

**SCHEDULE H  
(Form 990)**

**Hospitals**

OMB No. 1545-0047

**2015**

**Open to Public  
Inspection**

Department of the Treasury  
Internal Revenue Service

- ▶ 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](http://www.irs.gov/form990).

Name of the organization **COMMUNITY HOSPITAL OF BREMEN, INC.** Employer identification number **35-0835006**

**Part I Financial Assistance and Certain Other Community Benefits at Cost**

	Yes	No
<b>1 a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a .....	<b>X</b>	
<b>b</b> If "Yes," was it a written policy? .....	<b>X</b>	
<b>2</b> If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
<b>3</b> 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. <b>a</b> Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: .....	<b>X</b>	
<input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %		
<b>b</b> Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: .....	<b>X</b>	
<input checked="" type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %		
<b>c</b> 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.		
<b>4</b> 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"? .....	<b>X</b>	
<b>5 a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? .....	<b>X</b>	
<b>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? .....		<b>X</b>
<b>c</b> If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care? .....		
<b>6 a</b> Did the organization prepare a community benefit report during the tax year? .....	<b>X</b>	
<b>b</b> If "Yes," did the organization make it available to the public? .....	<b>X</b>	

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

**7 Financial Assistance and Certain Other Community Benefits at Cost**

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
<b>Financial Assistance and Means-Tested Government Programs</b>						
<b>a</b> Financial Assistance at cost (from Worksheet 1) .....			181,801.		181,801.	.94%
<b>b</b> Medicaid (from Worksheet 3, column a) .....			1944249.	677,956.	1266293.	6.57%
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b) .....						
<b>d Total</b> Financial Assistance and Means-Tested Government Programs .....			2126050.	677,956.	1448094.	7.51%
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4) .....		4,111	42,495.		42,495.	.22%
<b>f</b> Health professions education (from Worksheet 5) .....		3	17,500.		17,500.	.09%
<b>g</b> Subsidized health services (from Worksheet 6) .....	15,576	228	3156442.	953,423.	2203019.	11.43%
<b>h</b> Research (from Worksheet 7) .....						
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8) .....		650	283.		283.	.00%
<b>j Total.</b> Other Benefits .....	15,576	4,992	3216720.	953,423.	2263297.	11.74%
<b>k Total.</b> Add lines 7d and 7j .....	15,576	4,992	5342770.	1631379.	3711391.	19.25%

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.

Table with 7 columns: (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. Rows include Physical improvements and housing, Economic development, Community support, Environmental improvements, Leadership development and training for community members, Coalition building, Community health improvement advocacy, Workforce development, Other, and Total.

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense: Questions 1-4 regarding bad debt reporting and methodology. Section B. Medicare: Questions 5-7 regarding Medicare revenue and costs, and question 8 regarding shortfall treatment. Section C. Collection Practices: Questions 9a and 9b regarding debt collection policy.

Part IV Management Companies and Joint Ventures (owned 10% or more by officers, directors, trustees, key employees, and physicians - see instructions)

Table with 5 columns: (a) Name of entity, (b) Description of primary activity of entity, (c) Organization's profit % or stock ownership %, (d) Officers, directors, trustees, or key employees' profit % or stock ownership %, (e) Physicians' profit % or stock ownership %.

Part V Facility Information

Section A. Hospital Facilities

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

How many hospital facilities did the organization operate during the tax year? 1

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)

1 COMMUNITY HOSPITAL OF BREMEN, INC.
1020 HIGH ROAD
BREMEN, IN 46506
WWW.BREMENHOSPITAL.COM
16-005097-1

Table with columns: Licensed hospital, Gen. medical & surgical, Children's hospital, Teaching hospital, Critical access hospital, Research facility, ER-24 hours, ER-other, Other (describe), Facility reporting group. Row 1: X, , , , X, , X, , ,

**Part V Facility Information** (continued)

**Section B. Facility Policies and Practices**

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

Name of hospital facility or letter of facility reporting group COMMUNITY HOSPITAL OF BREMEN, INC.

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1

	Yes	No
<b>Community Health Needs Assessment</b>		
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? .....		X
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 .....		X
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 .....	X	
If "Yes," indicate what the CHNA report describes (check all that apply):		
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>12</u>		
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 .....	X	
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 .....		X
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 .....		X
7 Did the hospital facility make its CHNA report widely available to the public? .....	X	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):		
a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>PART V, PAGE 7</u>		
b <input type="checkbox"/> Other website (list url): _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> 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 .....	X	
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>12</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? .....	X	
a If "Yes," (list url): <u>HTTP://WWW.BREMENHOSPITAL.COM/RESOURCES.PHP</u>		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? .....		X
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.		
12a 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)? .....		X
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? .....		
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? \$		

**Part V Facility Information** (continued)

**Financial Assistance Policy (FAP)**

Name of hospital facility or letter of facility reporting group COMMUNITY HOSPITAL OF BREMEN, INC.

	Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:		
<b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? .....	<b>X</b>	
If "Yes," indicate the eligibility criteria explained in the FAP:		
<b>a</b> <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>100</u> % and FPG family income limit for eligibility for discounted care of <u>200</u> %		
<b>b</b> <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b> <input checked="" type="checkbox"/> Asset level		
<b>d</b> <input type="checkbox"/> Medical indigency		
<b>e</b> <input checked="" type="checkbox"/> Insurance status		
<b>f</b> <input checked="" type="checkbox"/> Underinsurance status		
<b>g</b> <input type="checkbox"/> Residency		
<b>h</b> <input type="checkbox"/> Other (describe in Section C)		
<b>14</b> Explained the basis for calculating amounts charged to patients? .....	<b>X</b>	
<b>15</b> Explained the method for applying for financial assistance? .....	<b>X</b>	
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):		
<b>a</b> <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</b> <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
<b>c</b> <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
<b>d</b> <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b> <input type="checkbox"/> Other (describe in Section C)		
<b>16</b> Included measures to publicize the policy within the community served by the hospital facility? .....	<b>X</b>	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):		
<b>a</b> <input type="checkbox"/> The FAP was widely available on a website (list url): _____		
<b>b</b> <input type="checkbox"/> The FAP application form was widely available on a website (list url): _____		
<b>c</b> <input type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): _____		
<b>d</b> <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b> <input type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>f</b> <input type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>g</b> <input type="checkbox"/> Notice of availability of the FAP was conspicuously displayed throughout the hospital facility		
<b>h</b> <input type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b> <input checked="" type="checkbox"/> Other (describe in Section C)		

**Billing and Collections**

<b>17</b> 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? .....	<b>X</b>	
<b>18</b> 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:		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies)		
<b>b</b> <input type="checkbox"/> Selling an individual's debt to another party		
<b>c</b> <input type="checkbox"/> Actions that require a legal or judicial process		
<b>d</b> <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>e</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		

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

Name of hospital facility or letter of facility reporting group COMMUNITY HOSPITAL OF BREMEN, INC.

	Yes	No
<b>19</b> Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? .....		<b>X</b>
If "Yes," check all actions in which the hospital facility or a third party engaged:		
a <input type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Actions that require a legal or judicial process		
d <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b> Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):		
a <input type="checkbox"/> Notified individuals of the financial assistance policy on admission		
b <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy prior to discharge		
c <input checked="" type="checkbox"/> Notified individuals of the financial assistance policy in communications with the individuals regarding the individuals' bills		
d <input checked="" type="checkbox"/> Documented its determination of whether individuals were eligible for financial assistance under the hospital facility's financial assistance policy		
e <input type="checkbox"/> Other (describe in Section C)		
f <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

<b>21</b> Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? .....	<b>21</b>	<b>X</b>	
If "No," indicate why:			
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions			
b <input type="checkbox"/> The hospital facility's policy was not in writing			
c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)			
d <input type="checkbox"/> Other (describe in Section C)			

**Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

<b>22</b> Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.			
a <input type="checkbox"/> The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged			
b <input type="checkbox"/> The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged			
c <input type="checkbox"/> The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged			
d <input checked="" type="checkbox"/> Other (describe in Section C)			
<b>23</b> During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? .....	<b>23</b>		<b>X</b>
If "Yes," explain in Section C.			
<b>24</b> During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? .....	<b>24</b>		<b>X</b>
If "Yes," explain in Section C.			

**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 HOSPITAL OF BREMEN, INC.:

PART V, SECTION B, LINE 5: IN CONDUCTING ITS MOST RECENT CHNA THE HOSPITAL TOOK INTO ACCOUNT INPUT FROM PERSONS WHO REPRESENTED THE COMMUNITY IT SERVED INCLUDING THOSE WITH SPECIAL KNOWLEDGE. A STEERING COMMITTEE COMPRISED OF LOCAL BUSINESS OWNERS, LOCAL OFFICIALS, HEALTHCARE PROVIDERS, MINORITY LEADERS, CLERGY, STUDENT REPRESENTATIVES, ACTIVE MEDICAL STAFF, HEALTH DEPARTMENT OFFICIALS, AND OTHER INTERESTED PARTIES DISCUSSED THE HEALTH-RELATED NEEDS OF THE COMMUNITY. A 33-QUESTION SURVEY WAS CREATED BASED ON THE INFORMATION COLLECTED DURING THE DISCUSSION. THE SURVEY WAS WIDELY DISSEMINATED TO THE RESIDENTS IN CHB'S SERVICES AREA THROUGH INCLUSION ON THE HOSPITAL'S WEBSITE, FACE-TO-FACE POLLING AT THREE POPULAR GROCERY STORES IN AND NEAR BREMEN, AND A PUBLICALLY AVAILABLE SURVEY, WHICH WAS POSTED ON ZOOMERANG.COM (NOW SURVEY MONKEY) AND DISTRIBUTED IN HARD COPY TO THE LOCAL AMISH POPULATION.

COMMUNITY HOSPITAL OF BREMEN, INC.:

PART V, SECTION B, LINE 7D: [HTTP://WWW.BREMENHOSPITAL.COM/RESOURCES.PHP](http://www.bremenhospital.com/resources.php)

COMMUNITY HOSPITAL OF BREMEN, INC.:

PART V, SECTION B, LINE 11: DUE TO LIMITED FINANCIAL RESOURCES, ONLY THE TOP 5 NEEDS IDENTIFIED BY THE MOST RECENT CHNA WERE ADDRESSED.

COMMUNITY HOSPITAL OF BREMEN, INC.:

**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.

PART V, SECTION B, LINE 16I: THE FINANCIAL ASSISTANCE SUMMARY, FINANCIAL ASSISTANCE POLICY, AND FINANCIAL ASSISTANCE APPLICATION CAN BE FOUND BY CLICKING ON "REGISTRATION/BILLING" UNDER THE "PATIENT & VISITORS" DROP DOWN MENU AND SCROLLING TO THE BOTTOM OF THE PAGE.

ADDITIONALLY, SEE THIS WEB ADDRESS FOR ALL THREE PUBLICATIONS  
[HTTP://WWW.BREMENHOSPITAL.COM/BUSINESS-OFFICE.PHP](http://www.bremenhospital.com/business-office.php)

COMMUNITY HOSPITAL OF BREMEN, INC.:

PART V, SECTION B, LINE 22D: THE MAXIMUM AMOUNT THAT CAN BE CHARGED TO FAP-ELIGIBLE INDIVIDUALS FOR EMERGENCY OR OTHER MEDICALLY NECESSARY CARE IS NOT MORE THAN THE AMOUNTS GENERALLY BILLED (AGB) TO INDIVIDUALS WHO HAVE INSURANCE COVERAGE FOR SUCH CARE. THE AGB IS DERIVED BY DIVIDING (1) THE SUM OF ALL CLAIMS FOR MEDICALLY NECESSARY SERVICES PROVIDED AT THE HOSPITAL AND PAID DURING THE RELEVANT PERIOD BY MEDICARE FEE-FOR-SERVICE AND ALL PRIVATE HEALTH INSURERS AS PRIMARY PAYERS, TOGETHER WITH ANY ASSOCIATED PORTIONS OF THESE CLAIMS PAID BY MEDICARE BENEFICIARIES OR INSURED INDIVIDUALS IN THE FORM OF CO-PAYS, CO-INSURANCE OR DEDUCTIBLES, BY (2) THE CHARGES SET FORTH IN THE HOSPITAL CHARGEMASTER AT THE TIME THE SERVICES ARE RENDERED.

PATIENTS WHO ARE DEEMED TO BE PRESUMPTIVELY ELIGIBLE FOR FINANCIAL ASSISTANCE WILL RECEIVE A FINANCIAL ADJUSTMENT TO THEIR FINAL STATEMENT BALANCE BASED ON THE PATIENT'S INDIVIDUAL SCORING CRITERIA.





**Part VI** Supplemental Information

Provide the following information.

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

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**PART I, LINE 6A:**

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**THE ORGANIZATION PREPARED AN ANNUAL COMMUNITY BENEFIT REPORT AND THAT REPORT IS AVAILABLE UPON REQUEST.**

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**PART II, COMMUNITY BUILDING ACTIVITIES:**

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**THE COMMUNITY HOSPITAL OF BREMEN OPERATES A 9,000 SQUARE FOOT MEDICAL OFFICE BUILDING. A PORTION OF THIS BUILDING IS DONATED TO COMMUNITY SERVICE AGENCIES. A SMALL PORTION OF THE BUILDING IS USED BY THE HOSPITAL FOR SUPPLY AND RECORD STORAGE. THE HOSPITAL DONATES AN OFFICE TO THE MARSHALL COUNTY OLDER ADULT SERVICES PROGRAM. THIS AGENCY PROVIDES MEDICATION ASSISTANCE, MEDICARE PART D AND MEDICARE ENROLLMENT ASSISTANCE, AND GRATIS TAX RETURN PREPARATION. WOMEN'S CARE CENTER PROVIDES A FULL RANGE OF PREGNANCY TESTING, PRENATAL SERVICES, CRIB CLUB, AND SINGLE PARENTING PROGRAMS IN BOTH ENGLISH AND SPANISH. AIM STRAIGHT MARRIAGE AND FAMILY PROGRAM ALSO HAS FULL TIME USE OF A SUITE IN THE CLINIC TO PROVIDE PREMARITAL COUNSELING, MARITAL COUNSELING, AND DIVORCE COUNSELING AND MEDIATION SERVICES. THE HOSPITAL PROVIDES A WIDE RANGE OF SUPPORT TO COMMUNITY SERVICE ORGANIZATIONS USING HOSPITAL SPACE INCLUDING ALL**

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**Part VI** Supplemental Information (Continuation)

UTILITIES, MAINTENANCE, HOUSEKEEPING SERVICES ETC.

PART III, LINE 4:

ORGANIZATION'S FINANCIAL STATEMENT FOOTNOTE DESCRIBING BAD DEBT EXPENSE IS LOCATED ON PAGE 7 OF THE AUDITED FINANCIAL STATEMENTS UNDER THE HEADING "ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS"

PART III, LINE 8:

THE TOTAL AMOUNT OF SHORTFALL SHOULD BE TREATED AS COMMUNITY BENEFIT EXPENSE. AMOUNTS DERIVED FROM FILED 2016 COST REPORT.

PART III, LINE 9B:

THE HOSPITAL PROVIDES CARE TO PATIENTS WHO MEET CERTAIN CRITERIA UNDER ITS CHARITY CARE POLICY WITHOUT CHARGE OR AT AMOUNTS LESS THAN ITS ESTABLISHED RATES. THE HOSPITALS POLICY INCLUDES PROVISIONS TO EXCLUDE ANY ACCOUNT BALANCES KNOWN TO HAVE PAYMENT ARRANGEMENTS OR QUALIFIED CHARITY CARE OR FINANCIAL ASSISTANCE FROM DEBT COLLECTION EFFORTS.

PART VI, LINE 2:

COMMUNITY HOSPITAL OF BREMEN (CHB) CONTRACTED WITH THE INDIANA RURAL HEALTH ASSOCIATION (IRHA) TO CONDUCT THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) COMPLETED IN 2012.

THE FINDINGS OF THE HEALTH NEEDS ASSESSMENT WERE SHARED WITH THE STEERING COMMITTEE, AND AN IMPLEMENTATION PLAN WAS DEVELOPED TO ADDRESS THE TOP 5 HEALTH CARE NEEDS OF THE COMMUNITY IDENTIFIED.

PART VI, LINE 3:

THE YEAR END BEGINNING AFTER DEC 27, 2015 WITH REGARDS TO THE FINAL

**Part VI** Supplemental Information (Continuation)

REGULATIONS OF INTERNAL REVENUE CODE SECTION 501(R) WILL START MAY 1, 2016 FOR THE HOSPITAL. THE 2015 FORM 990 DOES NOT COVER THIS TIME PERIOD AND THE HOSPITAL IS IN COMPLIANCE WITH 501(R) FOR THE FISCAL YEAR 2016.

WHEN THE PATIENT IS PHYSICALLY ADMITTED TO THE FACILITY, REGISTRATION PERSONNEL WILL OBTAIN BILLING INFORMATION. IF A PATIENT IS DETERMINED TO HAVE NO THIRD PARTY PAYER, THEY WILL BE DESIGNATED AS SELF PAY AND REFERRED TO A SELF PAY BILLING REPRESENTATIVE. THE SELF PAY BILLING REPRESENTATIVE WILL ESTABLISH CONTACT WITH THE PATIENT AND/OR PATIENT REPRESENTATIVE PRIOR TO DISCHARGE IF POSSIBLE, TO VERIFY THAT THERE WOULD BE NO CURRENT THIRD PARTY SOURCES RESPONSIBLE FOR PAYMENT, THAT THE PATIENT HAS NO OTHER VIABLE OUTSIDE SOURCES FOR PAYMENT OR THAT THE PATIENT DOES NOT HAVE ADEQUATE FINANCIAL RESOURCES TO PAY FOR HIS/HER CARE NOW OR OVER TIME. THE SELF PAY BILLING REPRESENTATIVE WILL BE RESPONSIBLE FOR INSURING THAT THE PATIENT OR PATIENT REPRESENTATIVE RECEIVES A HOSPITAL FINANCIAL ASSISTANCE APPLICATION. IN ADDITION, THEY WILL NOTIFY THE PATIENT THAT THEY NEED TO MEET WITH A FINANCIAL ASSISTANCE ADVOCATE AND WILL ASSIST THE PATIENT OR PATIENT REPRESENTATIVE WITH SCHEDULING AN APPOINTMENT. AT THE MEETING WITH THE FINANCIAL ASSISTANCE ADVOCATE, THE PATIENT WILL BE SCREENED FOR POTENTIAL ELIGIBILITY FOR STATE AND FEDERAL MEDICAL PAYMENT PROGRAMS AS WELL AS THE HOSPITAL'S INTERNAL FINANCIAL ASSISTANCE POLICY.

OUTPATIENTS, WHO ARE DESIGNATED AS SELF PAY, WILL BE MAILED A FLYER INFORMING THEM OF THE FINANCIAL OPTIONS AVAILABLE AND REQUESTING THAT IF THEY DO NEED ASSISTANCE WITH THEIR BILLS, THEY ARE TO CONTACT A BILLING REPRESENTATIVE TO SCHEDULE AN APPOINTMENT WITH THE PATIENT ADVOCATE TO BE SCREENED. THE BILLING REPRESENTATIVE'S CONTACT INFORMATION IS PROVIDED ON

**Part VI** Supplemental Information (Continuation)

THE FLYER.

FLYERS ARE LOCATED AT THE PATIENT REGISTRATION AREAS AND IN THE LOCAL PHYSICIAN OFFICES. IN ADDITION, A NOTICE IS PERIODICALLY PLACED IN THE COMMUNITY PAPER AND THE HOSPITAL'S NEWLETTER INFORMING THEM OF THE EXISTENCE OF THE ADVOCATE AND HOW TO SCHEDULE AN APPOINTMENT SHOULD THEY NEED ASSISTANCE WITH THEIR MEDICAL BILLS.

PART VI, LINE 4:

THE COMMUNITY HOSPITAL OF BREMEN IS A 24 BED CRITICAL ACCESS HOSPITAL LOCATED IN MARSHALL COUNTY, APPROXIMATELY 25 MILES SOUTHEAST OF SOUTH BEND, INDIANA. THE COMMUNITY SERVED BY COMMUNITY HOSPITAL OF BREMEN IS DEFINED AS FOLLOWS: ALL PEOPLE LIVING WITHIN THE FOLLOWING ZIP CODES: 46506, 46537, 46536, 46595, 46573, 46550, 46504, AND 46563

DESCRIPTION OF COMMUNITY:

THE PHYSICAL SERVICE AREA OF COMMUNITY HOSPITAL OF BREMEN IS LOCATED IN THE NORTH CENTRAL REGION OF INDIANA. THE COMMUNITY IS LARGELY RURAL AND IS COMPRISED OF SOUTHEASTERN ST. JOSEPH COUNTY, SOUTHWESTERN ELKHART COUNTY, NORTHEAST MARSHALL COUNTY, AND NORTHWEST KOSCIUSKO COUNTY.

POPULATION - ETHNICITY, AGE, HOUSEHOLDS & INCOME: ACCORDING TO IVANTAGE HEALTH ANALYTICS, IN CONJUNCTION WITH 2011 ESRI DATA, THE TOTAL POPULATION OF THE COMMUNITY IS 57,552; AND THE AVERAGE MEDIAN AGE IN THE COUNTY IS 37.07 YEARS OLD. FEMALES MAKE UP 50.5% OF THE OVERALL POPULACE. MINORITY POPULATIONS MAKE UP 9.71% OF THE TOTAL INHABITANTS OF THE COUNTY. THERE ARE 20,826 HOUSEHOLDS COMPRISED OF APPROXIMATELY 2.76 PERSONS EACH. THE AVERAGE HOUSEHOLD INCOME IS \$57,403; AND THE AVERAGE PER CAPITA INCOME IS \$20,772.

Part VI Supplemental Information (Continuation)

PART VI, LINE 5:

THE COMMUNITY HOSPITAL OF BREMEN IS THE MEALS ON WHEELS PROVIDER FOR THE COMMUNITY. THE HOSPITAL PREPARED AND SERVED AN AVERAGE OF 13 TO 15 MEALS PER DAY. THE \$2.85 SUBSIDY PER MEAL COVERS THE COST OF THE MEAL INGREDIENTS, BUT DOES NOT COVER THE LABOR COST OF PREPARING 3,410 MEALS PER YEAR.

THE HOSPITAL OFFERS SEVERAL GRATIS PROGRAMS TO MEMBERS OF THE COMMUNITY. PRENATAL AND CHILDBIRTH CLASSES ARE TAUGHT ON AN ONGOING BASIS. THESE CLASSES ARE FREE TO THOSE GIVING BIRTH AT THE HOSPITAL. A NOMINAL FEE IS CHARGED TO THOSE WHO ARE NOT. A HOSPITAL REGISTERED NURSE MAKES A WELL BABY HOME VISIT AND PROVIDES LACTATION ASSISTANCE TO THE HOME OF EVERY BABY BORN AT THE COMMUNITY HOSPITAL OF BREMEN. THE HOSPITAL OFFERS A FREE WALK-IN BLOOD PRESSURE CHECK PROGRAM. ON A CONTRACTED BASIS, THE HOSPITAL PROVIDES SPACE FOR A PATIENT ADVOCATE TWO DAYS PER MONTH TO SCREEN INDIVIDUALS FOR ELIGIBILITY FOR HEALTHCARE INSURANCE AND OR THE HOSPITAL'S FINANCIAL ASSISTANCE PROGRAM. THIS IS A HOSPITAL FUNDED SERVICE AND IS OPEN TO THE PUBLIC. COMMUNITY HOSPITAL OF BREMEN PROVIDES A JOB SHADOWING PROGRAM FOR LOCAL STUDENTS WHO ARE INTERESTED IN PURSUING A CAREER IN HEALTHCARE. SAFE SITTER BABYSITTING CLASSES AND CPR CLASSES ARE TAUGHT WITH A SMALL CHARGE TO COVER COURSE MATERIALS.

PART VI, LINE 6:

N/A - THE ORGANIZATION IS NOT PART OF AN AFFILIATED HEALTH CARE SYSTEM.

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:

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