

**SCHEDULE H  
(Form 990)**

**Hospitals**

OMB No. 1545-0047

**2012**

**Open to Public Inspection**

▶ **Complete if the organization answered "Yes" to Form 990, Part IV, question 20.**  
▶ **Attach to Form 990. ▶ See separate instructions.**

Department of the Treasury  
Internal Revenue Service

Name of the organization **INDIANA UNIVERSITY HEALTH WHITE MEMORIAL HOSPITAL, INC.**

Employer identification number  
**27-3532963**

**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 . . . . .	X	
<b>1b</b> If "Yes," was it a written policy? . . . . .	X	
<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 free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input checked="" type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input type="checkbox"/> Other _____ %	X	
<b>b</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: . . . . . <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 _____ %	X	
<b>c</b> If the organization used factors other than FPG in determining eligibility, describe in Part VI the income based criteria 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"? . . . . .	X	
<b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
<b>5b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? . . . . .	X	
<b>5c</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? . . . . .		X
<b>6a</b> Did the organization prepare a community benefit report during the tax year? . . . . .	X	
<b>6b</b> If "Yes," did the organization make it available to the public? . . . . .	X	

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

Financial Assistance and Means-Tested Government Programs	(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>a</b> Financial Assistance at cost (from Worksheet 1) . . . . .			939,333.		939,333.	3.65
<b>b</b> Medicaid (from Worksheet 3, column a) . . . . .			2,807,447.	1,525,006.	1,282,441.	4.98
<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 . . . . .			3,746,780.	1,525,006.	2,221,774.	8.63
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4) . . . . .			47,339.	2,035.	45,364.	.18
<b>f</b> Health professions education (from Worksheet 5) . . . . .			12,537.		12,537.	.05
<b>g</b> Subsidized health services (from Worksheet 6) . . . . .			706.		706.	
<b>h</b> Research (from Worksheet 7)						
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8) . . . . .			3,969.		3,969.	.02
<b>j Total.</b> Other Benefits . . . . .			64,551.	2,035.	62,576.	.25
<b>k Total.</b> Add lines 7d and 7j. . . . .			3,811,331.	1,527,041.	2,284,350.	8.88

**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						
3 Community support			1,054.		1,054.	
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy			2,085.		2,085.	
8 Workforce development						
9 Other						
10 Total			3,139.		3,139.	

**Part III Bad Debt, Medicare, & Collection Practices**

**Section A. Bad Debt Expense**

	Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? . . . . .	X	
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount. . . . .		
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit. . . . .		
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.		

**Section B. Medicare**

5 Enter total revenue received from Medicare (including DSH and IME) . . . . .	13,561,970.
6 Enter Medicare allowable costs of care relating to payments on line 5 . . . . .	12,580,535.
7 Subtract line 6 from line 5. This is the surplus (or shortfall) . . . . .	981,435.
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other	

**Section C. Collection Practices**

9a Did the organization have a written debt collection policy during the tax year? . . . . .	X	
b If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI . . . . .	X	

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

(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 %
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				



**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 facility reporting group INDIANA UNVRSTY HEALTH WHITE MEMORIAL

For single facility filers only: line number of hospital facility (from Schedule H, Part V, Section A) \_\_\_\_\_

		Yes	No
<b>Community Health Needs Assessment</b> (Lines 1 through 8c are optional for tax years beginning on or before March 23, 2012)			
<b>1</b>	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 9 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply):	X	
<b>a</b>	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b>	<input checked="" type="checkbox"/> Demographics of the community		
<b>c</b>	<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		
<b>d</b>	<input checked="" type="checkbox"/> How data was obtained		
<b>e</b>	<input checked="" type="checkbox"/> The health needs of the community		
<b>f</b>	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b>	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b>	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b>	<input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess the community's health needs		
<b>j</b>	<input type="checkbox"/> Other (describe in Part VI)		
<b>2</b>	Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>1</u> <u>2</u>		
<b>3</b>	In conducting its most recent CHNA, did the hospital facility take into account input from representatives of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted, . . . . .	X	
<b>4</b>	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI . . . . .		X
<b>5</b>	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):	X	
<b>a</b>	<input checked="" type="checkbox"/> Hospital facility's website		
<b>b</b>	<input checked="" type="checkbox"/> Available upon request from the hospital facility		
<b>c</b>	<input type="checkbox"/> Other (describe in Part VI)		
<b>6</b>	If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply to date):		
<b>a</b>	<input checked="" type="checkbox"/> Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA		
<b>b</b>	<input checked="" type="checkbox"/> Execution of the implementation strategy		
<b>c</b>	<input checked="" type="checkbox"/> Participation in the development of a community-wide plan		
<b>d</b>	<input checked="" type="checkbox"/> Participation in the execution of a community-wide plan		
<b>e</b>	<input checked="" type="checkbox"/> Inclusion of a community benefit section in operational plans		
<b>f</b>	<input checked="" type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the CHNA		
<b>g</b>	<input checked="" type="checkbox"/> Prioritization of health needs in its community		
<b>h</b>	<input checked="" type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community		
<b>i</b>	<input type="checkbox"/> Other (describe in Part VI)		
<b>7</b>	Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs . . .	X	
<b>8a</b>	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>8b</b>	If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .		
<b>c</b>	If "Yes" to line 8b, 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		INDIANA UNVRSTY HEALTH WHITE MEMORIAL	Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:				
9	Explained eligibility criteria for financial assistance, and whether such assistance includes free or discounted care? . . . . .		X	
10	Used federal poverty guidelines (FPG) to determine eligibility for providing <i>free</i> care? . . . . . If "Yes," indicate the FPG family income limit for eligibility for free care: <u>1</u> <u>0</u> <u>0</u> % If "No," explain in Part VI the criteria the hospital facility used.		X	
11	Used FPG to determine eligibility for providing <i>discounted</i> care? . . . . . If "Yes," indicate the FPG family income limit for eligibility for discounted care: <u>2</u> <u>0</u> <u>0</u> % If "No," explain in Part VI the criteria the hospital facility used.		X	
12	Explained the basis for calculating amounts charged to patients? . . . . . If "Yes," indicate the factors used in determining such amounts (check all that apply):		X	
a	<input checked="" type="checkbox"/> Income level			
b	<input type="checkbox"/> Asset level			
c	<input checked="" type="checkbox"/> Medical indigency			
d	<input checked="" type="checkbox"/> Insurance status			
e	<input checked="" type="checkbox"/> Uninsured discount			
f	<input checked="" type="checkbox"/> Medicaid/Medicare			
g	<input type="checkbox"/> State regulation			
h	<input type="checkbox"/> Other (describe in Part VI)			
13	Explained the method for applying for financial assistance? . . . . .		X	
14	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):		X	
a	<input checked="" type="checkbox"/> The policy was posted on the hospital facility's website			
b	<input checked="" type="checkbox"/> The policy was attached to billing invoices			
c	<input checked="" type="checkbox"/> The policy was posted in the hospital facility's emergency rooms or waiting rooms			
d	<input checked="" type="checkbox"/> The policy was posted in the hospital facility's admissions offices			
e	<input checked="" type="checkbox"/> The policy was provided, in writing, to patients on admission to the hospital facility			
f	<input checked="" type="checkbox"/> The policy was available on request			
g	<input type="checkbox"/> Other (describe in Part VI)			
<b>Billing and Collections</b>				
15	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 actions the hospital facility may take upon non-payment? . . . . .		X	
16	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 patient's eligibility under the facility's FAP:			
a	<input type="checkbox"/> Reporting to credit agency			
b	<input type="checkbox"/> Lawsuits			
c	<input type="checkbox"/> Liens on residences			
d	<input type="checkbox"/> Body attachments			
e	<input type="checkbox"/> Other similar actions (describe in Part VI)			
17	Did the hospital facility or an authorized third party perform any of the following actions during the tax year before making reasonable efforts to determine the patient's eligibility under the facility's FAP? . . . . . If "Yes," check all actions in which the hospital facility or a third party engaged:			X
a	<input type="checkbox"/> Reporting to credit agency			
b	<input type="checkbox"/> Lawsuits			
c	<input type="checkbox"/> Liens on residences			
d	<input type="checkbox"/> Body attachments			
e	<input type="checkbox"/> Other similar actions (describe in Part VI)			

**Part V Facility Information (continued)** INDIANA UNVRSTY HEALTH WHITE MEMORIAL

**18** Indicate which efforts the hospital facility made before initiating any of the actions listed in line 17 (check all that apply):

- a  Notified individuals of the financial assistance policy on admission
- b  Notified individuals of the financial assistance policy prior to discharge
- c  Notified individuals of the financial assistance policy in communications with the patients regarding the patients' bills
- d  Documented its determination of whether patients were eligible for financial assistance under the hospital facility's financial assistance policy
- e  Other (describe in Part VI)

**Policy Relating to Emergency Medical Care**

**19** Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that requires 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? . . . . .  
If "No," indicate why:

- a  The hospital facility did not provide care for any emergency medical conditions
- b  The hospital facility's policy was not in writing
- c  The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Part VI)
- d  Other (describe in Part VI)

	Yes	No
<b>19</b>	X	

**Changes to Individuals Eligible for Assistance under the FAP (FAP-Eligible Individuals)**

**20** 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  The hospital facility used its lowest negotiated commercial insurance rate when calculating the maximum amounts that can be charged
- b  The hospital facility used the average of its three lowest negotiated commercial insurance rates when calculating the maximum amounts that can be charged
- c  The hospital facility used the Medicare rates when calculating the maximum amounts that can be charged
- d  Other (describe in Part VI)


**21** During the tax year, did the hospital facility charge any of its FAP- eligible individuals, 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 Part VI.

<b>20</b>		X

**22** 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 Part VI.

<b>21</b>		X

**Part V Facility Information** (continued)

**Section C. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

How many non-hospital health care facilities did the organization operate during the tax year? \_\_\_\_\_

Name and address	Type of Facility (describe)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Schedule H (Form 990) 2012



**Part VI Supplemental Information**

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

FORM 990, SCHEDULE H, PART I, LINE 3C

THE FEDERAL POVERTY GUIDELINES ARE USED TO DETERMINE ELIGIBILITY.

FORM 990, SCHEDULE H, PART I, LINE 6A

INDIANA UNIVERSITY HEALTH WHITE MEMORIAL HOSPITAL'S COMMUNITY BENEFITS ARE INCLUDED IN THE INDIANA UNIVERSITY HEALTH'S (IU HEALTH) COMMUNITY BENEFIT REPORT WHICH IS MADE AVAILABLE TO THE PUBLIC ON ITS WEBSITE AT IUHEALTH.ORG. THE COMMUNITY BENEFIT REPORT IS ALSO MAILED TO NUMEROUS ORGANIZATIONS THROUGHOUT THE STATE OF INDIANA TO BROADLY SHARE IU HEALTH'S COMMUNITY BENEFIT EFFORTS STATEWIDE. THE COMMUNITY BENEFIT REPORT IS AVAILABLE BY REQUEST THROUGH THE INDIANA STATE DEPARTMENT OF HEALTH OR DIRECTLY FROM IU HEALTH.

FORM 990, SCHEDULE H, PART I, LINE 7

PERCENTAGE OF TOTAL EXPENSES LISTED ON SCHEDULE H, PART I, LINE 7, IS CALCULATED BASED ON NET COMMUNITY BENEFIT EXPENSE.

**Part VI Supplemental Information**

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

FORM 990, SCHEDULE H, PART I, LINE 7G:

SUBSIDIZED HEALTH SERVICES

INDIANA UNIVERSITY HEALTH WHITE MEMORIAL HOSPITAL, INC. DOES NOT INCLUDE ANY COSTS ASSOCIATED WITH PHYSICIAN CLINICS AS SUBSIDIZED HEALTH SERVICES.

PART I, LINE 7, COLUMN F:

BAD DEBT EXPENSE

THE BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25, COLUMN (A), BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE COMMUNITY BENEFIT PERCENTAGE OF TOTAL EXPENSES IS \$3,078,514.

FORM 990, SCHEDULE H, PART III, LINE 4

THE PROVISION FOR UNCOLLECTED PATIENT ACCOUNTS, FOR ALL PAYORS, IS RECOGNIZED WHEN SERVICES ARE PROVIDED BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS, TAKING INTO CONSIDERATION BUSINESS AND ECONOMIC CONDITIONS, CHANGES AND TRENDS IN HEALTH CARE

**Part VI Supplemental Information**

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

COVERAGE, AND OTHER COLLECTION INDICATORS. PERIODICALLY, MANAGEMENT ASSESSES THE ADEQUACY OF THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS BASED UPON ACCOUNTS RECEIVABLE PAYOR COMPOSITION AND AGING, THE SIGNIFICANCE OF INDIVIDUAL PAYORS TO OUTSTANDING ACCOUNTS RECEIVABLE BALANCES, AND HISTORICAL WRITE-OFF EXPERIENCE BY PAYOR CATEGORY, AS ADJUSTED FOR COLLECTION INDICATORS. THE RESULTS OF THIS REVIEW ARE THEN USED TO MAKE ANY MODIFICATIONS TO THE PROVISION FOR UNCOLLECTED PATIENT ACCOUNTS AND THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS. IN ADDITION, THE INDIANA UNIVERSITY HEALTH SYSTEM FOLLOWS ESTABLISHED GUIDELINES FOR PLACING CERTAIN PAST DUE PATIENT BALANCES WITH COLLECTION AGENCIES. PATIENT ACCOUNTS THAT ARE UNCOLLECTED, INCLUDING THOSE PLACED WITH COLLECTION AGENCIES, ARE INITIALLY CHARGED AGAINST THE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS IN ACCORDANCE WITH COLLECTION POLICIES OF THE INDIANA UNIVERSITY HEALTH SYSTEM AND, IN CERTAIN CASES, ARE RECLASSIFIED TO CHARITY CARE IF DEEMED TO OTHERWISE MEET FINANCIAL ASSISTANCE POLICIES OF THE INDIANA UNIVERSITY HEALTH SYSTEM.

**Part VI Supplemental Information**

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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.
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- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

FORM 990, SCHEDULE H, PART III, LINE 8

INDIANA UNIVERSITY HEALTH WHITE MEMORIAL HOSPITAL DID NOT HAVE A MEDICARE SHORTFALL FOR 2012. HOWEVER, IN YEARS IN WHICH IT DOES EXPERIENCE A MEDICARE SHORTFALL, THE MEDICARE SHORTFALL REPORTED ON SCHEDULE H, PART III, LINE 7 IS CALCULATED IN ACCORDANCE WITH THE FORM 990 INSTRUCTIONS, USING "ALLOWABLE COSTS" FROM IU HEALTH WHITE MEMORIAL HOSPITAL'S MEDICARE COST REPORT. "ALLOWABLE COSTS" FOR MEDICARE COST REPORT PURPOSES ARE NOT REFLECTIVE OF ALL COSTS ASSOCIATED WITH IU HEALTH WHITE MEMORIAL HOSPITAL'S PARTICIPATION IN MEDICARE PROGRAMS. FOR EXAMPLE THE MEDICARE COST REPORT EXCLUDES CERTAIN COSTS SUCH AS BILLED PHYSICIAN SERVICES, THE COST OF MEDICARE PART C & D, FEE SCHEDULE REIMBURSED SERVICES. INCLUSION OF ALL COSTS ASSOCIATED WITH IU HEALTH WHITE MEMORIAL HOSPITALS PARTICIPATION IN MEDICARE PROGRAMS WOULD RESULT IN A SIGNIFICANT MEDICARE SHORTFALL REPORTED ON SCHEDULE H PART III LINE 7. IU HEALTH WHITE MEMORIAL HOSPITAL'S SHORTFALL IS ATTRIBUTABLE TO REIMBURSEMENTS THAT ARE LESS THAN THE COST OF PROVIDING PATIENT CARE AND SERVICES TO MEDICARE BENEFICIARIES AND DOES NOT INCLUDE ANY AMOUNTS THAT

**Part VI Supplemental Information**

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- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
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RESULT FROM INEFFICIENCIES OR POOR MANAGEMENT. IU HEALTH WHITE ACCEPTS ALL MEDICARE PATIENTS KNOWING THERE MAY BE SHORTFALLS; THEREFORE IT HAS TAKEN THE POSITION THAT THE SHORTFALL SHOULD BE ACCOUNTED AS PART OF THE COMMUNITY BENEFIT.

FORM 990, SCHEDULE H, PART III, LINE 9B

IF A PATIENT CANNOT SATISFY STANDARD PAYMENT EXPECTATIONS, FINANCIAL SCREENING IS COMPLETED FOR ALTERNATIVE SOURCES OF BALANCE RESOLUTION. THIS FINANCIAL SCREENING MAY INCLUDE: A DISCOUNT OF CHARGES, ENROLLMENT IN MEDICAID OR ANOTHER TYPE OF GOVERNMENT ASSISTANCE PROGRAM, A LOW INTEREST OR INTEREST FREE LOAN, OR AN APPLICATION FOR FINANCIAL ASSISTANCE (CHARITY CARE). IF A PATIENT MEETS THE CHARITY CARE GUIDELINES, INDIANA UNIVERSITY HEALTH WHITE MEMORIAL WILL WAIVE COLLECTION EFFORTS AND TREAT THE QUALIFYING COSTS OF SERVICES AS CHARITY CARE.

FORM 990, SCHEDULE H, PART V, SECTION B, LINE 3

**Part VI Supplemental Information**

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IU HEALTH WHITE MEMORIAL HOSPITAL GATHERED DATA FROM A COMMUNITY LEADER'S FOCUS GROUP THROUGH DISCUSSIONS, BY SURVEY, AND THE COLLECTION OF DATA IN OTHER WAYS, INCLUDING BUT NOT LIMITED TO INFORMATION FROM DEMOGRAPHIC AND ECONOMIC INDICATORS, AS WELL AS OTHER AREA HEALTH NEEDS ASSESSMENTS. THOSE WHO PARTICIPATED IN IU HEALTH WHITE MEMORIAL FOCUS GROUP WERE: CUSTOMER SERVICE REPRESENTATIVE, WHITE OAK HEALTH CAMPUS, BOARD CHAIR OF NCNC, INC. TOWN COUNCIL MEMBER, DIRECTOR, WHITE COUNTY COMMUNITY FOUNDATION, SUPERINTENDENT, TWIN LAKES HIGH SCHOOLS, MONTICELLO, VP, WHITE COUNTY ECONOMIC DEVELOPMENT ORGANIZATION, ADMINISTRATOR, MONTICELLO ASSISTED LIVING HEALTH CARE, MAYOR, CITY OF MONTICELLO, MANAGER, WHITE COUNTY WORKONE AGENCY, COUNTY COUNCIL MEMBER, WHITE COUNTY COUNCIL, CITY COUNCIL MEMBER, MONTICELLO CITY COUNCIL, PRESIDENT AND CEO, WHITE COUNTY REMC. MEMBERS ALSO SPECIFICALLY ADDRESSED THE TOP THREE HEALTH NEEDS AND ESTABLISHED SEVERAL MEANS ON HOW TO IMPROVE UPON PARTNERSHIPS IN ORDER TO ADDRESS THESE NEEDS AND FINALIZE STRATEGIES.

FORM 990, SCHEDULE H, PART VI LINE 2

**Part VI Supplemental Information**

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## NEEDS ASSESSMENT

INDIANA UNIVERSITY HEALTH WHITE MEMORIAL HOSPITAL ASSESSES THE HEALTH CARE NEEDS OF THE COMMUNITY IT SERVES BY UTILIZING DETAILED COMMUNITY NEEDS ASSESSMENTS PREPARED BY ORGANIZATIONS SUCH AS INDIANA HOSPITAL ASSOCIATION, NORTH CENTRAL NURSING CLINICS, AS WELL AS OTHER LOCAL DEPARTMENTS OR CHAPTERS FOR EXAMPLE, THE WHITE COUNTY DEPARTMENT OF HEALTH, AND THE LOCAL UNITED WAY CHAPTER. INDIANA UNIVERSITY HEALTH WHITE MEMORIAL HOSPITAL STRIVES TO GARNER COMMUNITY INPUT WHILE ALIGNING OUR PROGRAMS, DESIGN OF COMMUNITY HEALTH NEEDS AND VISIBLE OPPORTUNITIES TO DEMONSTRATE WE PROVIDE BENEFITS THAT RESPOND TO MEET COMMUNITY NEEDS.

FORM 990, SCHEDULE H, PART VI LINE 3

## PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE

DURING THE PATIENT REGISTRATION PROCESS, PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE IS DISCUSSED WITH PATIENTS WHO ARE IDENTIFIED AS SELF-PAY AND/OR PATIENTS WHO MAY BE BILLED FOR SERVICES. MANY ASSISTANCE PROGRAMS ARE AVAILABLE UNDER FEDERAL, STATE, OR LOCAL GOVERNMENT PROGRAMS. SINCE

**Part VI Supplemental Information**

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A COMPLEX SET OF VARIABLES DOES DEFINE THE UNINSURED PATIENTS WE TREAT, INDIANA UNIVERSITY HEALTH WHITE MEMORIAL HOSPITAL PROVIDES AN EXTENSION TO OUR PATIENTS BY OFFERING AN ON-SITE SERVICE (CLAIMAID) WHO IS ABLE TO ASSIST PATIENTS THROUGH AN ELIGIBILITY SCREENING AND ENROLLMENT PROCESS. THIS HAS PROVEN TO BE BOTH NEEDED AND BENEFICIAL FOR THE PATIENTS INDIANA UNIVERSITY HEALTH WHITE MEMORIAL HOSPITAL SERVES AS IT PROVIDES ASSISTANCE WITH COLLECTING THE REQUIRED DOCUMENTATION.

ADDITIONALLY, INDIANA UNIVERSITY HEALTH WHITE MEMORIAL HOSPITAL SHOWS ITS COMMITMENT TO PROVIDING AFFORDABLE HEALTHCARE ACCESS BY TREATING ALL PATIENTS REGARDLESS OF THEIR ABILITY TO PAY. IN ORDER TO PROVIDE CONSISTENCY AND AWARENESS TO INDIVIDUALS, INFORMATION RELATED TO THE HOSPITAL'S FINANCIAL ASSISTANCE PROGRAM IS PROVIDED DURING THE REGISTRATION PROCESS, THROUGH THE ASSISTANCE OF A CLAIMAID ADVOCATE, THROUGH THE BILLING PROCESS, AND IS PROVIDED ON THE HOSPITAL WEBSITE. MEDICAL CARE MEETING FINANCIAL ASSISTANCE GUIDELINES IS DISCOUNTED ON A SLIDING SCALE ACCORDING TO THE FEDERAL POVERTY GUIDELINES. THE HOSPITAL

**Part VI Supplemental Information**

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EXPLAINS AND HELPS PATIENTS APPLY FOR FINANCIAL ASSISTANCE. FINANCIAL ASSISTANCE IS PROVIDED AT ANY POINT DURING THE BILLING PROCESS WITH THE PATIENT. UTMOST RESPECT AND SENSITIVITY IS PROVIDED TO ALL PATIENTS THROUGH THE COURSE OF CARE AND THE BILLING PROCESS.

FORM 990, SCHEDULE H, PART VI, LINE 4

COMMUNITY INFORMATION

INDIANA UNIVERSITY HEALTH WHITE MEMORIAL HOSPITAL IS LOCATED IN WHITE COUNTY, A COUNTY LOCATED IN NORTHWEST INDIANA. WHITE COUNTY INCLUDES ZIP CODES WITHIN THE TOWNS OF MONTICELLO, NORWAY, REYNOLDS, WOLCOTT, BROOKSTON, BUFFALO, BURNETTSVILLE, CHALMERS, IDAVILLE, AND MONON. BASED ON THE MOST RECENT CENSUS BUREAU (2010) STATISTICS, WHITE COUNTY'S POPULATION IS 24,643 PERSONS WITH APPROXIMATELY 51% BEING FEMALE AND 49% MALE. THE COUNTY'S POPULATION ESTIMATES BY RACE ARE 93.8% WHITE, 7.1% HISPANIC OR LATINO, 0.28% BLACK, 0.4% ASIAN, 0.3% AMERICAN INDIAN OR ALASKA NATIVE, AND 1.88% PERSONS REPORTING TWO OR MORE RACES.

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AT ALMOST 14%, THE 65+ POPULATION IS EXPECTED TO GROW THE FASTEST AMONG ALL WHITE COUNTY AGE COHORTS BETWEEN 2010 AND 2015. IN GENERAL, AN OLDER POPULATION CAN PRODUCE INCREASED DEMAND FOR HEALTHCARE SERVICES AND A POTENTIAL INCREASE IN THE PREVALENCE OF CERTAIN CHRONIC CONDITIONS.

FORM 990, SCHEDULE H, PART VI, LINE 5

PROMOTION OF COMMUNITY HEALTH

INDIANA UNIVERSITY HEALTH WHITE MEMORIAL HOSPITAL INVESTS IN ITS COMMUNITY TO IMPROVE THE QUALITY OF HEALTH OF COMMUNITY MEMBERS AND HAS PARTICIPATED IN A VARIETY OF COMMUNITY-BASED BUILDING ACTIVITIES THAT ADDRESS THE QUALITY OF LIFE IN THE COMMUNITIES IT SERVES. INDIANA UNIVERSITY HEALTH WHITE MEMORIAL HOSPITAL INVESTED IN COMMUNITY INITIATIVES BY PROVIDING BOTH RESOURCES AND EXPERTISE. ADDITIONALLY, INDIANA UNIVERSITY HEALTH WHITE MEMORIAL ESTABLISHED AND/OR PARTICIPATED IN COMMUNITY OUTREACH ACTIVITIES SUCH AS: JOB FAIRS, A WORKFORCE DEVELOPMENT PROGRAM, COUNSELING AND EDUCATION RELATED TO NUTRITION, TOBACCO CESSATION CLASSES, CHILD PASSENGER SAFETY AND CAR SEAT PROGRAM

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WITH FREE INSPECTION AND CAR SEATS PROVIDED, INJURY PREVENTION CLASS  
RELATED TO FALL INJURIES, AND CHOLESTEROL AND BLOOD PRESSURES TESTING.

INDIANA UNIVERSITY HEALTH WHITE MEMORIAL HOSPITAL CONTRIBUTES TO A  
VARIETY OF COMMUNITY SERVICE INITIATIVES.

HEALTH AND SAFETY FAIR

BLOOD PRESSURE READINGS

CHILD SAFETY

CAR SEAT SAFETY

FIRE SAFETY

WATER SAFETY

NUTRITION

STRESS MANAGEMENT

SMOKING CESSATION

BICYCLE SAFETY - BICYCLE HELMETS

POISON CONTROL

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WEATHER SAFETY

SKIN PROTECTION AND SUN DAMAGE

PUBLIC EDUCATION

SAFE SITTER CLASSES

CPR CLASSES

ORGAN/TISSUE DONATION AWARENESS

ADVANCED DIRECTIVES EDUCATION

CHILDBIRTH CLASSES

CHILD ABUSE/SHAKEN-INFANT SYNDROME

CHILD DEVELOPMENT CLASSES

HIGH SCHOOL AWARENESS FOR DANGERS OF ALCOHOL USE

PARTICIPATION IN EVERY 15-MINUTES

TECHNICALLY ADVANCE PROFESSIONAL (TAP) TRAINING-PROVIDES ADULTS WITH A

PLAN TO ACHIEVE THEIR GOALS IN BECOMING A HEALTHCARE PROFESSIONAL

MEDICATION ASSISTANCE PROGRAM - STAFFED AND PROVIDED IN HOSPITAL

SCHOLARSHIPS FOR LOCAL SCHOOL SYSTEMS

HIGH SCHOOL PROM SPONSOR

**Part VI Supplemental Information**

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LITTLE LEAGUE SPONSOR

COUNTY 4-H FAIR SPONSOR

MITTEN TREE - PROVIDES HATS, MITTENS, GLOVES AND SCARVES FOR LOCAL

CHILDREN

SPECIAL OLYMPIC SPONSOR AND PARTICIPANT

CHAMBER OF COMMERCE MEMBER

GOOD NEIGHBOR BY PROVIDING FREE COMMUNITY MEETING ROOMS WITH WI-FI,

PROJECTOR, SCREEN, AND LCD TELEVISIONS.

HEALTHCARE PROVIDER TRAINING

EMERGENCY MEDICAL TECHNICIAN TRAINING

EMERGENCY NURSING PEDIATRIC COURSE

TRAUMA NURSING CORE COURSE

ADVANCED CARDIAC LIFE SUPPORT

PEDIATRIC ADVANCE LIFE SUPPORT

NEONATAL RESUSCITATION PROGRAM

TB CERTIFICATION

HEALTHCARE PROVIDER CPR

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FORM 990, SCHEDULE H, PART VI, LINE 6

AFFILIATED HEALTH CARE SYSTEM

INDIANA UNIVERSITY HEALTH WHITE MEMORIAL HOSPITAL IS A PART OF THE IU HEALTH STATEWIDE HEALTHCARE SYSTEM WHICH CONTINUES TO BROADEN ITS REACH AND POSITIVE IMPACT THROUGHOUT THE STATE OF INDIANA. IU HEALTH IS INDIANA'S MOST COMPREHENSIVE ACADEMIC MEDICAL CENTER AND CONSISTS OF IU HEALTH METHODIST HOSPITAL, IU HEALTH UNIVERSITY HOSPITAL, RILEY HOSPITAL FOR CHILDREN AT IU HEALTH, IU HEALTH WEST HOSPITAL, IU HEALTH NORTH HOSPITAL, IU HEALTH ARNETT HOSPITAL, IU HEALTH BALL MEMORIAL HOSPITAL, IU HEALTH BLACKFORD HOSPITAL, IU HEALTH BLOOMINGTON HOSPITAL, IU HEALTH PAOLI HOSPITAL, IU HEALTH BEDFORD HOSPITAL, IU HEALTH TIPTON HOSPITAL, IU HEALTH LA PORTE HOSPITAL, IU HEALTH STARKE HOSPITAL, IU HEALTH GOSHEN HOSPITAL AND IU HEALTH MORGAN.

FORM 990, SCHEDULE H, PART VI, LINE 7

STATE FILING OF COMMUNITY BENEFIT REPORT

**Part VI Supplemental Information**

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; Part V, Section A; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments 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 hospitals 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.
- 8 Facility reporting group(s).** If applicable, for each hospital facility in a facility reporting group provide the descriptions required for Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 10, 11, 12h, 14g, 16e, 17e, 18e, 19c, 20d, 21, and 22.

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