

**SCHEDULE H  
(Form 990)**

**Hospitals**

OMB No. 1545-0047

**2020**

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.
- ▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

Name of the organization **LITTLE COMPANY OF MARY HOSPITAL OF INDIANA, INC** Employer identification number **35-0985964**

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

	Yes	No
<b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	<input checked="" type="checkbox"/>	
<b>b</b> If "Yes," was it a written policy?	<input checked="" type="checkbox"/>	
<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 checked="" 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: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %	<input checked="" type="checkbox"/>	
<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: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input checked="" type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	<input checked="" type="checkbox"/>	
<b>c</b> If the organization 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"?	<input checked="" type="checkbox"/>	
<b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	<input checked="" type="checkbox"/>	
<b>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		<input checked="" type="checkbox"/>
<b>c</b> If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		
<b>6a</b> Did the organization prepare a community benefit report during the tax year?	<input checked="" type="checkbox"/>	
<b>b</b> If "Yes," did the organization make it available to the public?	<input checked="" type="checkbox"/>	

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

**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)			968,534.		968,534.	.40%
<b>b</b> Medicaid (from Worksheet 3, column a)			26461509.	23521668.	2939841.	1.22%
<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			27430043.	23521668.	3908375.	1.62%
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4)			369.		369.	.00%
<b>f</b> Health professions education (from Worksheet 5)						
<b>g</b> Subsidized health services (from Worksheet 6)						
<b>h</b> Research (from Worksheet 7)						
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8)						
<b>j Total.</b> Other Benefits			369.		369.	.00%
<b>k Total.</b> Add lines 7d and 7j			27430412.	23521668.	3908744.	1.62%





**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 MEMORIAL HOSPITAL & HEALTH CARE CENTER

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"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>20</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
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 .....		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>SEE PART V, PAGE 8</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>20</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? .....		X
a If "Yes," (list url): _____		
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 MEMORIAL HOSPITAL & HEALTH CARE CENTER

	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>200</u> % and FPG family income limit for eligibility for discounted care of <u>400</u> %		
<b>b</b> <input type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b> <input type="checkbox"/> Asset level		
<b>d</b> <input type="checkbox"/> Medical indigency		
<b>e</b> <input type="checkbox"/> Insurance status		
<b>f</b> <input type="checkbox"/> Underinsurance status		
<b>g</b> <input type="checkbox"/> Residency		
<b>h</b> <input checked="" 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> Was widely publicized 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 checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
<b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
<b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
<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 checked="" 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 checked="" 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 checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
<b>h</b> <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b> <input type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information** (continued)

**Billing and Collections**

Name of hospital facility or letter of facility reporting group MEMORIAL HOSPITAL & HEALTH CARE CENTER

	Yes	No
<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 nonpayment? .....	X	
<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"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
<b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process		
<b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<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? .....		X
If "Yes," check all actions in which the hospital facility or a third party engaged:		
<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"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
<b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process		
<b>e</b> <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):		
<b>a</b> <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)		
<b>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)		
<b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C)		
<b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C)		
<b>e</b> <input type="checkbox"/> Other (describe in Section C)		
<b>f</b> <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? .....	X	
If "No," indicate why:		
<b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
<b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing		
<b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)		
<b>d</b> <input type="checkbox"/> Other (describe in Section C)		

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

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

Name of hospital facility or letter of facility reporting group MEMORIAL HOSPITAL & HEALTH CARE CENTER

		Yes	No
<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.		
<b>a</b>	<input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
<b>b</b>	<input checked="" type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
<b>c</b>	<input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
<b>d</b>	<input type="checkbox"/> The hospital facility used a prospective Medicare or Medicaid method		
<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? ..... If "Yes," explain in Section C.	<b>23</b>	<b>X</b>
<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? ..... If "Yes," explain in Section C.	<b>24</b>	<b>X</b>

LITTLE COMPANY OF MARY HOSPITAL  
OF INDIANA, 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, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 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.

MEMORIAL HOSPITAL & HEALTH CARE CENTER:

PART V, SECTION B, LINE 5: A SERIES OF FOCUS GROUP AND ADVISORY COUNCIL MEETINGS WERE CONDUCTED TO PROVIDE AN OPPORTUNITY AND FORUM FOR COMMUNITY REPRESENTATIVES TO PARTICIPATE IN IDENTIFYING HEALTH NEEDS. THERE WERE 156 PEOPLE THAT PARTICIPATED IN THE FOCUS GROUP FEEDBACK PROCESS FOR THE 2020 CHNA. THE ADVISORY COUNCILS WERE DEVELOPED IN 2014 AS A WAY FOR THE HOSPITAL TO STAY CONNECTED WITH EACH COUNTY OUTSIDE OF DUBOIS COUNTY AND MEET ON A CONTINUED BASIS TO UPDATE THE HOSPITAL ON COUNTY NEEDS.

MEMORIAL HOSPITAL & HEALTH CARE CENTER:

PART V, SECTION B, LINE 7D: THE MOST CURRENT TWO COMMUNITY HEALTH NEEDS ASSESSMENTS ARE AVAILABLE ON THE HOSPITAL'S MAIN WEBPAGE LABELED COMMUNITY NEEDS.

MEMORIAL HOSPITAL & HEALTH CARE CENTER:

PART V, SECTION B, LINE 11: THE MOST CURRENT IMPLEMENTATION STRATEGY FOR THE TAX YEAR 2020 IS THE 2020 IMPLEMENTATION STRATEGY WHICH COVERS THE TAX YEARS 2020, 2021, AND 2022.

THE KEY HEALTH ISSUES BEING ADDRESSED WITH REGARDS TO THE CONDUCTED NEEDS ASSESSMENT ARE ACCESS TO PRIMARY CARE, ACCESS TO MENTAL HEALTH SERVICES, OPPORTUNITIES REGARDING WOMEN'S SERVICES RELATED TO MAMMOGRAPHY, AND EDUCATING THE COMMUNITY ON HEALTH CARE TOPICS TO ADDRESS KEY MORTALITY RATES.

**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, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 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.

ACCESS TO PRIMARY CARE:

-RE-DEPLOY THE PROVIDERS WHO ARE ACCEPTING NEW PATIENTS IN AN ADVERTISING CAMPAIGN

-CONTINUE TO RECRUIT, DEVELOP, AND TRAIN RESIDENTS IN THE MEMORIAL HOSPITAL FAMILY MEDICINE RESIDENCY PROGRAM TO MEET THE LONG TERM NEEDS OF SOUTHWESTERN INDIANA BY 'GROWING OUR OWN'

-DEPLOY VIRTUAL HEALTH FOR PRIMARY CARE

-RECRUIT PHYSICIANS BASED ON THE MEDICAL STAFF DEVELOPMENT PLAN

-IMPLEMENT AN ELECTRONIC HEALTH RECORD TO ASSIST WITH ACCESS TO CARE

ACCESS TO MENTAL HEALTH SERVICES:

-PARTICIPATE IN THE HRSA GRANT IN MARTIN COUNTY IN PARTNERSHIP WITH INDIANA UNIVERSITY

-DETERMINE PARTNERS IN THE COMMUNITIES WE SERVE TO ADDRESS MENTAL HEALTH CONCERNS SPECIFICALLY AROUND SUBSTANCE ABUSE

OPPORTUNITIES REGARDING WOMEN'S SERVICES RELATED TO MAMMOGRAPHY:

-CONTINUE TO EDUCATE WOMEN ON THE IMPORTANCE OF MAMMOGRAMS. WE WILL COLLABORATE WITH AREA EMPLOYERS TO ENSURE WOMEN IN THE COMMUNITIES WE SERVE UNDERSTAND THIS SERVICE IS TYPICALLY PAID AT 100% DUE TO WELLNESS/PREVENTATIVE.

EDUCATING THE COMMUNITY ON HEALTH CARE TOPICS TO ADDRESS KEY MORTALITY RATES:

-CONTINUE OUTREACH PROGRAMMING TO EDUCATE THE COMMUNITIES WE SERVE ON CARDIOLOGY, ONCOLOGY, MAMMOGRAPHY, AND STROKE

**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, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 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.

-ACHIEVE PRIMARY STROKE CERTIFICATION

MEMORIAL HOSPITAL & HEALTH CARE CENTER:

PART V, SECTION B, LINE 13H: PRESUMPTIVE ELIGIBILITY FOR DECEASED AND INDIVIDUALS IN HOMELESS SITUATIONS.

MEMORIAL HOSPITAL & HEALTH CARE CENTER

PART V, LINE 16A, FAP WEBSITE:

[HTTPS://WWW.MHHCC.ORG/IMAGES/FINANCIAL-ASSISTANCE.PDF](https://www.mhhcc.org/images/financial-assistance.pdf)

MEMORIAL HOSPITAL & HEALTH CARE CENTER

PART V, LINE 16B, FAP APPLICATION WEBSITE:

[HTTPS://WWW.MHHCC.ORG/IMAGES/FINANCIAL-ASSISTANCE.PDF](https://www.mhhcc.org/images/financial-assistance.pdf)

MEMORIAL HOSPITAL & HEALTH CARE CENTER

PART V, LINE 16C, FAP PLAIN LANGUAGE SUMMARY WEBSITE:

[HTTPS://WWW.MHHCC.ORG/IMAGES/FINANCIAL-ASSISTANCE.PDF](https://www.mhhcc.org/images/financial-assistance.pdf)

MEMORIAL HOSPITAL & HEALTH CARE CENTER:

PART V, SECTION B, LINE 24: GROSS CHARGES FOR NON-MEDICALLY NECESSARY SERVICES (ELECTIVE SERVICES) INCLUDING COSMETIC, SURGICAL WEIGHT LOSS, EXPERIMENTAL (NON-FDA APPROVED DEVICES) PROCEDURES, SPECIALTY REPLACEMENT LENSES, HEARING AIDS, SERVICES DENIED BY INSURANCE FOR NO PRIOR AUTHORIZATION OR NON-EMERGENCY SERVICES PROVIDED AS A RESULT OF BEING

**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, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 20e, 21c, 21d, 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.

OUT-OF-NETWORK ARE NOT ELIGIBLE FOR DISCOUNTED CHARGES OR FINANCIAL ASSISTANCE.

MEMORIAL HOSPITAL & HEALTH CARE CENTER:

SCHEDULE H, PART V, LINE 7A:

[HTTPS://WWW.MHHCC.ORG/COMMUNITY-NEEDS-ASSESSMENTS/](https://www.mhhcc.org/community-needs-assessments/)



**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.

PART I, LINE 3C:

A PATIENT MAY QUALIFY FOR PARTIAL FINANCIAL ASSISTANCE IF THE PATIENT'S HOUSEHOLD INCOME IS BETWEEN 200% AND 400% OF THE FEDERAL POVERTY GUIDELINES. PRESUMPTIVE ELIGIBILITY FOR FREE CARE WITH REQUIRED VERIFICATION IS AVAILABLE FOR DECEASED INDIVIDUALS WITH NO ESTATE AND NO SURVIVING SPOUSE; AND, FOR INDIVIDUALS IN HOMELESS SITUATIONS RECEIVING ASSISTANCE FROM SUPPORTIVE SERVICES SUCH AS GOVERNMENTAL, RELIGIOUS OR COMMUNITY SERVICES.

PART I, LINE 7:

MEMORIAL HOSPITAL AND HEALTH CARE CENTER CALCULATED THE COST OF FINANCIAL ASSISTANCE AND MEANS-TESTED GOVERNMENT PROGRAMS, USING THE COST-TO-CHARGE RATIO DERIVED FROM SCHEDULE H, WORKSHEET 2, RATIO OF PATIENT CARE COST-TO-CHARGES. OTHER BENEFIT AMOUNTS REPORTED ON LINE 7 WERE CALCULATED USING COSTS CHARGED DIRECTLY TO THE INDIVIDUAL PROGRAMS VIA THE FINANCIAL ACCOUNTING SYSTEM.

PART I, LINE 7G:

**Part VI** Supplemental Information (Continuation)

THE ORGANIZATION DOES NOT PROVIDE ANY SUBSIDIZED HEALTH SERVICES  
ATTRIBUTABLE TO PHYSICIAN CLINICS.

PART III, LINE 2:

MEMORIAL HOSPITAL AND HEALTH CARE'S ANALYSIS AND ASSESSMENT OF THE BAD  
DEBT EXPENSE IS BASED ON THE EVALUATION OF ITS MAJOR PAYOR SOURCES OF  
REVENUE, THE AGING OF THE ACCOUNTS, HISTORICAL LOSSES, CURRENT ECONOMIC  
CONDITIONS, AND OTHER FACTORS UNIQUE TO ITS SERVICE AREA AND THE  
HEALTHCARE INDUSTRY. MANAGEMENT REGULARLY REVIEWS DATA ABOUT THE MAJOR  
PAYOR SOURCES OF REVENUE IN EVALUATING THE SUFFICIENCY OF THE ALLOWANCE  
FOR UNCOLLECTIBLE ACCOUNTS.

PART III, LINE 3:

PART III, SECTION A. BAD DEBT EXPENSE CONSIDERED COMMUNITY BENEFIT: NO  
OTHER BAD DEBT AMOUNTS HAVE BEEN INCLUDED AS COMMUNITY BENEFIT. THE  
HOSPITAL HAS A DETAILED FINANCIAL ASSISTANCE POLICY AND EDUCATES PATIENTS  
WITH LIMITED ABILITY TO PAY REGARDING FINANCIAL ASSISTANCE. FOR THIS  
REASON, THE ORGANIZATION BELIEVES IT ACCURATELY CAPTURES ALL CHARITY CARE  
DEDUCTIONS PROVIDED ACCORDING TO THE FINANCIAL ASSISTANCE POLICY AND THE  
AMOUNT OF BAD DEBT EXPENSE ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE  
ORGANIZATION'S CHARITY CARE POLICY IS NEGLIGIBLE.

PART III, LINE 4:

FOOTNOTE TO ORGANIZATION'S FINANCIAL STATEMENTS THAT DESCRIBES BAD DEBT  
EXPENSE:

SEE PAGE 16 OF THE AUDITED FINANCIAL STATEMENTS FOOTNOTE 3 UNDER HEADING  
"PATIENT SERVICE REVENUE"

**Part VI** Supplemental Information (Continuation)

PART III, LINE 8:

THE SOURCE USED TO DETERMINE THE AMOUNT OF MEDICARE ALLOWABLE COSTS REPORTED FOR PART III, SECTION B, MEDICARE HAS BEEN PROVIDED FROM THE YEAR ENDED JUNE 30, 2021: HOSPITAL STATEMENT OF REIMBURSABLE COST.

PART III, LINE 9B:

THE ORGANIZATION'S WRITTEN DEBT COLLECTION POLICY INCLUDES PROVISIONS ON THE COLLECTION PRACTICES TO BE FOLLOWED DURING THE FOLLOW-UP PERIOD AFTER A PATIENT IS DISCHARGED AND INCLUDES SPECIFIC INSTRUCTIONS FOR SELF-PAY WHO MAY QUALIFY FOR CHARITY CARE OR FINANCIAL ASSISTANCE.

PART VI, LINE 2:

NEEDS ASSESSED:

IN ADDITION TO THE COMMUNITY HEALTH NEEDS ASSESSMENT CONDUCTED EVERY THREE YEARS. THE ORGANIZATION ASSESSES THE HEALTH CARE NEEDS OF THE COMMUNITY IT SERVES WITH HOSPITAL COMMITTEES DEVELOPING STRATEGIC PLANS FOR THE HOSPITAL TO PROVIDE QUALITY CARE TO THE COMMUNITY MEMBERS. ADDITIONALLY, IN 2014, THE HOSPITAL IMPLEMENTED ADVISORY COUNCILS WITH THE ADJACENT COUNTIES TO DUBOIS COUNTY, INDIANA, AND MANAGEMENT COLLABORATES AND OBTAINS ONGOING FEEDBACK FOR NEEDED ASSISTANCE WITH THESE COUNCILS. THE COUNCIL'S PARTICIPANTS INCLUDE ECONOMIC DEVELOPMENT DIRECTORS, COUNTY HEALTH NURSE, CHAMBER OF COMMERCE LEADERS, EDUCATORS, EXECUTIVES, PASTORS, EMS, SHERIFFS, BUSINESS OWNERS, AND OTHER HEALTH CARE ORGANIZATION LEADERS.

PART VI, LINE 3:

PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE:

APPROPRIATE SIGNAGE IS VISIBLE IN THE HOSPITAL AND ALL HOSPITAL-OWNED

**Part VI** Supplemental Information (Continuation)

FACILITIES, SPECIFICALLY IN PATIENT ACCESS AREAS, CREATING AWARENESS FOR THE FINANCIAL ASSISTANCE PROGRAM AND THE FINANCIAL ASSISTANCE THAT IS AVAILABLE. THE FINANCIAL ASSISTANCE POLICY, APPLICATION, AND PLAIN LANGUAGE SUMMARY (COLLECTIVELY THE "FAP PACKET") ARE AVAILABLE FOR DOWNLOAD AT THE HOSPITAL'S WEBSITE PROVIDED IN SCH H, PART V. THE FAP PACKET CAN BE OBTAINED FREE OF CHARGE FROM THE HOSPITAL'S MAIN REGISTRATION DESK, THE REGISTRATION AREA OF THE EMERGENCY ROOM, OR THE CASHIER/FINANCIAL COUNSELOR'S OFFICE. REQUESTS FOR THE FAP PACKET CAN BE MADE VIA EMAILING FINANCIALASSISTANCE@MHHCC.ORG OR BY CALLING 812-996-0413.

PART VI, LINE 4:

DESCRIPTION OF COMMUNITY:

AS A REGIONAL HEALTH CENTER, THE STAFF PROVIDES A COMPREHENSIVE RANGE OF MEDICAL CARE FOR RESIDENTS OF DUBOIS AND SURROUNDING COUNTIES WITH A POPULATION OF APPROXIMATELY 168,000 WITH AVERAGE HOUSEHOLDS RANGING BETWEEN 5,000 TO 16,200 FOR THE COUNTIES. THE UNEMPLOYMENT RATE HAS BEEN BETWEEN 3.1 AND 4.4 AND PERSONAL PER CAPITAL INCOME RANGES BETWEEN \$36,000 AND \$51,000. THE POVERTY RATE RANGES FROM 7.6 TO 11.1. MORE THAN 80% OF THE ADULTS HAVE HIGH SCHOOL DIPLOMAS AND OVER 10% HAVE BACHELOR'S DEGREES. IN DUBOIS COUNTY THE PERCENT IS HIGHER WITH 18.7% OF ADULTS AGED 25 AND OLDER HAVING BACHELOR'S DEGREAS OR MORE EDUCATION. LESS THAN 7% OF THE POPULATION IS REPORTED AS HISPANIC.

PART VI, LINE 5:

OTHER COMMUNITY HEALTH PROMOTION:

THE ORGANIZATION FURTHERS ITS EXEMPT PURPOSE BY PROMOTING HEALTH OF THE COMMUNITY THROUGH THE FOLLOWING: THE MAJORITY OF THE ORGANIZATION'S

**Part VI** Supplemental Information (Continuation)

GOVERNING BODY IS COMPRISED OF PERSONS WHO RESIDE IN THE ORGANIZATION'S  
PRIMARY SERVICE AREA. ANY SURPLUS FUNDS ARE APPLIED DIRECTLY OR INDIRECTLY  
TO IMPROVE PATIENT CARE SERVICES. ALSO, THE ORGANIZATION OPERATES UNDER  
THE PREMISE OF AN OPEN MEDICAL STAFF WITH REGARD TO QUALIFIED PHYSICIANS  
IN THE 9 COUNTY COMMUNITY IT SERVES, HOWEVER IT DOES NOT ACTIVELY PURSUE  
THOSE PHYSICIANS WHO HAVE NOT APPROACHED THE ORGANIZATION REGARDING THESE  
PRIVILEGES.

PART VI, LINE 6:

AFFILIATED HEALTH CARE SYSTEM:

NOT APPLICABLE. THE ORGANIZATION IS NOT PART OF AN AFFILIATED HEALTH CARE  
SYSTEM.

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

IN