



**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

Name Of Hospital	
City Of Hospital	
Name Of Charity Benefit Representative	
Telephone Number	
Year Of Statement	

Eligibility Statement	Has the CEO identified your hospital as a "Nonprofit Hospital"?	Yes: _____ No: _____
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II. Documentation of Previously Filed Information

NAME OF DOCUMENT	DATE FILED WITH ISDH	ANY CHANGES (yes/no)
Community Benefit Plan		
Original Long-Range Hospital Objectives for charity care		
Hospital Mission Statement		
List of Communities Served		
Needs Assessment		
Copy of Charity Care Policy		
Statement of Public Notice		

III. Identification of New Objectives (Optional)

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ISDH	ANNUAL NONPROFIT HOSPITAL COMMUNITY BENEFIT STATEMENT
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IV. Allocation of Dollars and Persons Served Under Adopted Charity Policy

List Last Three Years			
Persons Served in twelve-month period			
Charity Care Allocation	(\$)	(\$)	(\$)

V. Annual Community Benefit Programs and Net Cost of Operation

NAME OF PROGRAM	NET COSTS OF PROGRAM
1.	(\$)
2.	(\$)
3.	(\$)
4.	(\$)
5.	(\$)

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, name of hospital web site that contains information on community benefits

www: _____

VI. Identification of Additional Non-Hospital Charity Costs.

ORGANIZATION PROVIDING CHARITY CARE	STREET ADDRESS	NET COSTS OF CHARITY CARE
		(\$)
		(\$)

Comments

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