



Annual Nonprofit Hospital Community Benefit Statement

State Form 50654 (10-01)
 Indiana State Department of Health
 Indiana Code 16-21-9

I. Identification of Nonprofit Hospital

Hospital Name: COMMUNITY HOSPITAL (ANDERSON)

City of Hospital: ANDERSON

Name of Charity Benefit Rep: KAREN DYKES

Telephone Number: (652) 982-225_ x_____

Year of Statement: 2009

Eligibility Statement Has the CEO identified your hospital as a "Nonprofit Hospital"? Yes No

II. Documentation of Previously Filed Information

Name of Document	Date Filed With ISDH	Any Changes
Community Benefit Plan	11/15/2010	<input type="radio"/> Yes <input checked="" type="radio"/> No
Original long-range hospital objectives for charity care		<input type="radio"/> Yes <input type="radio"/> No
Hospital Mission Statement		<input type="radio"/> Yes <input type="radio"/> No
List of Communities Served		<input type="radio"/> Yes <input type="radio"/> No
Needs Assessment		<input type="radio"/> Yes <input type="radio"/> No
Copy of Charity Care Policy		<input type="radio"/> Yes <input type="radio"/> No
Statement of Public Notice		<input type="radio"/> Yes <input type="radio"/> No

III. Identification of New Objectives (optional)

IV. Allocation of Dollars and Person Served Under Adopted Charity Policy

List Last Three Years	2009	2008	2007
Person Served in twelve-month period	3585	3648	3083
Charity Care Allocation	\$5,900,000	\$4,312,648	\$2,862,193

V. Annual Community Benefit Programs and Net Cost of Operation

Name of Program	Net Cost Of Program
1.)	

	\$0
2.)	\$0
3.)	\$0
4.)	\$0
5.)	\$0

Will hospital file additional paper document to provide more details or descriptions of projects that were funded to support community services?

Yes No

If applicable, address of hospital web site that contains information on community benefits.

VI. Identification of Additional Non-Hospital Charity Costs

Organization Providing Charity Care	Street Address	Net Costs of Charity Care
		\$0
		\$0

Comments

