success and resource allocation. At least one data driven project in the master plans for the community driven activities.
	Serve 360^{O}	100% of all CHE Leadership participate in community projects.
CHN	Healthy Hamilton County Binford Redevelopment and Growth	Support community driven projects and encourage data driven measurement approach to drive success and resource allocation. At least one data driven project in the master plans for the community driven activities.
	Serve 360^{O}	100% of all CHN Leadership participate in community projects.
CHS	Partnership for A Healthier Johnson County Serve 360^{O}	Support community driven projects and encourage data driven measurement approach to drive success and resource allocation. At least one data driven project in the master plans for the community driven activities. 100% of all CHS Leadership participate in community

		projects.
CHA	Madison County Coalition – United Way	Support community driven projects and encourage data driven measurement approach to drive success and resource allocation. At least one data driven project in the master plans for the community driven activities.
	Serve 360^{O}	100% of all CHA Leadership participate in community projects.
Westview	Westview Wellness Initiatives	Support community driven projects and encourage data driven measurement approach to drive success and resource allocation. At least one data driven project in the master plans for the community driven activities.
	Serve 360^{O}	100% of all Westview Leadership participate in community projects.
Howard	United Way Healthy Communities	Support community driven projects and encourage data driven measurement approach to drive success and resource allocation. At least one data driven project in the master plans for the community driven activities.
	Serve 360^{O}	100% of all Howard Leadership participate in community projects.

END OF IMPLEMENTATION DOCUMENT

Part VI Supplemental Information

1. ***Required descriptions. Provide the descriptions required for Part I, lines***

3c, **NA**

6a, **Yes**

7. See Form 990, Schedule H, Part VI for descriptions for Part I, lines 6a and 7 and Part III, lines 2,3,4 and 8.

Part II and Part III,

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See Form 990, Schedule H, Part VI for descriptions for Part III, lines 2, 3, 4, 8 and 9b.

2. ***Needs assessment. Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.***

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3. Patient education of eligibility for assistance. Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

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4. ***Community information. Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.***

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5*. Promotion of community health. Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).*

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6. ***Affiliated health care system. If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.***

N/A

7. ***State filing of community benefit report. If applicable, identify all states with which the organization, or a related organization, files a community benefit report.***

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