



**Part III Statement of Program Service Accomplishments**Check if Schedule O contains a response or note to any line in this Part III ☒**1** Briefly describe the organization's mission

TO IMPROVE THE HEALTH OF THE PEOPLE AND COMMUNITIES WE SERVE

**2** Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? ☐ Yes ☒ No

If "Yes," describe these new services on Schedule O

**3** Did the organization cease conducting, or make significant changes in how it conducts, any program services? ☐ Yes ☒ No

If "Yes," describe these changes on Schedule O

**4** Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported

<b>4a</b>	(Code )	(Expenses \$	716,643,035	including grants of \$	3,757,588 )	(Revenue \$	886,785,232 )
See Additional Data							

<b>4b</b>	(Code )	(Expenses \$	68,879,961	including grants of \$	46,486 )	(Revenue \$	49,828,471 )
See Additional Data							

<b>4c</b>	(Code )	(Expenses \$	19,579,121	including grants of \$		(Revenue \$	21,038,951 )
See Additional Data							






















(Code )	(Expenses \$	1,217,757	including grants of \$	1,217,757 )	(Revenue \$	
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FOUNDATIONS MEMORIAL HEALTH SYSTEM UTILIZES FOUNDATIONS TO PROVIDE GRANTS TO SUPPORT PATIENT CARE, EDUCATION, AND COMMUNITY HEALTH OUTREACH IN ADDITION TO FACILITATING PARTNERSHIPS AND COLLABORATION TO IMPROVE THE HEALTH OF THE COMMUNITY. THE THREE FOUNDATIONS INCLUDED IN THE MEMORIAL HEALTH SYSTEM GROUP 990 RETURN ARE MEMORIAL MEDICAL CENTER FOUNDATION (MMCF), TAYLORVILLE MEMORIAL HOSPITAL FOUNDATION (TMHF), AND PASSAVANT AREA HOSPITAL FOUNDATION (PAHF). IN FY2017, MMCF PROVIDED \$882,247 IN GRANTS TO ORGANIZATIONS. THIS INCLUDED OVER \$552,000 IN GRANTS TO MEMORIAL HEALTH SYSTEM AFFILIATES, OVER \$260,000 IN GRANTS TO SIU SCHOOL OF MEDICINE, AND \$69,305 IN GRANTS TO THE UIC NURSING PROGRAM AT UIS. MMCF PROVIDED \$159,574 IN GRANTS TO INDIVIDUALS. THESE GRANTS INCLUDE PATIENT ASSISTANCE TOTALING ALMOST \$99,000, SCHOLARSHIPS OF \$40,000, AND ASSISTANCE TO EMPLOYEES WITH CATASTROPHIC EVENTS OF \$20,000. IN FY2017, TMHF AWARDED \$31,098 IN GRANTS TO THE COMMUNITY AND TAYLORVILLE MEMORIAL HOSPITAL. SPECIFICALLY, \$22,098 IN GRANTS WERE PROVIDED TO SUPPORT PATIENT CARE, INCLUDING DISTRIBUTIONS FROM THE CUPS FUND A MAMMOGRAPHY ASSISTANCE PROGRAM PROVIDED TO WOMEN IN CHRISTIAN COUNTY WHO WERE UNINSURED OR DO NOT HAVE HEALTH INSURANCE. EDUCATION AND PROFESSIONAL CERTIFICATION GRANTS TOTALING \$9,000 WERE AWARDED TO BENEFIT THOSE PURSUING ADVANCED CERTIFICATIONS AND POST-SECONDARY EDUCATION IN NURSING AND OTHER HEALTHCARE RELATED FIELDS. IN FY2017, PAHF PROVIDED \$141,189 IN GRANTS AND OTHER ASSISTANCE. A TOTAL OF \$107,358 WAS GRANTED TO PASSAVANT MEMORIAL AREA HOSPITAL, \$4,705 FOR GENERAL SUPPORT, \$829 FOR REHABILITATION EQUIPMENT & SUPPLIES, \$4,060 FOR PLANT OPERATIONS EQUIPMENT & SUPPLIES, \$6,909 FOR COMMUNITY HEALTH IMPROVEMENT, \$15,875 FOR LIFELINE PROGRAM SUPPORT, AND \$74,980 TO ESTABLISH A FEDERALLY QUALIFIED HEALTH CENTER CALLED THE SIU SCHOOL OF MEDICINE CENTER FOR FAMILY MEDICINE-JACKSONVILLE. THIS CENTER WAS ESTABLISHED TO MEET PRIMARY CARE PHYSICIAN NEEDS OF LOW-INCOME FAMILIES THROUGH A PARTNERSHIP OF PASSAVANT MEMORIAL AREA HOSPITAL, MORGAN COUNTY HEALTH DEPARTMENT, AND SIU SCHOOL OF MEDICINE. \$25,000 WAS GRANTED TO ILLINOIS COLLEGE TO ASSIST IN FUNDING A RN-TO-BSN NURSING PROGRAM. \$8,000 WAS GRANTED TO MACMURRAY COLLEGE FOR NURSING SCHOLARSHIPS. \$831 WAS GRANTED TO JACKSONVILLE PUBLIC SCHOOLS FOR ITS AUTISM SUPPORT GROUP. IN ADDITION, COMMUNITIES IN PASSAVANT'S FIVE-COUNTY SERVICE AREA ALSO BENEFITED FROM FREE CANCER AND HEALTH SCREENINGS.

<b>4d</b>	Other program services (Describe in Schedule O )	(Expenses \$	1,217,757	including grants of \$	1,217,757 )	(Revenue \$	
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<b>4e</b>	Total program service expenses ▶	806,319,874
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**Part IV Checklist of Required Schedules**

	Yes	No
<b>1</b> Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A 	<b>1</b> Yes	
<b>2</b> Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)? 	<b>2</b> Yes	
<b>3</b> Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I 	<b>3</b>	No
<b>4 Section 501(c)(3) organizations.</b> Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II 	<b>4</b> Yes	
<b>5</b> Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C, Part III 	<b>5</b>	No
<b>6</b> Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I 	<b>6</b>	No
<b>7</b> Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II 	<b>7</b>	No
<b>8</b> Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III 	<b>8</b>	No
<b>9</b> Did the organization report an amount in Part X, line 21 for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? If "Yes," complete Schedule D, Part IV 	<b>9</b>	No
<b>10</b> Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? If "Yes," complete Schedule D, Part V 	<b>10</b> Yes	
<b>11</b> If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable		
<b>a</b> Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI 	<b>11a</b> Yes	
<b>b</b> Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII 	<b>11b</b>	No
<b>c</b> Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII 	<b>11c</b>	No
<b>d</b> Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX 	<b>11d</b> Yes	
<b>e</b> Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X 	<b>11e</b> Yes	
<b>f</b> Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X 	<b>11f</b> Yes	
<b>12a</b> Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII 	<b>12a</b>	No
<b>b</b> Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional 	<b>12b</b> Yes	
<b>13</b> Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	<b>13</b>	No
<b>14a</b> Did the organization maintain an office, employees, or agents outside of the United States?	<b>14a</b>	No
<b>b</b> Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV	<b>14b</b>	No
<b>15</b> Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? If "Yes," complete Schedule F, Parts II and IV	<b>15</b>	No
<b>16</b> Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? If "Yes," complete Schedule F, Parts III and IV	<b>16</b>	No
<b>17</b> Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I (see instructions) 	<b>17</b>	No
<b>18</b> Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II 	<b>18</b> Yes	
<b>19</b> Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III 	<b>19</b> Yes	

**Part IV Checklist of Required Schedules** (continued)

	Yes	No	
<b>20a</b> Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H . . . . .	20a	Yes	No
<b>b</b> If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return? . . . . .	20b	Yes	
<b>21</b> Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II . . . . .	21	Yes	
<b>22</b> Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? If "Yes," complete Schedule I, Parts I and III . . . . .	22	Yes	
<b>23</b> Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? If "Yes," complete Schedule J . . . . .	23	Yes	
<b>24a</b> Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than \$100,000 as of the last day of the year, that was issued after December 31, 2002? If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a . . . . .	24a		No
<b>b</b> Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception? . . . . .	24b		
<b>c</b> Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds? . . . . .	24c		
<b>d</b> Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year? . . . . .	24d		
<b>25a Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.</b> Did the organization engage in an excess benefit transaction with a disqualified person during the year? If "Yes," complete Schedule L, Part I . . . . .	25a		No
<b>b</b> Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? If "Yes," complete Schedule L, Part I . . . . .	25b		No
<b>26</b> Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? If "Yes," complete Schedule L, Part II . . . . .	26		No
<b>27</b> Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? If "Yes," complete Schedule L, Part III . . . . .	27	Yes	
<b>28</b> Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions) <b>a</b> A current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV . . . . . <b>b</b> A family member of a current or former officer, director, trustee, or key employee? If "Yes," complete Schedule L, Part IV . . . . . <b>c</b> An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? If "Yes," complete Schedule L, Part IV . . . . .	28a		No
<b>28b</b> Yes	28b	Yes	
<b>28c</b> Yes	28c	Yes	
<b>29</b> Did the organization receive more than \$25,000 in non-cash contributions? If "Yes," complete Schedule M . . . . .	29	Yes	
<b>30</b> Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? If "Yes," complete Schedule M . . . . .	30		No
<b>31</b> Did the organization liquidate, terminate, or dissolve and cease operations? If "Yes," complete Schedule N, Part I . . . . .	31		No
<b>32</b> Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? If "Yes," complete Schedule N, Part II . . . . .	32		No
<b>33</b> Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? If "Yes," complete Schedule R, Part I . . . . .	33	Yes	
<b>34</b> Was the organization related to any tax-exempt or taxable entity? If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1 . . . . .	34	Yes	
<b>35a</b> Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a	Yes	
<b>b</b> If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? If "Yes," complete Schedule R, Part V, line 2 . . . . .	35b	Yes	
<b>36 Section 501(c)(3) organizations.</b> Did the organization make any transfers to an exempt non-charitable related organization? If "Yes," complete Schedule R, Part V, line 2 . . . . .	36		No
<b>37</b> Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? If "Yes," complete Schedule R, Part VI . . . . .	37	Yes	
<b>38</b> Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? <b>Note.</b> All Form 990 filers are required to complete Schedule O . . . . .	38	Yes	

**Part V Statements Regarding Other IRS Filings and Tax Compliance**Check if Schedule O contains a response or note to any line in this Part V ☐

		Yes	No
<b>1a</b>	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable . . . . .	<b>1a</b>	391
<b>b</b>	Enter the number of Forms W-2G included in line 1a Enter -0- if not applicable . . . . .	<b>1b</b>	0
<b>c</b>	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? . . . . .	<b>1c</b>	Yes
<b>2a</b>	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return . . . . .	<b>2a</b>	7,789
<b>b</b>	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? <b>Note.</b> If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	<b>2b</b>	Yes
<b>3a</b>	Did the organization have unrelated business gross income of \$1,000 or more during the year? . . . . .	<b>3a</b>	Yes
<b>b</b>	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O . . . . .	<b>3b</b>	Yes
<b>4a</b>	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . . . . .	<b>4a</b>	No
<b>b</b>	If "Yes," enter the name of the foreign country <b>▶</b> _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)		
<b>5a</b>	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . . . .	<b>5a</b>	No
<b>b</b>	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction? . . . . .	<b>5b</b>	No
<b>c</b>	If "Yes," to line 5a or 5b, did the organization file Form 8886-T? . . . . .	<b>5c</b>	
<b>6a</b>	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . . . .	<b>6a</b>	Yes
<b>b</b>	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? . . . . .	<b>6b</b>	Yes
<b>7</b>	<b>Organizations that may receive deductible contributions under section 170(c).</b>		
<b>a</b>	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor? . . . . .	<b>7a</b>	Yes
<b>b</b>	If "Yes," did the organization notify the donor of the value of the goods or services provided? . . . . .	<b>7b</b>	Yes
<b>c</b>	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? . . . . .	<b>7c</b>	No
<b>d</b>	If "Yes," indicate the number of Forms 8282 filed during the year . . . . .	<b>7d</b>	
<b>e</b>	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract? . . . . .	<b>7e</b>	No
<b>f</b>	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . . . . .	<b>7f</b>	No
<b>g</b>	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? . . . . .	<b>7g</b>	
<b>h</b>	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? . . . . .	<b>7h</b>	
<b>8</b>	<b>Sponsoring organizations maintaining donor advised funds.</b> Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? . . . . .	<b>8</b>	
<b>9a</b>	Did the sponsoring organization make any taxable distributions under section 4966? . . . . .	<b>9a</b>	
<b>b</b>	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . . . .	<b>9b</b>	
<b>10</b>	<b>Section 501(c)(7) organizations.</b> Enter		
<b>a</b>	Initiation fees and capital contributions included on Part VIII, line 12 . . . . .	<b>10a</b>	
<b>b</b>	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities . . . . .	<b>10b</b>	
<b>11</b>	<b>Section 501(c)(12) organizations.</b> Enter		
<b>a</b>	Gross income from members or shareholders . . . . .	<b>11a</b>	
<b>b</b>	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them ) . . . . .	<b>11b</b>	
<b>12a</b>	<b>Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041? . . . . .	<b>12a</b>	
<b>b</b>	If "Yes," enter the amount of tax-exempt interest received or accrued during the year . . . . .	<b>12b</b>	
<b>13</b>	<b>Section 501(c)(29) qualified nonprofit health insurance issuers.</b>		
<b>a</b>	Is the organization licensed to issue qualified health plans in more than one state? <b>Note.</b> See the instructions for additional information the organization must report on Schedule O . . . . .	<b>13a</b>	
<b>b</b>	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans . . . . .	<b>13b</b>	
<b>c</b>	Enter the amount of reserves on hand . . . . .	<b>13c</b>	
<b>14a</b>	Did the organization receive any payments for indoor tanning services during the tax year? . . . . .	<b>14a</b>	No
<b>b</b>	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O . . . . .	<b>14b</b>	

**Part VI Governance, Management, and Disclosure** For each "Yes" response to lines 2 through 7b below, and for a "No" response to lines 8a, 8b, or 10b below, describe the circumstances, processes, or changes in Schedule O. See instructions.

Check if Schedule O contains a response or note to any line in this Part VI ☒

**Section A. Governing Body and Management**

		Yes	No
<b>1a</b>	Enter the number of voting members of the governing body at the end of the tax year		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O		
<b>1b</b>	Enter the number of voting members included in line 1a, above, who are independent		
<b>2</b>	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	Yes	
<b>3</b>	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?		No
<b>4</b>	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?		No
<b>5</b>	Did the organization become aware during the year of a significant diversion of the organization's assets?		No
<b>6</b>	Did the organization have members or stockholders?	Yes	
<b>7a</b>	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	Yes	
<b>7b</b>	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	Yes	
<b>8</b>	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:		
<b>a</b>	The governing body?	Yes	
<b>b</b>	Each committee with authority to act on behalf of the governing body?	Yes	
<b>9</b>	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O.		No

**Section B. Policies** (This Section B requests information about policies not required by the Internal Revenue Code.)

		Yes	No
<b>10a</b>	Did the organization have local chapters, branches, or affiliates?		No
<b>10b</b>	If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?		
<b>11a</b>	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	Yes	
<b>b</b>	Describe in Schedule O the process, if any, used by the organization to review this Form 990.		
<b>12a</b>	Did the organization have a written conflict of interest policy? If "No," go to line 13.	Yes	
<b>b</b>	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	Yes	
<b>c</b>	Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done.	Yes	
<b>13</b>	Did the organization have a written whistleblower policy?	Yes	
<b>14</b>	Did the organization have a written document retention and destruction policy?	Yes	
<b>15</b>	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?		
<b>a</b>	The organization's CEO, Executive Director, or top management official	Yes	
<b>b</b>	Other officers or key employees of the organization	Yes	
	If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).		
<b>16a</b>	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	Yes	
<b>b</b>	If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	Yes	

**Section C. Disclosure**

**17** List the States with which a copy of this Form 990 is required to be filed: IL

**18** Section 6104 requires an organization to make its Form 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.  
☐ Own website ☐ Another's website ☒ Upon request ☐ Other (explain in Schedule O)

**19** Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.

**20** State the name, address, and telephone number of the person who possesses the organization's books and records:  
 ▶ ROBERT W KAY SVP & CFO 701 NORTH FIRST STREET SPRINGFIELD, IL 62781 (217) 788-3198

Check if Schedule O contains a response or note to any line in this Part VII ☐

☐ Check this box if neither the organization nor any related organization compensated any current officer, director, or trustee

Form **990** (2016)

[illegible]

<b>1b Sub-Total</b>			
<b>c Total from continuation sheets to Part VII, Section A</b>			
<b>d Total (add lines 1b and 1c)</b>	10,183,220	8,283,962	3,944,524

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization ▶ 327

		Yes	No
<b>3</b>	Did the organization list any <b>former</b> officer, director or trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual . . . . .</i>	<b>3</b>	No
<b>4</b>	For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than \$150,000? <i>If "Yes," complete Schedule J for such individual . . . . .</i>	<b>4</b>	Yes
<b>5</b>	Did any person listed on line 1a receive or accrue compensation from any unrelated organization or individual for services rendered to the organization? <i>If "Yes," complete Schedule J for such person . . . . .</i>	<b>5</b>	No

## Section B. Independent Contractors

**1** Complete this table for your five highest compensated independent contractors that received more than \$100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation
SIU SCHOOL OF MEDICINE PO BOX 19607 SPRINGFIELD, IL 627949607	PHYSICIAN SERVICES	37,134,364
HAROLD O'SHEA BUILDERS INC 3401 CONSTITUTION DR SPRINGFIELD, IL 62711	CONSTRUCTION	20,219,934
SPRINGFIELD CLINIC PO BOX 19260 SPRINGFIELD, IL 627049260	PHYSICIAN SERVICES	10,900,181
MID-AMERICA EMERGENCY PHYSICIANS INC KERBER ECKBRAECKEL LLP SPRINGFIELD, IL 62701	ER STAFFING	8,983,644
CERNER CORPORATION PO BOX 959156 ST LOUIS, MO 631959156	HEALTH INFORMATION TECHNOLOGY	8,192,833

**2** Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization ► 119



Part VIII

Statement of Revenue

Check if Schedule O contains a response or note to any line in this Part VIII

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514		
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns . . .	1a	7,581				
	b	Membership dues . . .	1b					
	c	Fundraising events . . .	1c	286,405				
	d	Related organizations	1d	813,434				
	e	Government grants (contributions)	1e	1,054,659				
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	4,898,872				
	g	Noncash contributions included in lines 1a-1f \$		3,034,888				
	h	Total. Add lines 1a-1f . . . . .		7,060,951				
	Program Service Revenue			Business Code				
2a		PATIENT SERVICE REV	900099	879,027,696	879,027,696			
b		PROGRAM RELATED REV	900099	56,934,039	56,934,039			
c		HOSPICE SERVICES	621610	7,470,227	7,470,227			
d		HOME HEALTH SERVICES	621610	6,323,308	6,323,308			
e		PROGRAM RELATED RENT	621110	4,291,679	4,291,679			
f		All other program service revenue		3,499,053	3,499,053			
g		Total. Add lines 2a-2f . . . . .		957,546,002				
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts) . . . . .		7,768,056		7,768,056		
	4	Income from investment of tax-exempt bond proceeds		547		547		
	5	Royalties . . . . .						
	6a	Gross rents	(i) Real	(ii) Personal				
			1,857,576					
		b	Less rental expenses		1,154,274			
		c	Rental income or (loss)		703,302			
	d	Net rental income or (loss) . . . . .		703,302	106,652	21,592	575,058	
	7a	Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other				
			491,870,400	49,242				
		b	Less cost or other basis and sales expenses		472,826,150	459,382		
		c	Gain or (loss)		19,044,250	-410,140		
	d	Net gain or (loss) . . . . .		18,634,110			18,634,110	
	8a	Gross income from fundraising events (not including \$ 286,405 of contributions reported on line 1c) See Part IV, line 18 . . . . .	a	423,021				
		b	Less direct expenses . . . . .	b	279,763			
		c	Net income or (loss) from fundraising events . . . . .		143,258			143,258
	9a	Gross income from gaming activities See Part IV, line 19 . . . . .	a	19,487				
		b	Less direct expenses . . . . .	b	6,876			
		c	Net income or (loss) from gaming activities . . . . .		12,611			12,611
	10a	Gross sales of inventory, less returns and allowances . . . . .	a					
b		Less cost of goods sold . . . . .	b					
c		Net income or (loss) from sales of inventory . . . . .						
Miscellaneous Revenue		Business Code						
11a	PROMPT PAY INTEREST	622110	7,186,361			7,186,361		
b	REFERENCE LAB REVENUE	621500	5,744,348		5,744,348			
c	CAFETERIA REVENUE	722320	5,185,521		211,597	4,973,924		
d	All other revenue . . . . .		2,881,223		1,240,102	1,641,121		
e	Total. Add lines 11a-11d . . . . .		20,997,453					
12	Total revenue. See Instructions . . . . .		1,012,866,290	957,652,654	7,217,639	40,935,046		

**Part IX Statement of Functional Expenses**

Section 501(c)(3) and 501(c)(4) organizations must complete all columns. All other organizations must complete column (A).

Check if Schedule O contains a response or note to any line in this Part IX

**Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.**

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21.	3,966,450	3,966,450		
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22.	1,055,381	1,055,381		
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.				
<b>4</b> Benefits paid to or for members.				
<b>5</b> Compensation of current officers, directors, trustees, and key employees.	9,541,635	7,171,147	2,256,233	114,255
<b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B).	38,956		38,956	
<b>7</b> Other salaries and wages.	315,085,335	279,601,111	35,319,251	164,973
<b>8</b> Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).	18,933,446	16,795,390	2,137,176	880
<b>9</b> Other employee benefits.	48,489,874	42,096,678	6,345,679	47,517
<b>10</b> Payroll taxes.	22,497,813	19,540,490	2,943,542	13,781
<b>11</b> Fees for services (non-employees):				
<b>a</b> Management.				
<b>b</b> Legal.	1,166,411		1,166,411	
<b>c</b> Accounting.	54,137		54,137	
<b>d</b> Lobbying.	124,080		124,080	
<b>e</b> Professional fundraising services. See Part IV, line 17.				
<b>f</b> Investment management fees.	1,600,746		1,600,746	
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	128,905,507	118,168,842	10,736,665	
<b>12</b> Advertising and promotion.	2,168,152	671,549	1,496,603	
<b>13</b> Office expenses.	15,953,193	12,694,430	3,248,365	10,398
<b>14</b> Information technology.	15,308,966	13,105,094	2,203,822	50
<b>15</b> Royalties.				
<b>16</b> Occupancy.	16,954,735	15,430,755	1,523,980	
<b>17</b> Travel.	1,145,382	990,635	154,747	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials.				
<b>19</b> Conferences, conventions, and meetings.	538,902	158,822	380,080	
<b>20</b> Interest.	12,931,417	12,931,417		
<b>21</b> Payments to affiliates.				
<b>22</b> Depreciation, depletion, and amortization.	49,456,839	39,608,792	9,848,047	
<b>23</b> Insurance.	1,580,756	10,116	1,570,640	
<b>24</b> Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O):				
<b>a</b> PATIENT SERV SUPPLIES	97,162,619	97,162,619		
<b>b</b> MANAGEMENT FEE	57,330,282		57,330,282	
<b>c</b> PHARMACEUTICAL SUPPLIES	38,200,431	38,200,431		
<b>d</b> PURCHASED MEDICAL SERVI	30,842,826	30,842,826		
<b>e</b> All other expenses	63,282,378	56,116,899	7,139,853	25,626
<b>25</b> Total functional expenses. Add lines 1 through 24e.	954,316,649	806,319,874	147,619,295	377,480
<b>26</b> Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

**Part X Balance Sheet**Check if Schedule O contains a response or note to any line in this Part IX ☐

				(A) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b>	Cash—non-interest-bearing . . . . .		4,428,480	<b>1</b>	10,967,227
	<b>2</b>	Savings and temporary cash investments . . . . .		116,504,133	<b>2</b>	162,218,021
	<b>3</b>	Pledges and grants receivable, net . . . . .		181,231	<b>3</b>	194,207
	<b>4</b>	Accounts receivable, net . . . . .		236,722,442	<b>4</b>	214,675,686
	<b>5</b>	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L			<b>5</b>	
	<b>6</b>	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L			<b>6</b>	
	<b>7</b>	Notes and loans receivable, net . . . . .		11,865,524	<b>7</b>	11,713,043
	<b>8</b>	Inventories for sale or use . . . . .		13,910,605	<b>8</b>	12,904,693
	<b>9</b>	Prepaid expenses and deferred charges . . . . .		8,741,208	<b>9</b>	8,488,612
	<b>10a</b>	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	<b>10a</b> 806,546,762			
	<b>b</b>	Less: accumulated depreciation	<b>10b</b> 426,409,116	406,647,909	<b>10c</b>	380,137,646
	<b>11</b>	Investments—publicly traded securities . . . . .		399,196,024	<b>11</b>	437,640,201
	<b>12</b>	Investments—other securities. See Part IV, line 11 . . . . .		25,059,145	<b>12</b>	27,806,561
	<b>13</b>	Investments—program-related. See Part IV, line 11 . . . . .		10,558,130	<b>13</b>	10,984,263
	<b>14</b>	Intangible assets . . . . .			<b>14</b>	
	<b>15</b>	Other assets. See Part IV, line 11 . . . . .		91,887,062	<b>15</b>	97,403,474
<b>16</b>	<b>Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .		1,325,701,893	<b>16</b>	1,375,133,634	
<b>Liabilities</b>	<b>17</b>	Accounts payable and accrued expenses . . . . .		90,740,752	<b>17</b>	92,295,289
	<b>18</b>	Grants payable . . . . .		644,954	<b>18</b>	657,251
	<b>19</b>	Deferred revenue . . . . .		569,310	<b>19</b>	426,803
	<b>20</b>	Tax-exempt bond liabilities . . . . .			<b>20</b>	
	<b>21</b>	Escrow or custodial account liability. Complete Part IV of Schedule D			<b>21</b>	
	<b>22</b>	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L . . . . .			<b>22</b>	
	<b>23</b>	Secured mortgages and notes payable to unrelated third parties . . . . .		1,653,114	<b>23</b>	46,409,923
	<b>24</b>	Unsecured notes and loans payable to unrelated third parties . . . . .			<b>24</b>	
	<b>25</b>	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D		481,707,359	<b>25</b>	392,210,249
	<b>26</b>	<b>Total liabilities.</b> Add lines 17 through 25 . . . . .		575,315,489	<b>26</b>	531,999,515
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.</b>					
	<b>27</b>	Unrestricted net assets		652,479,668	<b>27</b>	747,635,845
	<b>28</b>	Temporarily restricted net assets . . . . .		71,555,700	<b>28</b>	68,965,415
	<b>29</b>	Permanently restricted net assets		26,351,036	<b>29</b>	26,532,859
	<b>Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.</b>					
	<b>30</b>	Capital stock or trust principal, or current funds . . . . .			<b>30</b>	
	<b>31</b>	Paid-in or capital surplus, or land, building or equipment fund . . . . .			<b>31</b>	
	<b>32</b>	Retained earnings, endowment, accumulated income, or other funds			<b>32</b>	
	<b>33</b>	<b>Total net assets or fund balances</b> . . . . .		750,386,404	<b>33</b>	843,134,119
<b>34</b>	<b>Total liabilities and net assets/fund balances</b> . . . . .		1,325,701,893	<b>34</b>	1,375,133,634	

**Part XI Reconciliation of Net Assets**Check if Schedule O contains a response or note to any line in this Part XI ☒

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	1,012,866,290
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	954,316,649
<b>3</b>	Revenue less expenses Subtract line 2 from line 1	<b>3</b>	58,549,641
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	750,386,404
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	29,242,768
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	4,955,306
<b>10</b>	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	<b>10</b>	843,134,119

**Part XII Financial Statements and Reporting**Check if Schedule O contains a response or note to any line in this Part XII ☐

	Yes	No
<b>1</b> Accounting method used to prepare the Form 990 <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O		
<b>2a</b> Were the organization's financial statements compiled or reviewed by an independent accountant? If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		No
<b>b</b> Were the organization's financial statements audited by an independent accountant? If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	Yes	
<b>c</b> If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O	Yes	
<b>3a</b> As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	Yes	
<b>b</b> If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits	Yes	

# Additional Data

**Software ID:**  
**Software Version:**  
**EIN:** 90-0756744  
**Name:** MEMORIAL HEALTH SYSTEM GROUP

Form 990 (2016)

**Form 990, Part III, Line 4a:**

HOSPITALSMEMORIAL HEALTH SYSTEM INCLUDES FOUR HOSPITALS, MEMORIAL MEDICAL CENTER (MMC), PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION (PAH), ABRAHAM LINCOLN MEMORIAL HOSPITAL (ALMH), AND TAYLORVILLE MEMORIAL HOSPITAL (TMH) THE HOSPITALS PROVIDE A WIDE VARIETY OF HEALTH CARE SERVICES TO INPATIENTS, OUTPATIENTS AND EMERGENCY DEPARTMENT SERVICES 142,280 PATIENT DAYS, 30,242 DISCHARGES, AND 649,753 OUTPATIENT VISITS WERE PROVIDED BY THE HOSPITALS IN FY2017 \$12 MILLION IN CHARITY CARE WAS PROVIDED AND THE HOSPITALS WROTE OFF AN ADDITIONAL \$15 MILLION IN BAD DEBT FOR CARE PROVIDED JACKSONVILLE CRNA PROVIDES PROFESSIONAL CERTIFIED REGISTERED NURSE ANESTHETIST SERVICES TO THE COMMUNITIES IN THE PASSAVANT AREA HOSPITAL SERVICE AREA FOR FY2017, SERVICES WERE PROVIDED FOR 6,094 CASES DURING FY2017, AFTER MEMORIAL MEDICAL CENTER RECEIVED THE 2016 AMERICAN HOSPITAL ASSOCIATION-MCKESSON QUEST FOR QUALITY PRIZE IN RECOGNITION OF EFFORTS TO DEVELOP AN INTEGRATED HEALTHCARE QUALITY, SAFETY, AND OPERATIONS IMPROVEMENT PROGRAM, THE AMERICAN HOSPITAL ASSOCIATION REQUESTED THAT MEMORIAL HEALTH SYSTEM SUBMIT AN UPDATED APPLICATION AS ITS REPRESENTATIVE TO A SIMILAR INTERNATIONAL QUALITY COMPETITION, THE INTERNATIONAL HOSPITAL FEDERATION (IHF) 2017 EXCELLENCE AWARD FOR QUALITY, SAFETY, AND PATIENT CENTERED CARE MEMORIAL HEALTH SYSTEM WAS SELECTED AS HONORABLE MENTION/RUNNER UP FOR THE INTERNATIONAL 2017 EXCELLENCE AWARD, FOR THE SUBMISSION, "REACHING NEW FRONTIERS OF QUALITY AND SAFETY USING AN INNOVATIVE 30/30/30 LEAN SIX SIGMA APPROACH" THE AWARD WAS PRESENTED DURING THE 41ST IHF WORLD HOSPITAL CONGRESS ON NOVEMBER 8, 2017, IN TAIPEI, TAIWAN MMC ALSO RETAINED OUR LEVEL 1 TRAUMA CENTER AND COMPREHENSIVE STROKE CENTER CERTIFICATION, THE HIGHEST LEVEL OF STROKE CERTIFICATION FROM THE JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO), AMERICAN HEART ASSOCIATION AND AMERICAN STROKE ASSOCIATION IN FY2017, PAH COMPLETED AND OPENED A CENTER FOR RADIATION THERAPY IN ORDER TO BETTER MEET THE NEEDS OF PATIENTS IN THE COMMUNITY PAH ALSO EXPANDED THEIR CENTER FOR PAIN MANAGEMENT AND RENOVATED A 20 BED PATIENT UNIT ADDITIONALLY, THE HOSPITAL MODERNIZED INFORMATION SECURITY SYSTEMS, NAMELY MCKESSON AND TOUCHWORKS IMPLEMENTATIONS IN FY2017, ALMH RECEIVED AN ENVIRONMENTAL EXCELLENCE AWARD FROM PRACTICE GREENHEALTH BASED ON THE STRENGTH OF ITS APPLICATION, ALMH RECEIVED THE EMERALD AWARD FOR DEMONSTRATING A SUPERIOR SUSTAINABILITY PROGRAM RESULTS OF THE PROGRAM FROM 2017 ARE HIGHLIGHTED AS FOLLOWS PRACTICE GREENHEALTH IS A NONPROFIT MEMBERSHIP ORGANIZATION FOUNDED ON THE PRINCIPLES OF POSITIVE ENVIRONMENTAL STEWARDSHIP AND BEST PRACTICES BY ORGANIZATIONS IN THE HEALTH CARE COMMUNITY THE HISTORY OF PRACTICE GREENHEALTH BEGAN IN JUNE OF 1998, WHEN THE AMERICAN HOSPITAL ASSOCIATION AND THE US ENVIRONMENTAL PROTECTION AGENCY SIGNED A LANDMARK AGREEMENT TO ADVANCE POLLUTION PREVENTION EFFORTS IN OUR NATION'S HEALTHCARE FACILITIES DURING FY2017, THE DIABETES SELF-MANAGEMENT PROGRAM BEGAN CARING FOR PATIENTS AT TMH IN FEBRUARY 2017, AS PART OF THE MEMORIAL WEIGHT LOSS AND WELLNESS CENTER PARTICIPANTS COMPLETE AN EIGHT-HOUR COURSE IN FOUR WEEKLY SESSIONS FOCUSING ON INFORMATION ABOUT TREATMENTS, LIFESTYLE MODIFICATIONS, MONITORING AND REDUCING THE RISK OF COMPLICATIONS ASSOCIATED WITH DIABETES MELLITUS

**Form 990, Part III, Line 4b:**

PHYSICIANS MEMORIAL PHYSICIAN SERVICES (MPS) IS A PRIMARY-CARE NETWORK THAT SERVES PATIENTS IN NEARLY 400,000 VISITS EACH YEAR IN CENTRAL ILLINOIS LOCATIONS IN CHATHAM, JACKSONVILLE, LINCOLN, PETERSBURG AND SPRINGFIELD MPS ALSO HAS AN ON-SITE CLINIC AT A LOCAL NURSING HOME TO IMPROVE ACCESS FOR THE ELDERLY RESIDENTS IN FEBRUARY 2017, MPS OPENED ITS FOURTH EXPRESSCARE LOCATION IN CHATHAM ALSO DURING FY2017, TO INCREASE PATIENT ACCESS TO CARE, A WALK-IN CLINIC WAS ESTABLISHED IN A RETAIL SETTING ALL OF THE MPS PRIMARY CARE CLINICS ARE NCQA DESIGNATED LEVEL 3 PATIENT CENTERED MEDICAL HOMES

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**Form 990, Part III, Line 4c:**

AMBULATORY & OTHER MEMORIAL HEALTH SYSTEM OPERATES THREE AMBULATORY AFFILIATES THAT ARE INCLUDED IN THE GROUP 990 RETURN SPRINGFIELD RESIDENTIAL SERVICES (SRS), MEMORIAL HOME SERVICES (MHSVC), AND MEMORIAL HEALTH VENTURES (MHV) SRS PROVIDES HOUSING FACILITIES AND SERVICES TO NON-ELDERLY ADULTS DIAGNOSED WITH MENTAL ILLNESSES BY MEANS OF CONSTRUCTING A HUD HOUSING PROJECT IN FY2017, SRS COMPLETED SEVERAL RENOVATION PROJECTS UTILIZING RESIDUAL RECEIPTS FUNDING ACCUMULATED OVER THE LIFE OF THE PROJECT THIS IS THE FIRST MAJOR RENOVATION EFFORT COMPLETED FOR THE PROJECT SINCE ITS INITIAL CONSTRUCTION IN 1994 MHSVC PROVIDES HOME HEALTH, HOSPICE AND MEDICAL EQUIPMENT SERVICES ACROSS A 14-COUNTY REGION IN CENTRAL ILLINOIS HOME HEALTH SERVICES INCLUDED SKILLED, HIGH-TECH NURSING, HOME HEALTH AIDES, PALLIATIVE CARE, SPECIALIZED WOUND CARE, TELEHEALTH, NUTRITIONAL SERVICES, SOCIAL SERVICES, AND REHABILITATION HOSPICE SERVICES INCLUDE PAIN AND SYMPTOM MANAGEMENT, BEREAVEMENT CARE, VOLUNTEER SERVICES, AS WELL AS EMOTIONAL AND SPIRITUAL CARE FOR TERMINALLY ILL PATIENTS AND THEIR FAMILIES THE HOSPICE PROGRAM ALSO HAS ON-STAFF MEDICAL SOCIAL WORKERS, HOME HEALTH AIDES, A CHAPLAIN AND DIETARY COUNSELING OTHER COMMUNITY EVENTS INCLUDE EXPENSES ASSOCIATED WITH VARIOUS HEALTH SCREENINGS PROVIDED BY OUR SKILLED NURSING MHV OWNS AND PROVIDES OVERSIGHT FOR JOINT VENTURES WITH ENTITIES ENTERED INTO BY MEMORIAL HEALTH SYSTEM ALL OF THESE VENTURES MUST BE IN KEEPING WITH THE HEALTH CARE SYSTEM MISSION OF PROVIDING CONTINUUM OF CARE TO PATIENTS IN CENTRAL ILLINOIS THEY INCLUDE A LONG TERM CARE FACILITY, AN AMBULATORY SURGICAL TREATMENT CENTER, AND EQUIPMENT LEASING IN FY2017, MEMORIAL HOSPICE AT HERITAGE, A 19 BED SKILLED NURSING UNIT, WAS OPENED TO HELP MEET THE UNIQUE NEEDS OF HOSPICE PATIENTS AND FAMILIES WHO MAY NEED A FACILITY SETTING FOR END-OF-LIFE CARE

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Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
MARY ROSE MOREHEAD ..... BOARD MEMBER ALMH	0 70 .....	X						0	0	0
PAUL KASA MD ..... BOARD MEMBER ALMH (THRU JAN 17)/MPS	50 00 .....	X						318,401	0	82,266
AMIR JOHN WAHAB MD ..... BOARD MEMBER ALMH	50 00 .....	X						527,406	0	112,554
GREG EIMER ..... BOARD MEMBER ALMH	0 70 .....	X						0	0	0
BRADLEY NIKLES ..... BOARD MEMBER ALMH (THRU JAN 17)	0 70 .....	X						0	0	0
MELISSA COX MD ..... BOARD MEMBER ALMH (THRU JAN 17)	0 70 .....	X						0	0	0
A PATRICK DOOLIN ..... BOARD MEMBER ALMH (THRU JAN 17)	0 70 .....	X						0	0	0
BRUCE D CARMITCHEL ..... BOARD MEMBER ALMH (FROM FEB 17)	0 70 .....	X						0	0	0
JUNE HARNACKE ..... BOARD MEMBER ALMH (FROM FEB 17)	0 70 .....	X						0	0	0
ANDREW H HAYES ..... BOARD MEMBER ALMH (FROM FEB 17)	0 70 .....	X						0	0	0



Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A)

(B)

(C)

(D)

(E)

(F)

Name and Title	Average hours per week (list any hours for related organizations below dotted line)	Position (do not check more than one box, unless person is both an officer and a director/trustee)						Reportable compensation from the organization (W- 2/1099-MISC)	Reportable compensation from related organizations (W- 2/1099-MISC)	Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
TRACY A MIZEUR MD ..... BOARD MEMBER ALMH (FROM FEB 17)	50 00 .....	X						286,623	0	61,600
DON A SIELAFF ..... BOARD MEMBER ALMH (FROM FEB 17)	0 70 .....	X						0	0	0
KEITH SNYDER ..... BRD MEM ALMH(THRUJAN17)/TREASALMH	0 70 .....	X		X				0	0	0
DAVID IRWIN ..... BRD MEM ALMH(THRUJAN17)/SECALMH	0 70 .....	X		X				0	0	0
LISA KRAMER ..... TREAS ALMH (THRU JAN 17)	0 70 .....	X		X				0	0	0
RONALD SCHILLING ..... IMMEDPASTCHRALMH(THRUJAN17)/BRDMEM	0 70 .....	X		X				0	0	0
WILLIAM BATES ..... CHRELECTALMH(THRUJAN17)/CHRALMH	0 70 .....	X		X				0	0	0
DAVID CAMPBELL ..... SECALMH(THRUJAN17)/CHRELECTALMH	0 70 .....	X		X				0	0	0
DERON POWELL ..... CHRALMH(THRUJAN17)/IMMEDPASTCHRALMH	0 70 .....	X		X				0	0	0
SUSAN KOCH EDD ..... BOARD MEMBER MMC	0 70 ..... 0 70	X						0	0	0

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
LYNNE BARKMEIER MD ..... BOARD MEMBER MMC	0 70 .....	X						0	0	0
JOSEPH HURWITZ ..... BOARD MEMBER MMC	2 00 .....	X						0	0	0
CRAIG SCHERMERHORN ..... BOARD MEMBER MMC (THRU DEC 16)	2 00 .....	X						0	0	0
KEVIN COAKLEY MD ..... BOARD MEMBER MMC	0 70 .....	X						0	0	0
NINA HARRIS ..... BOARD MEMBER MMC	1 00 .....	X						0	0	0
TODD WISE ..... BOARD MEMBER MMC (THRU DEC 16)	1 00 .....	X						0	0	0
MARK KUHNKE MD ..... BOARD MEMBER MMC (THRU DEC 16)	0 70 .....	X						0	0	0
HOWARD A PETERS III ..... BOARD MEMBER MMC (FROM JAN 17)	0 70 .....	X						0	0	0
JARROD C WALL MD PHD ..... BOARD MEMBER MMC (FROM JAN 17)	0 70 .....	X						0	0	0
LISA HARTZLER ..... BOARD MEMBER MMC	0 80 .....	X						0	0	0

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A)

(B)

(C)

(D)

(E)

(F)

Name and Title	Average hours per week (list any hours for related organizations below dotted line)	Position (do not check more than one box, unless person is both an officer and a director/trustee)						Reportable compensation from the organization (W- 2/1099-MISC)	Reportable compensation from related organizations (W- 2/1099-MISC)	Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JOHN BLACKBURN ..... BOARD MEMBER MMC	1 70 .....	X						0	0	0
DEAN ROBERT JR ..... 2NDVICECHR MMC	0 70 .....	X		X				0	0	0
DALE BECKER ..... TREASURER MMC	0 70 .....	X		X				0	0	0
DIANE RUTLEDGE PHD ..... 1VCHR MMC	1 50 .....	X		X				0	0	0
GEOFFREY ISRINGHAUSEN ..... SECRETARY MMC	1 00 .....	X		X				0	0	0
RANDALL GERMERAAD ..... CHR MMC/BRDMEMSRS (THRU FEB 17)	1 00 .....	X		X				0	0	0
JAMES REED JR ..... BRDMEMMMC/BRDMEMMMCF	0 70 .....	X						0	0	0
JENNIFER ISRINGHAUSEN ..... BOARD MEMBER MMCF	0 80 .....	X		X				0	0	0
DAVID GRIFFEN MD PHD ..... BOARD MEMBER MMCF	0 20 .....	X						0	0	0
J WILLIAM ROBERTS ..... BOARD MEMBER MMCF	0 20 .....	X						0	0	0

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A)

(B)

(C)

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(F)

Name and Title	Average hours per week (list any hours for related organizations below dotted line)	Position (do not check more than one box, unless person is both an officer and a director/trustee)						Reportable compensation from the organization (W- 2/1099-MISC)	Reportable compensation from related organizations (W- 2/1099-MISC)	Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
R LEE ALLEN ..... BOARD MEMBER MMCF (THRU DEC 16)	0 10 .....	X						0	0	0
J MARTIN GREEN ..... BOARD MEMBER MMCF	0 20 .....	X						0	0	0
HENRY DALE SMITH JR ..... BOARD MEMBER MMCF	0 40 .....	X						0	0	0
VALERA YAZELL ..... BOARD MEMBER MMCF	0 40 .....	X						0	0	0
DONALD YURDIN MD ..... BOARD MEMBER MMCF	0 30 .....	X						0	0	0
CHERYL MARTIN ..... BOARD MEMBER MMCF	0 30 .....	X						0	0	0
TRICIA NELSON BECKER ..... BOARD MEMBER MMCF (FROM JAN 17)	0 40 .....	X						0	0	0
CHERRILYN MAYFIELD ..... TREASURER MMCF	0 40 .....	X		X				0	0	0
G VIRGINIA CONLEE ..... SECRETARY MMCF	0 40 .....	X		X				0	0	0
BRIDGET LAMONT ..... CHAIR MMCF	0 50 .....	X		X				0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
ROB PIETROBURGO ..... VICE CHAIR MMCF	0 40 .....	X		X				0	0	0
MARK HANSEN MD ..... BOARD MEMBER MPS	50 00 .....	X						611,653	0	100,497
MARSHALL HALE MD ..... CHAIR MPS	50 00 .....	X		X				521,574	0	122,663
TRAVIS DOWELL ..... PRESIDENT MPS & VP MPS	50 00 .....	X		X				0	329,794	60,221
CARL NIEMANN ..... BOARD MEMBER TMH	0 70 .....	X						0	0	0
PAVI GILL MD JD ..... BOARD MEMBER TMH	0 70 .....	X						0	0	0
RONALD MIZER DDS ..... BOARD MEMBER TMH	0 70 .....	X						0	0	0
MARGARET PEG FRY ..... BOARD MEMBER TMH (THRU DEC 16)	0 70 .....	X						0	0	0
JOHN FERRY DDS ..... BOARD MEMBER TMH	0 70 .....	X						0	0	0
RICHARD WILSON ..... BOARD MEMBER TMH (THRU AUG 17)	0 70 .....	X						0	0	0





Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
DAVID HIXENBAUGH ..... BOARD MEMBER TMHF	0 70 .....	X						0	0	0
NANCY HANDEGAN ..... BOARD MEMBER TMHF	0 70 .....	X						0	0	0
MELISSA LIVINGSTON ..... BOARD MEMBER TMHF	0 70 .....	X						0	0	0
LINDSAY D BARRY ..... BOARD MEMBER TMHF (FROM JAN 17)	0 70 .....	X						0	0	0
DAVID L BRUMMER ..... BOARD MEMBER TMHF (FROM JAN 17)	0 70 .....	X						0	0	0
DUANNE R STOCK ..... BOARD MEMBER TMHF (FROM JAN 17)	0 70 .....	X						0	0	0
BILLY WILLIAMS ..... BRDMEMTMHF(THRUDEC16)/TREASTMHF	0 70 .....	X		X				0	0	0
ERIC KAHLE ..... BOARD MEMBER TMHF (THRU DEC 16)	0 70 .....	X						0	0	0
MICHELLE CAPELLIN ..... PRESTMHF	0 70 .....	X		X				0	0	0
MICHAEL BLAKEMAN ..... TREASTMHF	0 70 .....	X		X				0	0	0



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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
GLORIA BRUMMER ..... DIRECTMHF(THRUDEC16)/BRDMEMTMHF	0 70 .....	X		X				0	0	0
SCOTT MCCLURE ..... VPTMHF	0 70 .....	X		X				0	0	0
LEIGH STEINER PHD ..... BOARD MEMBER SRS/SEC(FROMMAR17)	0 40 ..... 0 40	X		X				0	7,054	0
JOHN MILHISER ..... BOARD MEMBER SRS	0 40 ..... 0 40	X						0	0	0
WANDA LEE ROHLFS ..... BOARD MEMBER SRS	0 40 ..... 0 40	X						0	0	0
BRENT BORAH ..... BOARD MEMBER SRS/TREAS (FROMMAR17)	0 40 ..... 0 40	X		X				0	0	0
JANICE GAMBACH ..... PRESIDENT SRS, ADMIN MBH	2 50 ..... 47 50	X		X				0	209,006	23,934
JENNIFER MORRISON ..... VCHRSRS(THRUFE17)/BRDMEMSRS	0 40 ..... 0 40	X		X				0	0	0
CATHERINE GONZALEZ JD ..... TREASSRS(THRUFE17)/VCHRSRS	0 40 ..... 0 40	X		X				0	0	0
MICHAEL O'SHEA ..... CHRSRS(THRUFE17)/BRDMEMSRS	0 40 ..... 0 40	X		X				0	0	0

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(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)										
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former					
SANDY ROBINSON II ..... SECSRS(THRU FEB17)/CHRSRS(FROM MAR18)	0 40 .....	X		X					0	0	0	
JAMESON ROSZHART ..... BRDMEM MHV/BRDMEM MHSVC/VPAMBNET	35 00 ..... 15 00	X							0	248,735	60,392	
HARRY SCHMIDT ..... BRD MEM MHSVC/ PRES PAH CRNA	50 00 .....	X		X					238,948	9,919	82,596	
R SCOTT KIRIAKOS ..... SVPCLININTMMC/BRD MEMMHV/CHAIR MHSVC	50 00 .....	X		X					456,840	0	126,207	
DOLAN DALPOAS ..... PRESIDENT ALMH/BRDMEM MHSVC/CEOALMH	49 30 ..... 0 70	X		X					0	377,014	53,633	
KIMBERLY BOURNE ..... PRES TMH&TMHF/BRD MEMMH SVC/CEOTMH	50 00 .....	X		X					0	295,666	71,352	
KATHRYN KEIM ..... SEC/TREAS MHV(FROM JAN 17)/VPFINANCE	50 00 .....	X		X					179,933	0	38,918	
DOUGLAS RAHN DBA ..... BRD MEMMH SVC&PRES PAH CRNA(THRU DEC16)	50 00 .....	X		X					0	497,240	93,420	
EDGAR CURTIS ..... PRES&CEOMHS/PRESMMC/BRD MEMMPS	25 00 ..... 25 00	X		X					0	2,428,712	309,424	
ROBERT KAY ..... SVP CFO SECTREAS MHSVC MP SMHV(THRU DEC16)	25 00 ..... 25 00	X		X					0	910,883	226,780	

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
KEVIN ENGLAND ..... VP BUS DEVELOP/VC/PRES MHV/VC MHSVC	25 00 ..... 25 00	X		X				0	334,720	173,190
CHARLES CALLAHAN PHD ..... EVPCCOMMC/CHRMHV/MPSBRDMEM/PRESMHSVC	25 00 ..... 25 00	X		X				738,245	0	118,891
BABU ELADASARI MD ..... PAH BRDMEM (THRU AUG 17), PPA PHYS	0 70 ..... 49 30	X						4,813	331,972	35,633
DOUGLAS AWE ..... BRDMEM PAH	0 70 ..... .....	X						0	0	0
KEITH BRADBURY ..... BRDMEM PAH	0 70 ..... .....	X						0	0	0
BARBARA FARLEY PHD ..... BRDMEM PAH	0 70 ..... .....	X						0	0	0
ERIC GIEBELHAUSEN MD ..... BRDMEM PAH (THRU DEC 16)	0 70 ..... .....	X						0	0	0
DONALD HEADEN ..... BRDMEM PAH	0 70 ..... .....	X						0	0	0
GILBERT JOEHL ..... BRDMEMPAHF, BRDMEMPAH	0 70 ..... .....	X						0	0	0
PHYLLIS LAPE PHD ..... BRDMEM PAH	0 70 ..... .....	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
STEVEN LILLOP MD ..... BRDMEM PAH	50 00 .....	X						792,288	0	133,415
ANTHONY GRIFFIN MD ..... BRDMEM PAH (FROM JAN 17)	50 00 .....	X						347,551	0	74,875
NANCY SPANGENBERG ..... BRDMEM PAH	0 70 .....	X						0	0	0
KELLY STAAKE ..... BRDMEM PAH	0 70 .....	X						0	0	0
GREG LEPPER ..... CRCRNAPAH(TLDE16)BMPAHF(TLAP17)IPCPAH	0 70 .....	X		X				0	0	0
REGINALD BENTON ..... VCCRNA&CRELCTPAH(THRUDEC16)CRCRNAPAH	1 40 ..... 0 70	X		X				0	0	0
GARY SCOTT ..... SECCRNAPAH(TILDEC16)TRSCRNAPAHBMPAHF	0 70 .....	X		X				0	0	0
THOMAS VEITH ..... TRSCRNAPAH(THRUDEC16)VCCRNACRELCTPAH	0 70 .....	X		X				0	0	0
GINNY FANNING ..... VP OF NOMINATIONS PAHF, PAH BRDMEM	1 40 ..... 0 70	X		X				0	0	0
JAMES HINCEN MD ..... PAHBRDMEM(THRUDEC16)PAH/CRNASEC(FROMJAN17)	0 70 .....	X		X				0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
FRANK CUMMINGS ..... BRDMEM PAHF	0 70 .....	X						0	0	0
ALBAN HAXHINASTO ..... BRDMEM PAHF	0 70 .....	X						0	0	0
KEITH R LAPE PHD ..... BRDMEM PAHF	0 70 .....	X						0	0	0
LISA MUSCH ..... BRDMEM PAHF	0 70 .....	X						0	0	0
CARRIE COLE ..... BRDMEM PAHF	0 70 .....	X						0	0	0
DIANA OLINGER ..... BRDMEM PAHF (FROM JAN 17)	0 70 .....	X						0	0	0
ANN PRATHER ..... BRDMEM PAHF (FROM JAN 17)	0 70 .....	X						0	0	0
HOBART HINDERLITER ..... BRDMEM PAHF (THRU FEB 16)	0 70 .....	X						0	0	0
RON TENDICK ..... BRDMEM PAHF (THRU MAR 16)	0 70 .....	X						0	0	0
MARY FERGURSON ..... PAHF PRESIDENT	0 70 .....	X		X				0	0	0

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LINDA DONOVAN ..... VP OF STEWARDSHIP AND GIFTS PAHF	0 70 .....	X		X				0	0	0
CHESTER WYNN ..... SECRETARYPAHF	0 70 .....	X		X				0	0	0
STEVE TURNER ..... TREASURERPAHF	0 70 .....	X		X				0	0	0
ELENA KEZELIS ..... EXEC DIR MMCf	50 00 .....				X			192,501	0	40,512
MARSHA PRATER PHD ..... SVP & CNO MMC	50 00 .....				X			477,504	0	224,798
LINDA JONES DNS ..... VP OPERATIONS MMC	50 00 .....				X			352,487	0	65,075
DREW EARLY ..... ADMINEDMMC(THRUNOV16)/VPOPERATIONS	50 00 .....				X			225,208	0	43,243
ANNA EVANS JD ..... GEN COUNSEL/VP INT AUDIT & COMPL MHS	25 00 ..... 25 00				X			0	333,283	217,567
RAJESH GOVINDAIAH MD ..... SVP & CMO MHS	25 00 ..... 25 00				X			0	589,348	84,547
DAVID GRAHAM MD ..... SVP & CIO MHS	25 00 ..... 25 00				X			0	555,143	170,395

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MITCHELL JOHNSON ..... VP & CHIEF STRATEGY OFFICER MHS	25 00 ..... 25 00				X			0	405,197	124,931
ROBERT SCOTT ..... VP & CHRO MHS	25 00 ..... 25 00				X			0	355,920	62,312
JENNIFER HARRIS ..... ADMIN PERIOPERATIVE SERVICES	50 00 ..... 25 00				X			211,781	0	23,532
MITCHELL ROGERS ..... ADMIN CARDIOVASCULAR SERVICES	50 00 ..... 25 00				X			288,398	0	41,105
CHARLES SHEAFF MD ..... CMO PAH	49 30 ..... 0 70				X			293,288	64,356	51,286
RANDALL MOORE ..... DIRECTOR PERIOP SERVICES PAH	50 00 ..... 25 00				X			261,547	0	70,443
FERDINAND SALVACION MD ..... PHYSICIAN MMC	50 00 ..... 25 00					X		620,313	0	129,061
JAMES BOHAN MD ..... PHYSICIAN MPS	50 00 ..... 25 00					X		554,785	0	93,078
CHRISTINA SCHEIBLER-VENTRESS MD ..... PHYSICIAN MPS	50 00 ..... 25 00					X		535,423	0	98,739
MICHAEL E SHEEDY MD ..... PHYSICIAN MPS	50 00 ..... 25 00					X		531,935	0	113,287

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NICOLE A FLORENCE MD ..... PHYSICIAN MPS	50 00 .....					X		525,741	0	114,292



## TY 2016 Affiliate Listing

**Name:** MEMORIAL HEALTH SYSTEM GROUP

**EIN:** 90-0756744

### TY 2016 Affiliate Listing

Name	Address	EIN	Name control
MEMORIAL MEDICAL CENTER	701 NORTH FIRST STREET SPRINGFIELD, IL 62781	37-0661220	MEMO
THE ABRAHAM LINCOLN MEMORIAL HOSPITAL	200 STAHLHUT DRIVE LINCOLN, IL 62656	37-0723793	ABRA
TAYLORVILLE MEMORIAL HOSPITAL	201 EAST PLEASANT TAYLORVILLE, IL 62568	37-0661250	TAYL
MEMORIAL HEALTH VENTURES	701 NORTH FIRST STREET SPRINGFIELD, IL 62781	36-3492266	MEMO
MEMORIAL HOME SERVICES	701 NORTH FIRST STREET SPRINGFIELD, IL 62781	37-0714225	MEMO
MEMORIAL PHYSICIAN SERVICES	701 NORTH FIRST STREET SPRINGFIELD, IL 62781	37-1181194	MEMO
MEMORIAL MEDICAL CENTER FOUNDATION	1 MEMORIAL PLAZA SPRINGFIELD, IL 62781	37-1110301	MEMO
TAYLORVILLE MEMORIAL HOSPITAL FOUNDATION INC	201 EAST PLEASANT TAYLORVILLE, IL 62568	37-1337485	TAYL
SPRINGFIELD RESIDENTIAL SERVICES	710 NORTH EIGHTH STREET SPRINGFIELD, IL 62702	37-1298589	SPRI
PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION	1600 WEST WALNUT STREET JACKSONVILLE, IL 62650	37-0661230	PASS
JACKSONVILLE CRNA'S INC	1600 WEST WALNUT STREET JACKSONVILLE, IL 62650	27-3083265	JACK
PASSAVANT AREA HOSPITAL FOUNDATION	1600 WEST WALNUT STREET JACKSONVILLE, IL 62650	46-1037396	PASS

<b>SCHEDULE A</b> (Form 990 or 990-EZ)	<b>Public Charity Status and Public Support</b> Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust. ▶ Attach to Form 990 or Form 990-EZ. ▶ Information about Schedule A (Form 990 or 990-EZ) and its instructions is at <a href="http://www.irs.gov/form990">www.irs.gov/form990</a> .	OMB No 1545-0047 <b>2016</b> <b>Open to Public Inspection</b>
	Department of the Treasury Internal Revenue Service <b>Name of the organization</b> MEMORIAL HEALTH SYSTEM GROUP	<b>Employer identification number</b> 90-0756744

**Part I Reason for Public Charity Status** (All organizations must complete this part.) See instructions.

The organization is not a private foundation because it is (For lines 1 through 12, check only one box.)

- 1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
- 2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ))
- 3 ☐ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state \_\_\_\_\_
- 5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)
- 6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7 ☒ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
- 8 ☐ A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II.)
- 9 ☐ An agricultural research organization described in **section 170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture. See instructions. Enter the name, city, and state of the college or university \_\_\_\_\_
- 10 ☐ An organization that normally receives (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)
- 11 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**
- 12 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.
- a ☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**
- b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**
- c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**
- d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
- e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
- f Enter the number of supported organizations \_\_\_\_\_
- g Provide the following information about the supported organization(s) \_\_\_\_\_

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-10 above (see instructions))	(iv) Is the organization listed in your governing document?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
<b>Total</b>						

Part II

Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)  
(Complete only if you checked the box on line 5, 7, 8, or 9 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support							
	Calendar year (or fiscal year beginning in) ►	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
1	Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant ")	1,504,857	1,822,258	10,672,422	2,108,711	1,969,241	18,077,489
2	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3	The value of services or facilities furnished by a governmental unit to the organization without charge						
4	<b>Total.</b> Add lines 1 through 3	1,504,857	1,822,258	10,672,422	2,108,711	1,969,241	18,077,489
5	The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						5,373,498
6	<b>Public support.</b> Subtract line 5 from line 4						12,703,991

Section B. Total Support							
Calendar year (or fiscal year beginning in) ►		(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
7	Amounts from line 4	1,504,857	1,822,258	10,672,422	2,108,711	1,969,241	18,077,489
8	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources	608,565	658,502	643,908	635,765	667,454	3,214,194
9	Net income from unrelated business activities, whether or not the business is regularly carried on	13,228	11,927	10,334	10,053	10,269	55,811
10	Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI )	392,049	403,871	441,129	445,285	442,508	2,124,842
11	<b>Total support.</b> Add lines 7 through 10						23,472,336
12	Gross receipts from related activities, etc. (see instructions)					<b>12</b>	73,531,796
13	<b>First five years.</b> If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and <b>stop here</b> . . . . . ► <input type="checkbox"/>						

Section C. Computation of Public Support Percentage				
14	Public support percentage for 2016 (line 6, column (f) divided by line 11, column (f))	<table><tr><td>14</td><td>54 120 %</td></tr></table>	14	54 120 %
14	54 120 %			
15	Public support percentage for 2015 Schedule A, Part II, line 14	<table><tr><td>15</td><td>57 580 %</td></tr></table>	15	57 580 %
15	57 580 %			
16a	<b>33 1/3% support test—2016.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization <span>▶ <input checked="" type="checkbox"/></span>			
b	<b>33 1/3% support test—2015.</b> If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization <span>▶ <input type="checkbox"/></span>			
17a	<b>10%-facts-and-circumstances test—2016.</b> If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization <span>▶ <input type="checkbox"/></span>			
b	<b>10%-facts-and-circumstances test—2015.</b> If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization <span>▶ <input type="checkbox"/></span>			
18	<b>Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions <span>▶ <input type="checkbox"/></span>			

**Part III Support Schedule for Organizations Described in Section 509(a)(2)**

(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ►	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
<b>1</b> Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
<b>2</b> Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
<b>3</b> Gross receipts from activities that are not an unrelated trade or business under section 513						
<b>4</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
<b>5</b> The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>6 Total.</b> Add lines 1 through 5						
<b>7a</b> Amounts included on lines 1, 2, and 3 received from disqualified persons						
<b>b</b> Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
<b>c</b> Add lines 7a and 7b						
<b>8 Public support.</b> (Subtract line 7c from line 6.)						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►	(a)2012	(b)2013	(c)2014	(d)2015	(e)2016	(f)Total
<b>9</b> Amounts from line 6						
<b>10a</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
<b>b</b> Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
<b>c</b> Add lines 10a and 10b						
<b>11</b> Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
<b>12</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
<b>13 Total support.</b> (Add lines 9, 10c, 11, and 12.)						

**14 First five years.** If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ☐

**Section C. Computation of Public Support Percentage**

<b>15</b> Public support percentage for 2016 (line 8, column (f) divided by line 13, column (f))	<b>15</b>	
<b>16</b> Public support percentage from 2015 Schedule A, Part III, line 15	<b>16</b>	

**Section D. Computation of Investment Income Percentage**

<b>17</b> Investment income percentage for <b>2016</b> (line 10c, column (f) divided by line 13, column (f))	<b>17</b>	
<b>18</b> Investment income percentage from <b>2015</b> Schedule A, Part III, line 17	<b>18</b>	

**19a 33 1/3% support tests—2016.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ☐

**b 33 1/3% support tests—2015.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ☐

**20 Private foundation.** If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ☐

**Part IV Supporting Organizations**

(Complete only if you checked a box on line 12 of Part I. If you checked 12a of Part I, complete Sections A and B. If you checked 12b of Part I, complete Sections A and C. If you checked 12c of Part I, complete Sections A, D, and E. If you checked 12d of Part I, complete Sections A and D, and complete Part V.)

**Section A. All Supporting Organizations**

	Yes	No
<b>1</b> Are all of the organization's supported organizations listed by name in the organization's governing documents? <i>If "No," describe in <b>Part VI</b> how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.</i>	<b>1</b>	
<b>2</b> Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? <i>If "Yes," explain in <b>Part VI</b> how the organization determined that the supported organization was described in section 509(a)(1) or (2).</i>	<b>2</b>	
<b>3a</b> Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? <i>If "Yes," answer (b) and (c) below.</i>	<b>3a</b>	
<b>b</b> Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? <i>If "Yes," describe in <b>Part VI</b> when and how the organization made the determination.</i>	<b>3b</b>	
<b>c</b> Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? <i>If "Yes," explain in <b>Part VI</b> what controls the organization put in place to ensure such use.</i>	<b>3c</b>	
<b>4a</b> Was any supported organization not organized in the United States ("foreign supported organization")? <i>If "Yes" and if you checked 12a or 12b in Part I, answer (b) and (c) below.</i>	<b>4a</b>	
<b>b</b> Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? <i>If "Yes," describe in <b>Part VI</b> how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.</i>	<b>4b</b>	
<b>c</b> Did the organization support any foreign supported organization that does not have an IRS determination under sections 501(c)(3) and 509(a)(1) or (2)? <i>If "Yes," explain in <b>Part VI</b> what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.</i>	<b>4c</b>	
<b>5a</b> Did the organization add, substitute, or remove any supported organizations during the tax year? <i>If "Yes," answer (b) and (c) below (if applicable). Also, provide detail in <b>Part VI</b>, including (i) the names and EIN numbers of the supported organizations added, substituted, or removed, (ii) the reasons for each such action, (iii) the authority under the organization's organizing document authorizing such action, and (iv) how the action was accomplished (such as by amendment to the organizing document).</i>	<b>5a</b>	
<b>b</b> <b>Type I or Type II only.</b> Was any added or substituted supported organization part of a class already designated in the organization's organizing document?	<b>5b</b>	
<b>c</b> <b>Substitutions only.</b> Was the substitution the result of an event beyond the organization's control?	<b>5c</b>	
<b>6</b> Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? <i>If "Yes," provide detail in <b>Part VI</b>.</i>	<b>6</b>	
<b>7</b> Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>	<b>7</b>	
<b>8</b> Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>	<b>8</b>	
<b>9a</b> Was the organization controlled directly or indirectly at any time during the tax year by one or more disqualified persons as defined in section 4946 (other than foundation managers and organizations described in section 509(a)(1) or (2))? <i>If "Yes," provide detail in <b>Part VI</b>.</i>	<b>9a</b>	
<b>b</b> Did one or more disqualified persons (as defined in line 9a) hold a controlling interest in any entity in which the supporting organization had an interest? <i>If "Yes," provide detail in <b>Part VI</b>.</i>	<b>9b</b>	
<b>c</b> Did a disqualified person (as defined in line 9a) have an ownership interest in, or derive any personal benefit from, assets in which the supporting organization also had an interest? <i>If "Yes," provide detail in <b>Part VI</b>.</i>	<b>9c</b>	
<b>10a</b> Was the organization subject to the excess business holdings rules of section 4943 because of section 4943(f) (regarding certain Type II supporting organizations, and all Type III non-functionally integrated supporting organizations)? <i>If "Yes," answer line 10b below.</i>	<b>10a</b>	
<b>b</b> Did the organization have any excess business holdings in the tax year? <i>(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)</i>	<b>10b</b>	

**Part IV Supporting Organizations** (continued)

	Yes	No
<b>11</b> Has the organization accepted a gift or contribution from any of the following persons?		
<b>a</b> A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization?		
<b>b</b> A family member of a person described in (a) above?		
<b>c</b> A 35% controlled entity of a person described in (a) or (b) above? <i>If "Yes" to a, b, or c, provide detail in Part VI</i>		
<b>11a</b>		
<b>11b</b>		
<b>11c</b>		

**Section B. Type I Supporting Organizations**

	Yes	No
<b>1</b> Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? <i>If "No," describe in Part VI how the supported organization(s) effectively operated, supervised, or controlled the organization's activities. If the organization had more than one supported organization, describe how the powers to appoint and/or remove directors or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year.</i>		
<b>1</b>		
<b>2</b> Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? <i>If "Yes," explain in Part VI how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised or controlled the supporting organization.</i>		
<b>2</b>		

**Section C. Type II Supporting Organizations**

	Yes	No
<b>1</b> Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? <i>If "No," describe in Part VI how control or management of the supporting organization was vested in the same persons that controlled or managed the supported organization(s).</i>		
<b>1</b>		

**Section D. All Type III Supporting Organizations**

	Yes	No
<b>1</b> Did the organization provide to each of its supported organizations, by the last day of the fifth month of the organization's tax year, (i) a written notice describing the type and amount of support provided during the prior tax year, (ii) a copy of the Form 990 that was most recently filed as of the date of notification, and (iii) copies of the organization's governing documents in effect on the date of notification, to the extent not previously provided?		
<b>1</b>		
<b>2</b> Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization(s) or (ii) serving on the governing body of a supported organization? <i>If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s).</i>		
<b>2</b>		
<b>3</b> By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? <i>If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.</i>		
<b>3</b>		

**Section E. Type III Functionally-Integrated Supporting Organizations**

<b>1</b> Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions)		
<b>a</b> <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
<b>b</b> <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
<b>c</b> <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).		
<b>2</b> Activities Test <b>Answer (a) and (b) below.</b>		
<b>a</b> Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? <i>If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.</i>		
<b>2a</b>		
<b>b</b> Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? <i>If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.</i>		
<b>2b</b>		
<b>3</b> Parent of Supported Organizations <b>Answer (a) and (b) below.</b>		
<b>a</b> Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? <i>Provide details in Part VI.</i>		
<b>3a</b>		
<b>b</b> Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? <i>If "Yes," describe in Part VI the role played by the organization in this regard.</i>		
<b>3b</b>		

**Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations**

- 1** ☐ Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970. **See instructions.** All other Type III non-functionally integrated supporting organizations must complete Sections A through E.

**Section A - Adjusted Net Income**

	(A) Prior Year	(B) Current Year (optional)
<b>1</b> Net short-term capital gain	<b>1</b>	
<b>2</b> Recoveries of prior-year distributions	<b>2</b>	
<b>3</b> Other gross income (see instructions)	<b>3</b>	
<b>4</b> Add lines 1 through 3	<b>4</b>	
<b>5</b> Depreciation and depletion	<b>5</b>	
<b>6</b> Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	<b>6</b>	
<b>7</b> Other expenses (see instructions)	<b>7</b>	
<b>8 Adjusted Net Income</b> (subtract lines 5, 6 and 7 from line 4)	<b>8</b>	

**Section B - Minimum Asset Amount**

	(A) Prior Year	(B) Current Year (optional)
<b>1</b> Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year)	<b>1</b>	
<b>a</b> Average monthly value of securities	<b>1a</b>	
<b>b</b> Average monthly cash balances	<b>1b</b>	
<b>c</b> Fair market value of other non-exempt-use assets	<b>1c</b>	
<b>d Total</b> (add lines 1a, 1b, and 1c)	<b>1d</b>	
<b>e Discount</b> claimed for blockage or other factors (explain in detail in Part VI)		
<b>2</b> Acquisition indebtedness applicable to non-exempt use assets	<b>2</b>	
<b>3</b> Subtract line 2 from line 1d	<b>3</b>	
<b>4</b> Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions)	<b>4</b>	
<b>5</b> Net value of non-exempt-use assets (subtract line 4 from line 3)	<b>5</b>	
<b>6</b> Multiply line 5 by .035	<b>6</b>	
<b>7</b> Recoveries of prior-year distributions	<b>7</b>	
<b>8 Minimum Asset Amount</b> (add line 7 to line 6)	<b>8</b>	

**Section C - Distributable Amount**

		Current Year
<b>1</b> Adjusted net income for prior year (from Section A, line 8, Column A)	<b>1</b>	
<b>2</b> Enter 85% of line 1	<b>2</b>	
<b>3</b> Minimum asset amount for prior year (from Section B, line 8, Column A)	<b>3</b>	
<b>4</b> Enter greater of line 2 or line 3	<b>4</b>	
<b>5</b> Income tax imposed in prior year	<b>5</b>	
<b>6 Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	<b>6</b>	
<b>7</b> <input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)		

Part V

Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations (continued)

Section D - Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI) See instructions	
7 Total annual distributions. Add lines 1 through 6	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI) See instructions	
9 Distributable amount for 2016 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2016	(iii) Distributable Amount for 2016
1 Distributable amount for 2016 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2016 (reasonable cause required--see instructions)			
3 Excess distributions carryover, if any, to 2016			
a			
b			
c From 2013. . . . .			
d From 2014. . . . .			
e From 2015. . . . .			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2016 distributable amount			
i Carryover from 2011 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2016 from Section D, line 7 \$			
a Applied to underdistributions of prior years			
b Applied to 2016 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2016, if any Subtract lines 3g and 4a from line 2 (if amount greater than zero, see instructions)			
6 Remaining underdistributions for 2016 Subtract lines 3h and 4b from line 1 (if amount greater than zero, see instructions)			
7 Excess distributions carryover to 2017. Add lines 3j and 4c			
8 Breakdown of line 7			
a			
b Excess from 2013. . . . .			
c Excess from 2014. . . . .			
d Excess from 2015. . . . .			
e Excess from 2016. . . . .			



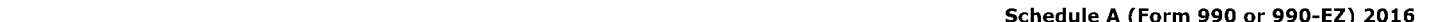
**Part VI Supplemental Information.**

Provide the explanations required by Part II, line 10; Part II, line 17a or 17b; Part III, line 12; Part IV, Section A, lines 1, 2, 3b, 3c, 4b, 4c, 5a, 6, 9a, 9b, 9c, 11a, 11b, and 11c; Part IV, Section B, lines 1 and 2; Part IV, Section C, line 1; Part IV, Section D, lines 2 and 3; Part IV, Section E, lines 1c, 2a, 2b, 3a and 3b; Part V, line 1; Part V, Section B, line 1e; Part V Section D, lines 5, 6, and 8; and Part V, Section E, lines 2, 5, and 6. Also complete this part for any additional information. (See instructions).

<b>Facts And Circumstances Test</b>
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**990 Schedule A, Supplemental Information**

Return Reference	Explanation
SCHEDULE A, PART I	<p>MEMBERS OF THE GROUP REASON FOR PUBLIC CHARITY STATUS BELOW</p> <p>MEMORIAL MEDICAL CENTER PART I LINE 3 HOSPITALS OR COOPERATIVE HOSPITAL SERVICE ORGANIZATION DESCRIBED IN SECTION 170(B) (1) (A) (III) PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION PART I LINE 3 HOSPITALS OR COOPERATIVE HOSPITAL SERVICE ORGANIZATION DESCRIBED IN SECTION 170(B) (1) (A) (III) JACKSONVILLE CRNA'S PART I LINE 10 AN ORGANIZATION THAT THE SUPPORT CRITERIA OF 509 (A)(2) AS SUPPORTED BY PART III OF SCHEDULE A ABRAHAM LINCOLN MEMORIAL HOSPITAL PART I LINE 3 HOSPITALS OR COOPERATIVE HOSPITAL SERVICE ORGANIZATION DESCRIBED IN SECTION 170(B) (1) (A) (III) TAYLORVILLE MEMORIAL HOSPITAL PART I LINE 3 HOSPITALS OR COOPERATIVE HOSPITAL SERVICE ORGANIZATION DESCRIBED IN SECTION 170(B) (1) (A) (III) MEMORIAL PHYSICIAN SERVICES PART I LINE 10 AN ORGANIZATION THAT THE SUPPORT CRITERIA OF 509 (A)(2) AS SUPPORTED BY PART III OF SCHEDULE A SPRINGFIELD RESIDENTIAL SERVICES PART I LINE 7 IS AN ORGANIZATION THAT NORMALLY RECEIVES A SUBSTANTIAL PART OF ITS SUPPORT FROM A GOVERNMENTAL UNIT OR FROM THE GENERAL PUBLIC DESCRIBED IN SECTION 170(B)(1)(A)(VI) MEMORIAL HOME SERVICES PART I LINE 7 IS AN ORGANIZATION THAT NORMALLY RECEIVES A SUBSTANTIAL PART OF ITS SUPPORT FROM A GOVERNMENTAL UNIT OR FROM THE GENERAL PUBLIC DESCRIBED IN SECTION 170(B)(1)(A)(VI) MEMORIAL HEALTH VENTURES PART I LINE 10 AN ORGANIZATION THAT THE SUPPORT CRITERIA OF 509 (A)(2) AS SUPPORTED BY PART III OF SCHEDULE A MEMORIAL MEDICAL CENTER FOUNDATION PART I LINE 7 IS AN ORGANIZATION THAT NORMALLY RECEIVES A SUBSTANTIAL PART OF ITS SUPPORT FROM A GOVERNMENTAL UNIT OR FROM THE GENERAL PUBLIC DESCRIBED IN SECTION 170(B)(1)(A)(VI) PASSAVANT AREA HOSPITAL FOUNDATION PART I LINE 7 IS AN ORGANIZATION THAT NORMALLY RECEIVES A SUBSTANTIAL PART OF ITS SUPPORT FROM A GOVERNMENTAL UNIT OR FROM THE GENERAL PUBLIC DESCRIBED IN SECTION 170(B)(1)(A)(VI) TAYLORVILLE MEMORIAL HOSPITAL FOUNDATION PART I LINE 7 IS AN ORGANIZATION THAT NORMALLY RECEIVES A SUBSTANTIAL PART OF ITS SUPPORT FROM A GOVERNMENTAL UNIT OR FROM THE GENERAL PUBLIC DESCRIBED IN SECTION 170(B)(1)(A)(VI)</p>



**SCHEDULE C**  
(Form 990 or 990-EZ)

Department of the Treasury  
Internal Revenue Service

**Political Campaign and Lobbying Activities**

For Organizations Exempt From Income Tax Under section 501(c) and section 527  
▶ **Complete if the organization is described below.** ▶ **Attach to Form 990 or Form 990-EZ.**  
▶ **Information about Schedule C (Form 990 or 990-EZ) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).**

OMB No 1545-0047

**2016**

**Open to Public Inspection**

**If the organization answered "Yes" on Form 990, Part IV, Line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then**

- Section 501(c)(3) organizations Complete Parts I-A and B Do not complete Part I-C
- Section 501(c) (other than section 501(c)(3)) organizations Complete Parts I-A and C below Do not complete Part I-B
- Section 527 organizations Complete Part I-A only

**If the organization answered "Yes" on Form 990, Part IV, Line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then**

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)) Complete Part II-A Do not complete Part II-B
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)) Complete Part II-B Do not complete Part II-A

**If the organization answered "Yes" on Form 990, Part IV, Line 5 (Proxy Tax) (see separate instructions) or Form 990-EZ, Part V, line 35c (Proxy Tax) (see separate instructions), then**

- Section 501(c)(4), (5), or (6) organizations Complete Part III

Name of the organization MEMORIAL HEALTH SYSTEM GROUP	Employer identification number 90-0756744
--	--

**Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.**

<b>1</b>	Provide a description of the organization's direct and indirect political campaign activities in Part IV	
<b>2</b>	Political expenditures	▶ \$
<b>3</b>	Volunteer hours	

**Part I-B Complete if the organization is exempt under section 501(c)(3).**

<b>1</b>	Enter the amount of any excise tax incurred by the organization under section 4955	▶ \$
<b>2</b>	Enter the amount of any excise tax incurred by organization managers under section 4955	▶ \$
<b>3</b>	If the organization incurred a section 4955 tax, did it file Form 4720 for this year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>4a</b>	Was a correction made?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>b</b>	If "Yes," describe in Part IV	

**Part I-C Complete if the organization is exempt under section 501(c), except section 501(c)(3).**

<b>1</b>	Enter the amount directly expended by the filing organization for section 527 exempt function activities	▶ \$
<b>2</b>	Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities	▶ \$
<b>3</b>	Total exempt function expenditures Add lines 1 and 2 Enter here and on Form 1120-POL, line 17b	▶ \$
<b>4</b>	Did the filing organization file Form 1120-POL for this year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>5</b>	Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments For each organization listed, enter the amount paid from the filing organization's funds Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC) If additional space is needed, provide information in Part IV	

(a) Name	(b) Address	(c) EIN	(d) Amount paid from filing organization's funds If none, enter -0-	(e) Amount of political contributions received and promptly and directly delivered to a separate political organization If none, enter -0-
2				
3				
4				
5				
6				

**Part II-A** Complete if the organization is exempt under section 501(c)(3) and filed Form 5768 (election under section 501(h)).

**A** Check ☐ if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures)

**B** Check ☐ if the filing organization checked box A and "limited control" provisions apply

**Limits on Lobbying Expenditures**  
(The term "expenditures" means amounts paid or incurred.)**(a)** Filing  
organization's  
totals**(b)** Affiliated  
group totals

**1a** Total lobbying expenditures to influence public opinion (grass roots lobbying)

**b** Total lobbying expenditures to influence a legislative body (direct lobbying)

**c** Total lobbying expenditures (add lines 1a and 1b)

**d** Other exempt purpose expenditures

**e** Total exempt purpose expenditures (add lines 1c and 1d)

**f** Lobbying nontaxable amount Enter the amount from the following table in both columns

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
Not over \$500,000	20% of the amount on line 1e
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000
Over \$17,000,000	\$1,000,000

**g** Grassroots nontaxable amount (enter 25% of line 1f)

**h** Subtract line 1g from line 1a If zero or less, enter -0-

**i** Subtract line 1f from line 1c If zero or less, enter -0-

**j** If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?

☐ Yes ☐ No**4-Year Averaging Period Under section 501(h)**

(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the separate instructions for lines 2a through 2f.)

**Lobbying Expenditures During 4-Year Averaging Period**

Calendar year (or fiscal year beginning in)	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) Total
<b>2a</b> Lobbying nontaxable amount					
<b>b</b> Lobbying ceiling amount (150% of line 2a, column(e))					
<b>c</b> Total lobbying expenditures					
<b>d</b> Grassroots nontaxable amount					
<b>e</b> Grassroots ceiling amount (150% of line 2d, column (e))					
<b>f</b> Grassroots lobbying expenditures					

**Part II-B Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).**

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity

		(a)		(b)
		Yes	No	Amount
<b>1</b>	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
<b>a</b>	Volunteers?		No	
<b>b</b>	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
<b>c</b>	Media advertisements?		No	
<b>d</b>	Mailings to members, legislators, or the public?		No	
<b>e</b>	Publications, or published or broadcast statements?		No	
<b>f</b>	Grants to other organizations for lobbying purposes?	Yes		124,080
<b>g</b>	Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
<b>h</b>	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
<b>i</b>	Other activities?		No	
<b>j</b>	Total. Add lines 1c through 1i			124,080
<b>2a</b>	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
<b>b</b>	If "Yes," enter the amount of any tax incurred under section 4912			
<b>c</b>	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
<b>d</b>	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

**Part III-A Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).**

		Yes	No
<b>1</b>	Were substantially all (90% or more) dues received nondeductible by members?	<b>1</b>	
<b>2</b>	Did the organization make only in-house lobbying expenditures of \$2,000 or less?	<b>2</b>	
<b>3</b>	Did the organization agree to carry over lobbying and political expenditures from the prior year?	<b>3</b>	

**Part III-B Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No" OR (b) Part III-A, line 3, is answered "Yes."**

<b>1</b>	Dues, assessments and similar amounts from members	<b>1</b>	
<b>2</b>	Section 162(e) nondeductible lobbying and political expenditures (do not include amounts of political expenses for which the section 527(f) tax was paid).	<b>2a</b>	
<b>a</b>	Current year	<b>2b</b>	
<b>b</b>	Carryover from last year	<b>2c</b>	
<b>c</b>	Total	<b>3</b>	
<b>3</b>	Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	<b>4</b>	
<b>4</b>	If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?	<b>5</b>	
<b>5</b>	Taxable amount of lobbying and political expenditures (see instructions)		

**Part IV Supplemental Information**

Provide the descriptions required for Part I-A, line 1, Part I-B, line 4, Part I-C, line 5, Part II-A (affiliated group list), Part II-A, lines 1 and 2 (see instructions), and Part II-B, line 1. Also, complete this part for any additional information.

Return Reference	Explanation
PART II-B, LINE 1	MEMORIAL HEALTH SYSTEM ENGAGES LOBBYISTS TO ASSIST IT IN SECURING FEDERAL GRANTS AND MONITORING STATE REGULATIONS IN SUPPORT OF FURTHERING MEMORIAL HEALTH SYSTEM'S MISSION, WHICH IS "TO IMPROVE THE HEALTH OF THE PEOPLE AND COMMUNITIES WE SERVE" THIS INCLUDES ASSISTING MEMORIAL HEALTH SYSTEM IN DEVELOPING PRESENTATIONS TO THE ILLINOIS CONGRESSIONAL DELEGATION REQUESTING APPROPRIATIONS FOR PRIORITY PROJECTS INVOLVING LOCAL PATIENT SAFETY, QUALITY IMPROVEMENT AND IMPROVED LOCAL ACCESS TO MEDICAL CARE THE LOBBYISTS ALSO ASSIST MEMORIAL IN COMMUNICATING THE IMPORTANCE OF ADEQUATE MEDICAID FUNDING IN SUPPORT OF THE SUBSTANTIAL SERVICES MEMORIAL'S AFFILIATES PROVIDE TO THOSE IN POVERTY AND IN MONITORING LEGISLATIVE AND REGULATORY DEVELOPMENTS THAT WOULD AFFECT MEMORIAL MEDICAL CENTER'S ABILITY TO CONTINUE DELIVERING ITS ALREADY SUBSTANTIAL COMMUNITY BENEFIT THE FOLLOWING ORGANIZATIONS PAID FUNDS TO HEALTHCARE ASSOCIATIONS TO AID AND ASSIST HOSPITALS AND HEALTHCARE ENTITIES REGARDING LEGISLATIVE CHANGES THESE COSTS INCLUDE AMOUNTS PAID DIRECTLY TO LOBBYISTS FROM THE VARIOUS ENTITIES AND ALSO INCLUDE AMOUNTS PAID INDIRECTLY TO LOBBYISTS THROUGH ASSOCIATION DUES MEMORIAL MEDICAL CENTER - \$54,355 PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION - \$24,981 ABRAHAM LINCOLN MEMORIAL HOSPITAL - \$17,102 MEMORIAL PHYSICIAN SERVICES - \$ 1,701 MEMORIAL HOME SERVICES - \$ 4,543 TAYLORVILLE MEMORIAL HOSPITAL - \$21,398

efile GRAPHIC print - DO NOT PROCESS		As Filed Data -		DLN: 93493226009978	
<div>SCHEDULE D (Form 990)</div> <div>Department of the Treasury Internal Revenue Service</div>		<div>Supplemental Financial Statements</div> <div>► Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b. ► Attach to Form 990.</div> <div>Information about Schedule D (Form 990) and its instructions is at <a href="http://www.irs.gov/form990">www.irs.gov/form990</a>.</div>			<div>OMB No 1545-0047</div> <div>2016</div> <div>Open to Public Inspection</div>
Name of the organization MEMORIAL HEALTH SYSTEM GROUP				Employer identification number 90-0756744	
Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" on Form 990, Part IV, line 6.					
		(a) Donor advised funds		(b) Funds and other accounts	
1	Total number at end of year				
2	Aggregate value of contributions to (during year)				
3	Aggregate value of grants from (during year)				
4	Aggregate value at end of year				
5	Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?				<input type="checkbox"/> Yes <input type="checkbox"/> No
6	Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Part II Conservation Easements. Complete if the organization answered "Yes" on Form 990, Part IV, line 7.					
1	Purpose(s) of conservation easements held by the organization (check all that apply) <input type="checkbox"/> Preservation of land for public use (e g , recreation or education) <input type="checkbox"/> Preservation of an historically important land area <input type="checkbox"/> Protection of natural habitat <input type="checkbox"/> Preservation of a certified historic structure <input type="checkbox"/> Preservation of open space				
2	Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year				
a	Total number of conservation easements	Held at the End of the Year			
b	Total acreage restricted by conservation easements	2a			
c	Number of conservation easements on a certified historic structure included in (a)	2b			
d	Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2c			
		2d			
3	Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ►				
4	Number of states where property subject to conservation easement is located ►				
5	Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?				<input type="checkbox"/> Yes <input type="checkbox"/> No
6	Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ►				
7	Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ► \$				
8	Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?				<input type="checkbox"/> Yes <input type="checkbox"/> No
9	In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements				
Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets. Complete if the organization answered "Yes" on Form 990, Part IV, line 8.					
1a	If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items				
b	If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items				
(i) Revenue included on Form 990, Part VIII, line 1		► \$			
(ii) Assets included in Form 990, Part X		► \$			
2	If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items				
a	Revenue included on Form 990, Part VIII, line 1	► \$			
b	Assets included in Form 990, Part X	► \$			
For Paperwork Reduction Act Notice, see the Instructions for Form 990.					
		Cat No 52283D		Schedule D (Form 990) 2016	

Part III

Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets (continued)

3

Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply)

a

☐ Public exhibition

b

☐ Scholarly research

c

☐ Preservation for future generations

d

☐ Loan or exchange programs

e

☐ Other

4

Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII

5

During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection?

☐ Yes

☐ No

Part IV

Escrow and Custodial Arrangements.

Complete if the organization answered "Yes" on Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

1a

Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X?

☐ Yes

☐ No

b

If "Yes," explain the arrangement in Part XIII and complete the following table

c

Beginning balance

d

Additions during the year

e

Distributions during the year

f

Ending balance

	Amount
1c	
1d	
1e	
1f	

2a

Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability?

☐ Yes

☐ No

b

If "Yes," explain the arrangement in Part XIII Check here if the explanation has been provided in Part XIII

☐

Part V

Endowment Funds. Complete if the organization answered "Yes" on Form 990, Part IV, line 10.

	(a)Current year	(b)Prior year	(c)Two years back	(d)Three years back	(e)Four years back
1a Beginning of year balance	12,076,607	12,661,077	12,566,252	11,521,169	10,981,342
b Contributions	17,776	14,970	1,107,070	501,283	264,661
c Net investment earnings, gains, and losses	1,356,991	677,746	-470,568	1,052,498	723,768
d Grants or scholarships	22,103	904,938	189,207	123,660	
e Other expenditures for facilities and programs	298,395	280,079	263,145	304,976	374,978
f Administrative expenses	92,851	92,169	89,325	80,062	73,624
g End of year balance	13,038,025	12,076,607	12,661,077	12,566,252	11,521,169

2

Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as

a

Board designated or quasi-endowment

10 190 %

b

Permanent endowment

69 550 %

c

Temporarily restricted endowment

20 260 %

The percentages on lines 2a, 2b, and 2c should equal 100%

3a

Are there endowment funds not in the possession of the organization that are held and administered for the organization by

(i) unrelated organizations

3a(i)

Yes

No

(ii) related organizations

3a(ii)

Yes

b

If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R?

3b

Yes

4

Describe in Part XIII the intended uses of the organization's endowment funds

Part VI

Land, Buildings, and Equipment.

Complete if the organization answered 'Yes' on Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land	6,740,917	9,232,529		15,973,446
b Buildings	3,183,033	437,603,360	206,842,877	233,943,516
c Leasehold improvements		11,754,303	6,285,610	5,468,693
d Equipment	5,623	268,593,870	191,930,273	76,669,220
e Other		69,433,127	21,350,356	48,082,771
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c))				380,137,646

Schedule D (Form 990) 2016

Part VII

Investments—Other Securities. Complete if the organization answered 'Yes' on Form 990, Part IV, line 11b.  
See Form 990, Part X, line 12.

(a) Description of security or category (including name of security)	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1) Financial derivatives . . . . .		
(2) Closely-held equity interests . . . . .		
(3) Other _____		
(A)		
(B)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Column (b) must equal Form 990, Part X, col (B) line 12.) ▶		

Part VIII

Investments—Program Related. Complete if the organization answered 'Yes' on Form 990, Part IV, line 11c.  
See Form 990, Part X, line 13.

(a) Description of investment	(b) Book value	(c) Method of valuation Cost or end-of-year market value
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. (Column (b) must equal Form 990, Part X, col (B) line 13.) ▶		

Part IX

Other Assets. Complete if the organization answered 'Yes' on Form 990, Part IV, line 11d See Form 990, Part X, line 15

(a) Description	(b) Book value
See Additional Data Table	
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 15.) . . . . . ▶	97,403,474

Part X

Other Liabilities. Complete if the organization answered 'Yes' on Form 990, Part IV, line 11e or 11f.  
See Form 990, Part X, line 25.

1. (a) Description of liability	(b) Book value	
(1) Federal income taxes		
See Additional Data Table		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
Total. (Column (b) must equal Form 990, Part X, col (B) line 25.) ▶	392,210,249	

2. Liability for uncertain tax positions In Part XIII, provide the text of the footnote to the organization's financial statements that reports the organization's liability for uncertain tax positions under FIN 48 (ASC 740) Check here if the text of the footnote has been provided in Part XIII

☒



**Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return**

Complete if the organization answered 'Yes' on Form 990, Part IV, line 12a.

<b>1</b>	Total revenue, gains, and other support per audited financial statements . . . . .	<b>1</b>	
<b>2</b>	Amounts included on line 1 but not on Form 990, Part VIII, line 12		
<b>a</b>	Net unrealized gains (losses) on investments . . . . .	<b>2a</b>	
<b>b</b>	Donated services and use of facilities . . . . .	<b>2b</b>	
<b>c</b>	Recoveries of prior year grants . . . . .	<b>2c</b>	
<b>d</b>	Other (Describe in Part XIII ) . . . . .	<b>2d</b>	
<b>e</b>	Add lines <b>2a</b> through <b>2d</b> . . . . .	<b>2e</b>	
<b>3</b>	Subtract line <b>2e</b> from line <b>1</b> . . . . .	<b>3</b>	
<b>4</b>	Amounts included on Form 990, Part VIII, line 12, but not on line <b>1</b>		
<b>a</b>	Investment expenses not included on Form 990, Part VIII, line 7b . . . . .	<b>4a</b>	
<b>b</b>	Other (Describe in Part XIII ) . . . . .	<b>4b</b>	
<b>c</b>	Add lines <b>4a</b> and <b>4b</b> . . . . .	<b>4c</b>	
<b>5</b>	Total revenue Add lines <b>3</b> and <b>4c</b> . (This must equal Form 990, Part I, line 12 ) . . . . .	<b>5</b>	

**Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.**

Complete if the organization answered 'Yes' on Form 990, Part IV, line 12a.

<b>1</b>	Total expenses and losses per audited financial statements . . . . .	<b>1</b>	
<b>2</b>	Amounts included on line 1 but not on Form 990, Part IX, line 25		
<b>a</b>	Donated services and use of facilities . . . . .	<b>2a</b>	
<b>b</b>	Prior year adjustments . . . . .	<b>2b</b>	
<b>c</b>	Other losses . . . . .	<b>2c</b>	
<b>d</b>	Other (Describe in Part XIII ) . . . . .	<b>2d</b>	
<b>e</b>	Add lines <b>2a</b> through <b>2d</b> . . . . .	<b>2e</b>	
<b>3</b>	Subtract line <b>2e</b> from line <b>1</b> . . . . .	<b>3</b>	
<b>4</b>	Amounts included on Form 990, Part IX, line 25, but not on line <b>1</b> :		
<b>a</b>	Investment expenses not included on Form 990, Part VIII, line 7b . . . . .	<b>4a</b>	
<b>b</b>	Other (Describe in Part XIII ) . . . . .	<b>4b</b>	
<b>c</b>	Add lines <b>4a</b> and <b>4b</b> . . . . .	<b>4c</b>	
<b>5</b>	Total expenses Add lines <b>3</b> and <b>4c</b> . (This must equal Form 990, Part I, line 18 ) . . . . .	<b>5</b>	

**Part XIII Supplemental Information**

Provide the descriptions required for Part II, lines 3, 5, and 9, Part III, lines 1a and 4, Part IV, lines 1b and 2b, Part V, line 4, Part X, line 2, Part XI, lines 2d and 4b, and Part XII, lines 2d and 4b. Also complete this part to provide any additional information.

Return Reference	Explanation
See Additional Data Table	

**Part XIII** Supplemental Information *(continued)*

Return Reference	Explanation

Additional Data

Software ID:

Software Version:

EIN: 90-0756744

Name: MEMORIAL HEALTH SYSTEM GROUP

Form 990, Schedule D, Part IX, - Other Assets

(a) Description	(b) Book value
(1) UNAMORTIZED BOND DISCOUNTS AND ISSUE COSTS	967,788
(2) DUE FROM AFFILIATES	643,149
(3) BENEFICIAL INTEREST IN TRUSTS	49,012,055
(4) INSURANCE RECOVERIES	2,708,306
(5) NET EDUCATIONAL GRANTS/TUITION REIMBURSEMENT RECEIVABLE	104,967
(6) AR CLEARING	163,580
(7) CHARITABLE REMAINDER TRUST	239
(8) CASH SURRENDER VALUE OF LIFE INSURANCE	149,802
(9) REAL ESTATE INVESTMENT	2,202,719
(10) LONG TERM ASSET	635,000
(11) LONG TERM PLEDGE RECEIVABLE	1,505,893
(12) PHYSICIAN LOANS	173,811
(13) FARM LAND	16,626,922
(14) INTEREST IN NET ASSETS OF PAHF	4,553,534
(15) MALPRACTICE RECEIVABLE	1,690,807
(16) WORKERS COMP RECEIVABLE	145,357
(17) MINIMUM PENSION ASSET	4,942,445
(18) DUE FROM THIRD-PARTY PAYOR	177,342
(19) MCDEKK NOTES RECEIVABLE	10,999,758

Form 990, Schedule D, Part X, - Other Liabilities

1 (a) Description of Liability	(b) Book Value
DEFERRED COMPENSATION	4,101,592
ESTIMATED THIRD PARTY PAYOR SETTLEMENTS	40,187,296
MINIMUM PENSION LIABILITY	2,303,675
RESERVE FOR POST EMPLOYMENT BENEFITS	14,020,988
SWAP LIABILITY	3,166,609
WORKERS' COMPENSATION AND PROFESSIONAL LIABILITY	29,827,567
ENVIRONMENTAL HAZARDS LIABILITY	1,997,537
DUE TO AFFILIATES	2,597,125
CHARITABLE GIFT ANNUITY PAYABLE	195,536
TENANT SECURITY DEPOSITS	138,972

**Form 990, Schedule D, Part X, - Other Liabilities**

<b>1</b> <b>(a)</b> Description of Liability	<b>(b)</b> Book Value
OTHER PAYABLES	106,026
SELF INSURANCE ACCRUAL	905,225
SERP/RESTORATION PENSION PLAN	2,381,930
INTERCOMPANY DEBT TO MEMORIAL HEALTH SYSTEM (37-1110690)	290,280,171

**Supplemental Information**

Return Reference	Explanation
PART V, LINE 4	<p>PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION'S ENDOWMENT CONSISTS OF 10 DONOR-RESTRICTED FUNDS WITH INCOME TO BE USED FOR CAPITAL PURCHASES, OPERATIONS, SCHOLARSHIPS, AND INDIGENT CARE MEMORIAL HOME SERVICES PERMANENTLY RESTRICTED ENDOWMENT FUND WITH INCOME TO BE USED FOR OPERATING EXPENSES MEMORIAL MEDICAL CENTER'S FOUNDATION ENDOWMENT CONSISTS OF 36 INDIVIDUAL DONOR-RESTRICTED FUNDS ESTABLISHED FOR A VARIETY OF PURPOSES THE FOUNDATION HAS A POLICY OF APPROPRIATING FOR DISTRIBUTION EACH YEAR 5% OF ITS ENDOWMENT FUND'S MOVING AVERAGE FAIR VALUE OVER THE PRIOR 36 MONTHS AS OF SEPTEMBER 30 OF THE PRECEDING FISCAL YEAR IN WHICH THE DISTRIBUTION IS PLANNED IN ESTABLISHING THIS POLICY, THE FOUNDATION CONSIDERED THE LONG-TERM EXPECTED RETURN ON ITS ENDOWMENTS ACCORDINGLY, OVER THE LONG TERM THE FOUNDATION EXPECTS THE CURRENT SPENDING POLICY TO ALLOW ITS ENDOWMENT TO GROW AT AN AVERAGE OF THE LONG-TERM RATE OF INFLATION TAYLORVILLE MEMORIAL HOSPITAL FOUNDATION'S NET INCOME REALIZED FROM THE FUND SHALL BE DISTRIBUTED AT LEAST ANNUALLY TO, FOR OR ON BEHALF OF ONE OR MORE GRADUATES FROM HIGH SCHOOLS IN CHRISTIAN COUNTY, ILLINOIS, WHO ARE ENROLLED IN ADVANCED STUDY AND EXHIBIT A DESIRE TO PURSUE A COURSE LEADING TO A DEGREE THAT WOULD BENEFIT TAYLORVILLE MEMORIAL HOSPITAL PASSAVANT AREA HOSPITAL FOUNDATION HAS TWO PERMANENTLY RESTRICTED ENDOWMENT FUNDS WITH INCOME TO BE USED AS THE GOVERNING BODY DEEMS FIT PAHF HAS ONE TEMPORARILY RESTRICTED ENDOWMENT FUND THAT'S INCOME IS TO BE USED FOR A SPECIFIC PURPOSE</p>

**Supplemental Information**

Return Reference	Explanation
PART X, LINE 2	<p>THE AUTHORITATIVE GUIDANCE IN ASC 740, INCOME TAXES, CREATES A SINGLE MODEL TO ADDRESS UNCERTAINTY IN TAX POSITIONS AND CLARIFIES THE ACCOUNTING FOR INCOME TAXES BY PRESCRIBING THE MINIMUM RECOGNITION THRESHOLD A TAX POSITION IS REQUIRED TO MEET BEFORE BEING RECOGNIZED IN THE FINANCIAL STATEMENTS UNDER THE REQUIREMENTS OF THIS GUIDANCE, TAX-EXEMPT ORGANIZATIONS COULD BE REQUIRED TO RECORD AN OBLIGATION AS THE RESULT OF A TAX POSITION THEY HAVE HISTORICALLY TAKEN ON VARIOUS TAX EXPOSURE ITEMS EACH OF MHS'S SUBSIDIARIES, EXCLUDING THOSE DESCRIBED IN THE FOLLOWING PARAGRAPH, IS A SEPARATELY INCORPORATED NOT-FOR-PROFIT CORPORATION AS DESCRIBED UNDER SECTION 501(C)(3) OF THE CODE AND IS TAX-EXEMPT FROM FEDERAL INCOME TAXES ON RELATED INCOME PURSUANT TO SECTION 501(A) OF THE CODE THEY DO, HOWEVER, OPERATE CERTAIN PROGRAMS THAT MAY RESULT IN UNRELATED BUSINESS INCOME UPON REVIEW AS REQUIRED BY ASC 740, INCOME TAX NO TAX PROVISION WAS RECORDED FOR THE YEARS ENDED SEPTEMBER 30, 2017 OR 2016 MEMORIAL PROPERTIES (MP), MEMORIAL HEALTH PARTNERS (MHP), MHS QALICB, LLC (QALICB), AND MCDEKK, LLC (MCDEKK) ARE CONSIDERED DISREGARDED ENTITIES FOR TAX PURPOSES AND ARE EXEMPT FROM INCOME TAX MEMORIAL HOME SERVICES OF CENTRAL ILLINOIS (MHSCI) IS A TAXABLE FOR-PROFIT CORPORATION AND PASSAVANT PHYSICIAN ASSOCIATION (PPA) IS A TAXABLE NOT-FOR-PROFIT CORPORATION BOTH ARE SUBJECT TO FEDERAL AND STATE INCOME TAXES</p>

SCHEDULE G (Form 990 or 990-EZ)	<div>Supplemental Information Regarding Fundraising or Gaming Activities</div> <div>Complete if the organization answered "Yes" on Form 990, Part IV, lines 17, 18, or 19, or if the organization entered more than \$15,000 on Form 990-EZ, line 6a</div> <div>▶ Attach to Form 990 or Form 990-EZ.</div> <div>▶ Information about Schedule G (Form 990 or 990-EZ) and its instructions is at <a href="http://www.irs.gov/form990">www.irs.gov/form990</a>.</div>	OMB No 1545-0047
		2016
		Open to Public Inspection

Department of the Treasury Internal Revenue Service	Name of the organization MEMORIAL HEALTH SYSTEM GROUP	Employer identification number 90-0756744
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Part I Fundraising Activities

Complete if the organization answered "Yes" on Form 990, Part IV, line 17.  
Form 990-EZ filers are not required to complete this part.

1 Indicate whether the organization raised funds through any of the following activities. Check all that apply.

a <input type="checkbox"/> Mail solicitations	e <input type="checkbox"/> Solicitation of non-government grants
b <input type="checkbox"/> Internet and email solicitations	f <input type="checkbox"/> Solicitation of government grants
c <input type="checkbox"/> Phone solicitations	g <input type="checkbox"/> Special fundraising events
d <input type="checkbox"/> In-person solicitations	

2a Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services? ☐ Yes ☐ No

b If "Yes," list the ten highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least \$5,000 by the organization.

(i) Name and address of individual or entity (fundraiser)	(ii) Activity	(iii) Did fundraiser have custody or control of contributions?		(iv) Gross receipts from activity	(v) Amount paid to (or retained by) fundraiser listed in col (i)	(vi) Amount paid to (or retained by) organization
		Yes	No			
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
Total ▶						

3 List all states in which the organization is registered or licensed to solicit contributions or has been notified it is exempt from registration or licensing.

**Part II Fundraising Events.** Complete if the organization answered "Yes" on Form 990, Part IV, line 18, or reported more than \$15,000 of fundraising event contributions and gross income on Form 990-EZ, lines 1 and 6b. List events with gross receipts greater than \$5,000.

Revenue		(a) Event #1 <b>FESTIVAL OF TREES (MMCF)</b> (event type)	(b) Event #2 <b>SHARING WISHES HOSPICE GALA</b> (event type)	(c) Other events <b>5</b> (total number)	(d) Total events (add col (a) through col (c))
<b>1</b>	Gross receipts . . . . .	580,237	68,917	60,272	709,426
<b>2</b>	Less Contributions . . . . .	199,426	63,007	23,972	286,405
<b>3</b>	Gross income (line 1 minus line 2) . . . . .	380,811	5,910	36,300	423,021
Direct Expenses	<b>4</b> Cash prizes . . . . .				
	<b>5</b> Noncash prizes . . . . .	64,482		6,699	71,181
	<b>6</b> Rent/facility costs . . . . .	12,770	5,939	3,165	21,874
	<b>7</b> Food and beverages . . . . .	61,056	11,297	4,151	76,504
	<b>8</b> Entertainment . . . . .	600	8,250	600	9,450
	<b>9</b> Other direct expenses . . . . .	82,263	2,685	15,806	100,754
	<b>10</b> Direct expense summary Add lines 4 through 9 in column (d) . . . . . ▶				279,763
	<b>11</b> Net income summary Subtract line 10 from line 3, column (d) . . . . . ▶				143,258

**Part III Gaming.** Complete if the organization answered "Yes" on Form 990, Part IV, line 19, or reported more than \$15,000 on Form 990-EZ, line 6a.

Revenue		(a) Bingo	(b) Pull tabs/Instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col (a) through col (c))
<b>1</b>	Gross revenue . . . . .			19,487	19,487
Direct Expenses	<b>2</b> Cash prizes . . . . .			2,625	2,625
	<b>3</b> Noncash prizes . . . . .				
	<b>4</b> Rent/facility costs . . . . .				
	<b>5</b> Other direct expenses . . . . .			4,251	4,251
	<b>6</b> Volunteer labor . . . . .	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes 100.000 % <input type="checkbox"/> No	
	<b>7</b> Direct expense summary Add lines 2 through 5 in column (d) . . . . . ▶				6,876
	<b>8</b> Net gaming income summary Subtract line 7 from line 1, column (d) . . . . . ▶				12,611

**9** Enter the state(s) in which the organization conducts gaming activities IL

**a** Is the organization licensed to conduct gaming activities in each of these states?

☒ Yes ☐ No

**b** If "No," explain \_\_\_\_\_

**10a** Were any of the organization's gaming licenses revoked, suspended or terminated during the tax year?

☐ Yes ☒ No

**b** If "Yes," explain \_\_\_\_\_



- 11** Does the organization conduct gaming activities with nonmembers? ☒ **Yes** ☐ **No**
- 12** Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming? ☐ **Yes** ☒ **No**
- 13** Indicate the percentage of gaming activity conducted in
- |                                      |            |           |
|--------------------------------------|------------|-----------|
| <b>a</b> The organization's facility | <b>13a</b> | %         |
| <b>b</b> An outside facility         | <b>13b</b> | 100 000 % |
- 14** Enter the name and address of the person who prepares the organization's gaming/special events books and records

Name ▶ JAN FELLHAUER

Address ▶ 1600 W WALNUT  
JACKSONVILLE, IL 62650

- 15a** Does the organization have a contract with a third party from whom the organization receives gaming revenue? ☐ **Yes** ☒ **No**
- b** If "Yes," enter the amount of gaming revenue received by the organization ▶ \$ \_\_\_\_\_ and the amount of gaming revenue retained by the third party ▶ \$ \_\_\_\_\_
- c** If "Yes," enter name and address of the third party

Name ▶ \_\_\_\_\_

Address ▶ \_\_\_\_\_

**16** Gaming manager information

Name ▶ JAN FELLHAUER

Gaming manager compensation ▶ \$ 7,354

Description of services provided ▶ MANAGING DUCK RACE EVENT

☐ Director/officer
 ☒ Employee
 ☐ Independent contractor
**17** Mandatory distributions

- a** Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license? ☐ **Yes** ☒ **No**
- b** Enter the amount of distributions required under state law distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ \$ \_\_\_\_\_

**Part IV Supplemental Information.** Provide the explanations required by Part I, line 2b, columns (iii) and (v); and Part III, lines 9, 9b, 10b, 15b, 15c, 16, and 17b, as applicable. Also complete this part to provide any additional information (see instructions).

Return Reference

Explanation

SCHEDULE H  
(Form 990)

Hospitals

OMB No 1545-0047

2016

Open to Public Inspection

► 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).

Department of the Treasury

Name of the organization

MEMORIAL HEALTH SYSTEM GROUP

Employer identification number

90-0756744

Part I

Financial Assistance and Certain Other Community Benefits at Cost

	Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a Yes	
b If "Yes," was it a written policy?	1b Yes	
2 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		
3 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		
a 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	3a Yes	
<input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other 30000 0000000000 %		
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	3b Yes	
<input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other 30100 0000000000 %		
c 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		
4 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"?	4 Yes	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a Yes	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b Yes	
c 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?	5c	No
6a Did the organization prepare a community benefit report during the tax year?	6a Yes	
b If "Yes," did the organization make it available to the public?	6b Yes	
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

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
a Financial Assistance at cost (from Worksheet 1)			11,154,800		11,154,800	1 190 %
b Medicaid (from Worksheet 3, column a)			155,207,066	113,653,983	41,553,083	4 440 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			166,361,866	113,653,983	52,707,883	5 630 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			2,107,043	260	2,106,783	0 220 %
f Health professions education (from Worksheet 5)			11,946,388	3,729,252	8,217,136	0 880 %
g Subsidized health services (from Worksheet 6)			22,828,600		22,828,600	2 440 %
h Research (from Worksheet 7)			310,175		310,175	0 030 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)			40,648,513		40,648,513	4 340 %
j Total. Other Benefits			77,840,719	3,729,512	74,111,207	7 910 %
k Total. Add lines 7d and 7j			244,202,585	117,383,495	126,819,090	13 540 %

**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
<b>1</b> Physical improvements and housing			1,000		1,000	0 %
<b>2</b> Economic development			1,447		1,447	0 %
<b>3</b> Community support			70,904		70,904	0 010 %
<b>4</b> Environmental improvements						
<b>5</b> Leadership development and training for community members			3,984		3,984	0 %
<b>6</b> Coalition building			5,284		5,284	0 %
<b>7</b> Community health improvement advocacy			27,940		27,940	0 %
<b>8</b> Workforce development			142,514		142,514	0 020 %
<b>9</b> Other						
<b>10 Total</b>			253,073		253,073	0 030 %

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

**Section A. Bad Debt Expense**

<b>1</b> Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	<b>1</b>	Yes	No
<b>2</b> Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	<b>2</b>	17,593,936	
<b>3</b> 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.	<b>3</b>		
<b>4</b> 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**

<b>5</b> Enter total revenue received from Medicare (including DSH and IME).	<b>5</b>	223,133,871
<b>6</b> Enter Medicare allowable costs of care relating to payments on line 5.	<b>6</b>	235,523,084
<b>7</b> Subtract line 6 from line 5. This is the surplus (or shortfall).	<b>7</b>	-12,389,213
<b>8</b> 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 type="checkbox"/> Cost to charge ratio <input checked="" type="checkbox"/> Other		

**Section C. Collection Practices**

<b>9a</b> Did the organization have a written debt collection policy during the tax year?	<b>9a</b>	Yes	No
<b>b</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.	<b>9b</b>	Yes	No

**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 %
<b>1</b>				
<b>2</b>				
<b>3</b>				
<b>4</b>				
<b>5</b>				
<b>6</b>				
<b>7</b>				
<b>8</b>				
<b>9</b>				
<b>10</b>				
<b>11</b>				
<b>12</b>				
<b>13</b>				

**Part V Facility Information****Section A. Hospital Facilities**

(list in order of size from largest to smallest—see instructions)

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

4

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)

	Other (Describe)	ER-other	ER-24 hours	Research facility	Critical access hospital	Teaching hospital	Children's hospital	General medical & surgical	Licensed hospital	Facility reporting group
See Additional Data Table										

**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)  
MEMORIAL MEDICAL CENTER**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** \_\_\_\_\_

1

**Community Health Needs Assessment**

	Yes	No
<b>1</b> 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? . . . . .	<b>1</b>	No
<b>2</b> 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 . . . . .	<b>2</b>	No
<b>3</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 12 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply)	<b>3</b>	Yes
<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 significant 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 checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA 20 <u>14</u>		
<b>5</b> 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 . . . . .	<b>5</b>	Yes
<b>6 a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b>	Yes
<b>b</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 . . . . .	<b>6b</b>	Yes
<b>7</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)	<b>7</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>HTTPS //WWW.CHOOSEMEMORIAL.ORG/HEALTHYCOMMUNITIES</u>		
<b>b</b> <input type="checkbox"/> Other website (list url) _____		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input type="checkbox"/> Other (describe in Section C)		
<b>8</b> 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 . . . . .	<b>8</b>	Yes
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u>	<b>10</b>	Yes
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) <u>HTTPS //WWW.CHOOSEMEMORIAL.ORG/HEALTHYCOMMUNITIES</u>	<b>10b</b>	
<b>11</b> 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		
<b>12a</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)? . . . . .	<b>12a</b>	No
<b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b> If "Yes" on 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)**

		MEMORIAL MEDICAL CENTER	
Name of hospital facility or letter of facility reporting group _____			
		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? If "Yes," indicate the eligibility criteria explained in the FAP	<b>13</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 300 000000000000 % and FPG family income limit for eligibility for discounted care of _____%			
<b>b</b> <input type="checkbox"/> Income level other than FPG (describe in Section C)			
<b>c</b> <input checked="" type="checkbox"/> Asset level			
<b>d</b> <input checked="" type="checkbox"/> Medical indigency			
<b>e</b> <input checked="" type="checkbox"/> Insurance status			
<b>f</b> <input checked="" type="checkbox"/> Underinsurance discount			
<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>14</b>	Yes
<b>15</b>	Explained the method for applying for financial assistance? . . . . . 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>15</b>	Yes
<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? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	<b>16</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) WWW MEMORIALMEDICAL COM/FINANCIAL/FINANCIAL-HELP			
<b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) WWW MEMORIALMEDICAL COM/FINANCIAL/FINANCIAL-HELP			
<b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) WWW MEMORIALMEDICAL COM/FINANCIAL/FINANCIAL-HELP			
<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 checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
<b>j</b> <input type="checkbox"/> Other (describe in Section C)			

**Part V Facility Information** (continued)**Billing and Collections**

MEMORIAL MEDICAL CENTER

**Name of hospital facility or letter of facility reporting group**

		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 non-payment? . . . . .	<b>17</b>	Yes	
<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? . . . . .	<b>19</b>		No
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 <b>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process <b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications <b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations <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? . . . . .	<b>21</b>	Yes	
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)**

MEMORIAL MEDICAL CENTER

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**22** 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 a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☒ 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
- c** ☐ 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
- d** ☐ The hospital facility used a prospective Medicare or Medicaid method

**23** 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

**24** 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

	Yes	No
<b>22</b>		
<b>23</b>		No
<b>24</b>		No



**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)  
ABRAHAM LINCOLN MEMORIAL HOSPITAL**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** \_\_\_\_\_

2

**Community Health Needs Assessment**

	Yes	No
<b>1</b> 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? . . . . .	<b>1</b>	No
<b>2</b> 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 . . . . .	<b>2</b>	No
<b>3</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 12 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply)	<b>3</b> Yes	
<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 significant 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 checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C) _____		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA 20 <u>14</u>		
<b>5</b> 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 . . . . .	<b>5</b> Yes	
<b>6 a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b>	No
<b>b</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 . . . . .	<b>6b</b> Yes	
<b>7</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)	<b>7</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>WWW.CHOOSEMEMORIAL.ORG/HEALTHYCOMMUNITIES</u>		
<b>b</b> <input type="checkbox"/> Other website (list url) _____		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input type="checkbox"/> Other (describe in Section C) _____		
<b>8</b> 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 . . . . .	<b>8</b> Yes	
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u>		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) <u>WWW.CHOOSEMEMORIAL.ORG/HEALTHYCOMMUNITIES</u>	<b>10</b> Yes	
<b>a</b> _____		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b> 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		
<b>12a</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)? . . . . .	<b>12a</b>	No
<b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b> If "Yes" on 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)

ABRAHAM LINCOLN MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group

	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? If "Yes," indicate the eligibility criteria explained in the FAP	<b>13</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 300 000000000000 % and FPG family income limit for eligibility for discounted care of %		
<b>b</b> <input type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b> <input checked="" type="checkbox"/> Asset level		
<b>d</b> <input checked="" type="checkbox"/> Medical indigency		
<b>e</b> <input checked="" type="checkbox"/> Insurance status		
<b>f</b> <input checked="" type="checkbox"/> Underinsurance discount		
<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>14</b> Yes	
<b>15</b> Explained the method for applying for financial assistance? 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>15</b> Yes	
<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? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	<b>16</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) WWW ALMH ORG/FINANCIAL/FINANCIAL-ASSISTANCE		
<b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) WWW ALMH ORG/FINANCIAL/FINANCIAL-ASSISTANCE		
<b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) WWW ALMH ORG/FINANCIAL/FINANCIAL-ASSISTANCE		
<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 checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information** (continued)**Billing and Collections**

ABRAHAM LINCOLN MEMORIAL HOSPITAL

**Name of hospital facility or letter of facility reporting group**

		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 non-payment? . . . . .	<b>17</b>	Yes	
<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? . . . . .	<b>19</b>		No
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 <b>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process <b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications <b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations <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? . . . . .	<b>21</b>	Yes	
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)**

ABRAHAM LINCOLN MEMORIAL HOSPITAL

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**22** 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 a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☒ 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
- c** ☐ 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
- d** ☐ The hospital facility used a prospective Medicare or Medicaid method

**23** 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

**24** 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

	Yes	No
<b>22</b>		
<b>23</b>		No
<b>24</b>		No

**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)  
TAYLORVILLE MEMORIAL HOSPITAL**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** \_\_\_\_\_**3****Community Health Needs Assessment**

	Yes	No
<b>1</b> 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? . . . . .	<b>1</b>	No
<b>2</b> 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 . . . . .	<b>2</b>	No
<b>3</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 12 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply)	<b>3</b>	Yes
<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 significant 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 checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA <u>20 14</u>		
<b>5</b> 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 . . . . .	<b>5</b>	Yes
<b>6 a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b>	No
<b>b</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 . . . . .	<b>6b</b>	Yes
<b>7</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)	<b>7</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>HTTPS //WWW.CHOOSEMEMORIAL.ORG/HEALTHYCOMMUNITIES</u>		
<b>b</b> <input type="checkbox"/> Other website (list url) _____		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input type="checkbox"/> Other (describe in Section C)		
<b>8</b> 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 . . . . .	<b>8</b>	Yes
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 16</u>		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) <u>HTTPS //WWW.CHOOSEMEMORIAL.ORG/HEALTHYCOMMUNITIES</u>	<b>10</b>	Yes
<b>a</b>		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b> 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		
<b>12a</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)? . . . . .	<b>12a</b>	No
<b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b> If "Yes" on 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)**

TAYLORVILLE MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group		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? If "Yes," indicate the eligibility criteria explained in the FAP	<b>13</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 300 000000000000 % and FPG family income limit for eligibility for discounted care of _____%			
<b>b</b> <input type="checkbox"/> Income level other than FPG (describe in Section C)			
<b>c</b> <input checked="" type="checkbox"/> Asset level			
<b>d</b> <input checked="" type="checkbox"/> Medical indigency			
<b>e</b> <input checked="" type="checkbox"/> Insurance status			
<b>f</b> <input checked="" type="checkbox"/> Underinsurance discount			
<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>14</b> Yes	
<b>15</b>	Explained the method for applying for financial assistance? . . . . . 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>15</b> Yes	
<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? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	<b>16</b> Yes	
<b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) WWW TAYLORVILLEMEMORIAL ORG/FINANCIAL/FINANCIAL-ASSISTANCE			
<b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) WWW TAYLORVILLEMEMORIAL ORG/FINANCIAL/FINANCIAL-ASSISTANCE			
<b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) WWW TAYLORVILLEMEMORIAL ORG/FINANCIAL/FINANCIAL-ASSISTANCE			
<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 checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
<b>j</b> <input type="checkbox"/> Other (describe in Section C)			

**Part V Facility Information** (continued)**Billing and Collections**

TAYLORVILLE MEMORIAL HOSPITAL

**Name of hospital facility or letter of facility reporting group**

		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 non-payment? . . . . .	<b>17</b>	Yes	
<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? . . . . .	<b>19</b>		No
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 <b>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process <b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications <b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations <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? . . . . .	<b>21</b>	Yes	
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)**

TAYLORVILLE MEMORIAL HOSPITAL

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**22** 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 a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☒ 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
- c** ☐ 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
- d** ☐ The hospital facility used a prospective Medicare or Medicaid method

**23** 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

**24** 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

	Yes	No
<b>22</b>		
<b>23</b>		No
<b>24</b>		No



**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)  
PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIA**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** \_\_\_\_\_

4

**Community Health Needs Assessment**

	Yes	No
<b>1</b> 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? . . . . .	<b>1</b>	No
<b>2</b> 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 . . . . .	<b>2</b>	No
<b>3</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 12 . . . . . If "Yes," indicate what the CHNA report describes (check all that apply)	<b>3</b>	Yes
<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 significant 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 checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA 20 <u>14</u>		
<b>5</b> 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 . . . . .	<b>5</b>	Yes
<b>6 a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	<b>6a</b>	No
<b>b</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 . . . . .	<b>6b</b>	Yes
<b>7</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)	<b>7</b>	Yes
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>WWW.CHOOSEMEMORIAL.ORG/HEALTHYCOMMUNITIES</u>		
<b>b</b> <input type="checkbox"/> Other website (list url) _____		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input type="checkbox"/> Other (describe in Section C)		
<b>8</b> 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 . . . . .	<b>8</b>	Yes
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>16</u>		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url) <u>WWW.CHOOSEMEMORIAL.ORG/HEALTHYCOMMUNITIES</u>	<b>10</b>	Yes
<b>a</b>		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .	<b>10b</b>	
<b>11</b> 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		
<b>12a</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)? . . . . .	<b>12a</b>	No
<b>b</b> If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .	<b>12b</b>	
<b>c</b> If "Yes" on 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)

PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIA																																																																																								
Name of hospital facility or letter of facility reporting group																																																																																								
	<table><tr><td></td><td>Yes</td><td>No</td></tr><tr><td>Did the hospital facility have in place during the tax year a written financial assistance policy that</td><td></td><td></td></tr><tr><td><b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? 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<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>14</b> Yes																																																																																							
<b>15</b> Explained the method for applying for financial assistance? 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>15</b> Yes																																																																																							
<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? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	<b>16</b> Yes																																																																																							
<b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) WWW PASSAVANTHOSPITAL COM/FINANCIAL/FINANCIAL-ASSISTANCE																																																																																								
<b>b</b> <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) WWW PASSAVANTHOSPITAL COM/FINANCIAL/FINANCIAL-ASSISTANCE																																																																																								
<b>c</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) WWW PASSAVANTHOSPITAL COM/FINANCIAL/FINANCIAL-ASSISTANCE																																																																																								
<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 checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations																																																																																								
<b>j</b> <input type="checkbox"/> Other (describe in Section C)																																																																																								

**Part V Facility Information** (continued)**Billing and Collections**

PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIA

**Name of hospital facility or letter of facility reporting group**

	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 non-payment? . . . . .	<b>17</b> Yes	
<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? . . . . .	<b>19</b>	No
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 <b>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process <b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications <b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations <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? . . . . .	<b>21</b> Yes	
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)**

PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIA

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**22** 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 a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☒ 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
- c** ☐ 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
- d** ☐ The hospital facility used a prospective Medicare or Medicaid method

**23** 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

**24** 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

	Yes	No
<b>22</b>		
<b>23</b>		No
<b>24</b>		No

**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, 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.

[illegible]

**Part V** **Facility Information** *(continued)***Section D. 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? 20

Name and address	Type of Facility (describe)
<b>1</b> See Additional Data Table	
<b>2</b>	
<b>3</b>	
<b>4</b>	
<b>5</b>	
<b>6</b>	
<b>7</b>	
<b>8</b>	
<b>9</b>	
<b>10</b>	

**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

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART I, LINE 3C	OTHER THAN USING THE FPG, MHS QUALIFIES UNINSURED PATIENTS FOR 100% FINANCIAL ASSISTANCE USING THE PRESUMPTIVE ELIGIBILITY CRITERIA AS DEFINED IN THE ILLINOIS FAIR BILLING ACT AND LISTED IN THE FAP OTHER THAN THE FPG, OTHER CRITERIA FOR AN UNINSURED PATIENT WITH ANNUAL FAMILY INCOME OVER 300% OF THE FPG IS THAT THE SUM OF THE ACCOUNT BALANCES ON ACCOUNTS WITHIN A 12 MONTH PERIOD MUST EXCEED 25% OF THEIR ANNUAL FAMILY INCOME OTHER THAN THE FPG FOR INSURED PATIENTS, CRITERIA INCLUDES PROOF OF ONE OR MORE OF THE PRESUMPTIVE ELIGIBILITY CATEGORIES LISTED IN THE FAP IN THE EVENT OF AN ILLNESS WHICH IS CATASTROPHIC AND WHERE PROPER DOCUMENTATION HAS BEEN SUBMITTED, BUT THE PATIENT STILL OWES MONIES THAT CAUSES AN UNDUE HARDSHIP UPON THE HOUSEHOLD, THE PATIENT FINANCIAL SERVICES DIRECTOR ALONG WITH SENIOR LEADERSHIP MAY REVIEW AND DETERMINE IF AN ADDITIONAL FINANCIAL ASSISTANCE DISCOUNT IS MERITED THE DEFINITION OF "CATASTROPHIC AND THE AMOUNT OF FINANCIAL ASSISTANCE WILL BE DETERMINED ON A CASE BY CASE BASIS, CONSIDERING ALL FINANCIAL, FAMILY, AND HEALTH CIRCUMSTANCES OF THE PATIENT

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 6A	<p>MEMORIAL HEALTH SYSTEM (EIN 37-1110690) PREPARED A COMMUNITY BENEFIT ANNUAL REPORT FOR THE ENTIRE HEALTH SYSTEM A LINK TO THE REPORT IS AVAILABLE ONLINE FROM ALL FOUR MHS HOSPITAL WEBSITES AS WELL AS THE WEBSITES OF OTHER MHS AFFILIATES</p> <p><a href="https://www.memorialmedical.com/portals/0/master-documents/community%20benefit/fy17-mhs-community-benefit-annual-report.pdf">HTTPS //WWW MEMORIALMEDICAL COM/PORTALS/0/MASTER-DOCUMENTS/COMMUNITY%20BENEFIT/FY17-MHS-COMMUNITY-BENEFIT-ANNUAL-REPORT PDF</a> A PDF VERSION IS AVAILABLE TO ANYONE UPON REQUEST THE COMMUNITY BENEFIT ANNUAL REPORT IS ALSO INCLUDED WITHIN MEMORIAL HEALTH SYSTEM'S COMPLETE ANNUAL REPORT, WHICH IS DISTRIBUTED IN PRINT TO MEMBERS OF THE COMMUNITY AT LARGE</p>



**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART I, LINE 7	FOR MMC, THE COSTING METHODOLOGY FOR CHARITY CARE, MEDICAID, AND OTHER MEANS TESTED PROGRAMS WAS DERIVED FROM MMC'S COST ACCOUNTING SYSTEM. THIS SYSTEM HAS THE ABILITY TO COMPUTE THE ACTUAL COST OF ALL MEDICAL PROCEDURES AT THE PATIENT-ACCOUNT LEVEL REGARDLESS OF PAYER TYPE OR WHETHER THE PATIENT WAS INPATIENT OR OUTPATIENT. ALMH, PAH AND TMH UTILIZED MEDICARE COSTING DATA FROM THE FY2017 MEDICARE COST REPORT AS FILED. THE ONLY CATEGORY BY WHICH MMC USED A COST TO CHARGE RATIO FOR SCHEDULE H IS FOR THE DETERMINATION OF BAD DEBT EXPENSE AT COST IN PART III, SECTION A, LINE 2.

# 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7G	MEMORIAL HEALTH SYSTEM HOSPITALS (MMC, ALMH, TMH, AND PAH) INCLUDED SUBSIDIZED HEALTH SERVICES FOR MEMORIAL PHYSICIAN SERVICES WHICH HAS PHYSICIAN CLINICS FOR \$21,300,533

# 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7, COLUMN (F)	THE BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25, COLUMN (A), BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGE IN THIS COLUMN IS \$ 17,593,936

# 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 3B	MHS USES AN AMOUNT IN EXCESS OF 300% OF THE FPG AS A FACTOR IN DETERMINING ELIGIBILITY FOR PROVIDING PARTIAL FINANCIAL ASSISTANCE TO THE UNINSURED THE VALUE OF 301% WAS ENTERED TO SATISFY A MANDATORY FIELD ENTRY REQUIREMENT TO QUALIFY FOR ELECTRONIC FILING

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 3A	MHS (ALMH, MMC, PAH AND TMH) USES AN AMOUNT LESS THAN 300% OF THE FEDERAL POVERTY GUIDELINES (FPG) AS A FACTOR IN DETERMINING ELIGIBILITY FOR PROVIDING FINANCIAL ASSISTANCE TO THE UNINSURED INSURED PATIENTS MAY QUALIFY FOR FINANCIAL ASSISTANCE IF THE PATIENT HAS INCOME BELOW 300% OF FPG AND MEETS AT LEAST ONE OF THE PRESUMPTIVE ELIGIBILITY CATEGORIES LISTED IN THE FINANCIAL ASSISTANCE POLICY (FAP)

Form and Line Reference	Explanation
<p>PART II, COMMUNITY BUILDING ACTIVITIES</p>	<p>MMC PARTICIPATES IN NUMEROUS COMMUNITY BUILDING ACTIVITIES THAT ARE NOT ACCOUNTED FOR ELSE WHERE ON SCHEDULE H. MMC SUPPORTED PHYSICAL IMPROVEMENTS AND HOUSING WITH DONATIONS TO A NEIGHBORHOOD ASSOCIATION THAT IS ADDRESSING BLIGHTED PROPERTIES AND LOCAL CRIME. ECONOMIC DEVELOPMENT WAS SUPPORTED THROUGH VOLUNTEER LEADERSHIP INVOLVEMENT IN THE GREATER SPRINGFIELD CHAMBER OF COMMERCE, THE MID-ILLINOIS MEDICAL DISTRICT AND DOWNTOWN SPRINGFIELD COMMUNITY SUPPORT INCLUDED LEADERSHIP PARTICIPATION ON BOARDS AND COMMITTEES FOR LINCOLN LAND COMMUNITY COLLEGE, SALVATION ARMY, MERCY COMMUNITIES SHELTER, HELPING HANDS HOMELESS SHELTER, YMCA, LLCC OPEN DOORS MENTORSHIP PROGRAM, ILLINOIS DEPARTMENT OF PUBLIC HEALTH ABUSE PREVENTION, RONALD MCDONALD HOUSE AND UNITED WAY OF CENTRAL ILLINOIS. COMMUNITY SUPPORT ALSO INCLUDED CONTRIBUTIONS TO SPRINGFIELD URBAN LEAGUE, GIRL SCOUTS, BOY SCOUTS, AND SPRINGFIELD PUBLIC SCHOOLS FOUNDATION. LEADERSHIP DEVELOPMENT: CENTRAL ILLINOIS ORGANIZATION DEVELOPMENT NETWORK, CENTRAL ILLINOIS VOLUNTEERISM CONFERENCE, GOOD AS GOLD VOLUNTEER AWARDS, AND SERV SPRINGFIELD. COALITION BUILDING INCLUDED PARTICIPATION ON THE BOARD OF YMCA OF SPRINGFIELD TO IMPROVE COMMUNITY ACCESS TO HEALTHY ACTIVITIES, WORK WITH THE AMERICAN CANCER SOCIETY, THE BREASTFEEDING TASK FORCE OF WEST CENTRAL ILLINOIS, AND PARTICIPATION IN ADDRESSING THE ISSUE OF HIGH SPEED RAILROADS. COMMUNITY HEALTH IMPROVEMENT ADVOCACY WAS SUPPORTED THROUGH LEADERSHIP INVOLVEMENT IN THE ILLINOIS HEALTH AND HOSPITAL ASSOCIATION, VHA MID-AMERICA, SOUTHERN ILLINOIS UNIVERSITY SCHOOL OF MEDICINE, THE FOUNDATION FOR REHABILITATION PSYCHOLOGY, AND THE UNITED WAY HEALTH VISION COUNCIL. A DONATION WAS ALSO MADE TO FAITH COALITION FOR THE COMMON GOOD. AS THE LARGEST LOCAL EMPLOYER OUTSIDE OF STATE GOVERNMENT, MMC IS AN IMPORTANT ECONOMIC LINK THAT PROVIDES EMPLOYMENT AND BENEFITS FOR THOUSANDS OF FAMILIES. WORKFORCE DEVELOPMENT IS A KEY AREA OF COMMUNITY BUILDING. MMC SUPPORTS ECONOMIC DEVELOPMENT THROUGH FINANCIAL SUPPORT OF SPRINGFIELD CHAMBER OF COMMERCE'S QUANTUM GROWTH PARTNERSHIP, A COLLABORATIVE COMMUNITY INITIATIVE WORKING TOWARD LONG-TERM IMPROVEMENT OF WORK AND EDUCATIONAL OPPORTUNITIES THROUGHOUT THE COMMUNITY, AND ALSO SUPPORTS THE SANGAMON CEO YOUTH MENTORSHIP PROGRAM. MMC WORKS WITH OTHER ORGANIZATIONS TO EXPAND OPPORTUNITIES TO TRAIN AND RECRUIT HEALTHCARE PROFESSIONALS TO INCREASE ACCESS TO CARE IN RURAL AREAS. MMC AND SIU MEDICINE JOINTLY OFFERED AN EXPLORER POST PROGRAM FOR HIGH SCHOOL YOUTH TO EXPLORE HEALTHCARE CAREER OPPORTUNITIES. MMC ALSO COLLABORATES WITH LOCAL SCHOOLS TO OFFER MULTIPLE OPPORTUNITIES FOR STUDENTS TO EXPLORE HEALTHCARE CAREER OPTIONS, INCLUDING TEENS EXPERIENCING NURSING SUMMER CAMP AND SCRUBS. AS ONE OF THE LARGEST EMPLOYERS IN LOGAN COUNTY, ALMH IS AN IMPORTANT ECONOMIC LINK THAT PROVIDES EMPLOYMENT AND BENEFITS FOR APPROXIMATELY 315 FAMILIES. EACH YEAR, ALMH PROVIDES DONATIONS TO THE LINCOLN/LOGAN COUNTY FOOD PANTRY. SUPPORT IS ALSO PROVIDED FOR THE LOCAL MULTIPLE SCLEROSIS WALK, UNITED WAY OF LOGAN COUNTY, THE AMERICAN CANCER SOCIETY'S RELAY FOR LIFE AND THE COLON CANCER 5K HELD IN LOGAN COUNTY. ALMH IS A MEMBER OF THE LINCOLN/LOGAN COUNTY CHAMBER OF COMMERCE WHICH IS ACTIVELY WORKING TO IMPROVE THE ECONOMIC VITALITY OF LOGAN COUNTY. ALMH ALSO PROVIDES IN-KIND SUPPORT IN THE FORM OF MEETING SPACE FOR THE CHAMBER OF COMMERCE AND VARIOUS COMMUNITY GROUPS. ALMH'S COMMUNITY BUILDING ACTIVITIES INCLUDE STAFF WHO VOLUNTEER FOR LOCAL NONPROFIT ORGANIZATIONS AND INITIATIVES THAT IMPACT THE HEALTH AND QUALITY OF LIFE FOR OUR COMMUNITY INCLUDING THE, LINCOLN ROTARY CLUB, COMMUNITY/CHILDREN'S WELLNESS EXPO, COMMUNITY ACTION PARTNERSHIP OF CENTRAL ILLINOIS' HEALTH ADVISORY COMMITTEE, ZONTA CLUB AND THE LOCAL EMERGENCY PLANNING COMMITTEE. TMH IS ONE OF THE LARGEST EMPLOYERS IN CHRISTIAN COUNTY AND PROVIDES EMPLOYMENT AND BENEFITS FOR APPROXIMATELY 350 FAMILIES. TMH IS A MEMBER OF THE GREATER TAYLORVILLE CHAMBER OF COMMERCE AND THE CHRISTIAN COUNTY ECONOMIC DEVELOPMENT CORPORATION, WHICH ARE WORKING TO IMPROVE THE ECONOMIC VITALITY OF CHRISTIAN COUNTY. COMMUNITY SUPPORT IS PROVIDED BY LEADERSHIP ON THE BOARD OF THE UNITED WAY OF CHRISTIAN COUNTY. COALITION BUILDING WAS DONE THROUGH MEMBERSHIP IN THE CHRISTIAN COUNTY PREVENTION COALITION, WHICH IS DEDICATED TO STOPPING DRUG AND ALCOHOL ABUSE, ESPECIALLY ON THE PART OF YOUNG PEOPLE. COMMUNITY HEALTH IMPROVEMENT ADVOCACY IS SUPPORTED THROUGH LEADERSHIP INVOLVEMENT IN THE ILLINOIS HOSPITAL SMALL AND RURAL CONSTITUENCY SECTION. THIS SECTION OF THE ILLINOIS HOSPITAL ASSOCIATION SUPPORTS SMALL AND RURAL HOSPITALS AS THEY STRIVE TO PROVIDE NEEDED HEALTHCARE SERVICES TO THE COMMUNITIES THEY SERVE. LEADERS AND EMPLOYEES OF TMH SERVE ON SEVERAL OTHER COMMITTEES AND BOARDS, SUCH AS SPRINGFIELD REGIONAL EMERGENCY PREPAREDNESS, LOCAL EMERGENCY PLANNING COMMITTEE OF CHRISTIAN COUNTY, AND CHRISTIAN COUNTY ECONOMIC DEVELOPMENT CORPORATION. PAH'S COMMUNITY BUILDING ACTIVITIES INCLUDE PRO</p>

Form and Line Reference	Explanation
PART II, COMMUNITY BUILDING ACTIVITIES	PROMOTING ECONOMIC DEVELOPMENT BY SUPPORTING OUR AREA CHAMBER OF COMMERCE, JACKSONVILLE MAIN STREET, AND THE JACKSONVILLE REGIONAL ECONOMIC DEVELOPMENT CORPORATION, SUPPORTING ORGANIZATIONS WHO PROMOTE AND ADVOCATE FOR COMMUNITY HEALTH IMPROVEMENT, ALONG WITH SUPPORTING OUR LOCAL SCHOOLS AND OTHER LOCAL NON-PROFIT ORGANIZATIONS

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 2	MEMORIAL HEALTH SYSTEM'S ACCOUNTING POLICY FOR BAD DEBT EXPENSE IS DESCRIBED ON PAGE 14 OF THE NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS IN THE MEMORIAL HEALTH SYSTEM'S CONSOLIDATED FINANCIAL STATEMENTS



## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 4	MEMORIAL HEALTH SYSTEM'S ACCOUNTING POLICY FOR BAD DEBT EXPENSE IS DESCRIBED ON PAGE 14 OF THE NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS IN THE MEMORIAL HEALTH SYSTEM'S CONSOLIDATED FINANCIAL STATEMENTS

# 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 8	<p>THE COSTING METHODOLOGY UTILIZED FOR THE DETERMINATION OF MEMORIAL HEALTH SYSTEM HOSPITALS' MEDICARE ALLOWABLE COST (SCHEDULE H, PART III, LINE 6) WAS CALCULATED AS FOLLOWS MMC, ALMH, TMH, AND PAH UTILIZED MEDICARE COSTING DATA FROM THE FY2017 MEDICARE COST REPORT AS FILED MMC WAS ABLE TO CAPTURE THE MEDICARE COSTING FOR INPATIENT MEDICAL SURGICAL, INPATIENT PSYCHIATRIC, INPATIENT REHABILITATION AND OUTPATIENT MEDICAL SURGICAL SERVICES DURING FY2017 THIS COSTING DATA EXCLUDED THE DIRECT MEDICAL EDUCATION COST FOR THE RESIDENCY PROGRAM ASSOCIATED WITH THE SOUTHERN ILLINOIS UNIVERSITY SCHOOL OF MEDICINE THIS COST WAS INCLUDED IN THE HEALTH PROFESSIONAL EDUCATION SECTION OF PART I, LINE 7 (F) OF SCHEDULE H OTHER SECTIONS OF MEDICARE COSTS THAT WOULD NORMALLY BE EXCLUDED FROM THE MEDICARE COST REPORT BUT SHOULD BE INCLUDED FOR PURPOSES OF THIS SCHEDULE ARE THE FOLLOWING 1 MMC'S ESRD PROGRAM-THIS PROGRAM IS RELATED TO THE END-STAGE RENAL DIALYSIS PROGRAM THE PROGRAM IS REFLECTED ON THE W/S I OF THE COST REPORT BUT DOES NOT HAVE A SETTLEMENT 2 MMC'S OUTPATIENT CLINICAL LAB CHARGES-THESE MEDICARE OUTPATIENT CHARGES ARE PAID ON A FEE-FOR-SERVICE BASIS AND ARE NOT REFLECTED ON THE AS FILED MEDICARE COST REPORT 3 MMC'S OUTPATIENT THERAPY SERVICES-THESE MEDICARE OUTPATIENT CHARGES RELATED TO THERAPEUTIC SERVICES, SUCH AS PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH THERAPY SERVICES, ARE SUBJECT TO A FEE-FOR-SERVICE PAYMENT METHOD AND NOT FILED ON THE MEDICARE COST REPORT 4 PART B PROFESSIONAL FEES-MMC HAS ITS PART B MEDICARE PROFESSIONAL FEES BILLED THROUGH A SEPARATE CORPORATION OF MEMORIAL HEALTH SYSTEM THE BILLING SERVICE IS CALLED PHYSICIAN BILLING SERVICE IT BILLS FOR THE PROFESSIONAL FEES ON BEHALF OF MMC AND SWEEPS THE MEDICARE PAYMENTS BACK TO IT SOME OF THE PROFESSIONAL FEES BILLED BY PHYSICIAN BILLING SERVICE ARE CRNA, HEARING CENTER, SPINE WORKS CLINIC, HEART FAILURE CLINIC, CLINICAL PSYCHOLOGISTS, DIETARY CONSULTING, BARIATRIC SURGERY, EXPRESS CARE LAB AND RADIOLOGY SERVICES, AND EKG INTERPRETATIONS THESE SERVICES ARE TYPICALLY EXCLUDED FROM THE MEDICARE COST REPORT BUT SHOULD BE INCLUDED FOR PURPOSE OF SCHEDULE H THE MEDICARE CHARGES ASSOCIATED WITH BULLET POINTS 1 THROUGH 4 ABOVE WERE APPLIED TO THE CALCULATED COST TO CHARGE RATIOS FROM THE MEDICARE COST REPORT TO DETERMINE ITS COST THIS COST DATA, ALONG WITH THE COST DATA ALREADY COMPILED FROM THE AS FILED MEDICARE COST REPORT WAS THE BASIS FOR ALLOWABLE MEDICARE COST OF \$235,523,084 THE TOTAL SHORTFALL REPORTED ON SCHEDULE H, PART III, LINE 7 WAS \$12,389,213 THE ENTIRE SHORTFALL SHOULD BE CONSIDERED A COMMUNITY BENEFIT FOR MMC, ALMH, TMH, AND PAH THIS SHORTFALL REFLECTS THE EXCESS COSTS INCURRED BY THE FOUR MHS HOSPITALS THAT CURRENT FEE-FOR-SERVICE PAYMENTS PRESENTLY DO NOT COVER THESE ARE VITAL SERVICES TO THE COMMUNITY THESE HOSPITALS SERVE THAT CURRENT MEDICARE PAYMENTS DO NOT COVER MEDICARE IS AN IMPORTANT PAYER TO THE COMMUNITIES OF SPRINGFIELD, LINCOLN, JACKSONVILLE, AND TAYLORVILLE ACCORDINGLY, ALL MHS HOSPITALS ACCEPT MEDICARE PATIENTS REGARDLESS OF WHETHER THEIR TREATMENT WILL RESULT IN A PAYMENT OR NOT BY PROVIDING THESE SERVICES TO MEDICARE PATIENTS, THE MHS HOSPITALS PROMOTE ACCESS TO HEALTH CARE THAT MIGHT NOT BE PROVIDED OTHERWISE ELDERLY ARE OFTEN CONSIDERED AN UNDERSERVED POPULATION WHO EXPERIENCE ISSUES WITH ACCESS TO HEALTHCARE SERVICES, BOTH AT THE URBAN AND RURAL COMMUNITY LEVEL WITHOUT TAX EXEMPT HOSPITALS, CMS AND THE U S GOVERNMENT WOULD HAVE TO BEAR THE BURDEN OF DIRECTLY PROVIDING SERVICES TO THE ELDERLY</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART III, LINE 9B	<p>PER THE FINANCIAL ASSISTANCE POLICY, MMC, ALMH, TMH, AND PAH WILL NOT PURSUE COLLECTION ACTION IN COURT AGAINST A PATIENT WHO QUALIFIES FOR FINANCIAL ASSISTANCE IF THE PATIENT HAS CLEARLY DEMONSTRATED THAT HE OR SHE DOES NOT HAVE SUFFICIENT INCOME OR ASSETS TO MEET ANY PART OF THEIR FINANCIAL OBLIGATION TO THE APPLICABLE HOSPITAL PER THE FINANCIAL ASSISTANCE POLICY, IF AN UNINSURED PATIENT HAS REQUESTED FINANCIAL ASSISTANCE AND/OR APPLIED FOR OTHER COVERAGE AND IS COOPERATING WITH THE HOSPITAL, THE HOSPITAL WILL NOT PURSUE COLLECTION ACTION UNTIL A DECISION HAS BEEN MADE THAT THERE IS NO LONGER A REASONABLE BASIS TO BELIEVE THE PATIENT MAY QUALIFY FOR FINANCIAL ASSISTANCE OR OTHER COVERAGE PER THE FINANCIAL ASSISTANCE POLICY, IF AN UNINSURED PATIENT COMPLIES WITH A PAYMENT PLAN THAT HAS BEEN AGREED UPON BY THE HOSPITAL, THE HOSPITAL WILL NOT PURSUE COLLECTION ACTION PER THE FINANCIAL ASSISTANCE POLICY, IF THE HOSPITAL HAS GIVEN THE PATIENT THE OPPORTUNITY TO ASSESS THE ACCURACY OF THE BILL AND HAS SUFFICIENT REASON TO BELIEVE THAT THE PATIENT DOES NOT QUALIFY FOR ADDITIONAL FINANCIAL ASSISTANCE UNDER ALL TERMS OF THIS POLICY REGARDING HIS OR HER PARTIAL OBLIGATION, AND THE PATIENT CONTINUES WITH NON-PAYMENT, COLLECTION ACTION MAY BE TAKEN BY THE HOSPITAL TO ENFORCE THE TERMS OF ANY PAYMENT PLAN ONCE FINANCIAL ASSISTANCE STATUS IS DETERMINED, IT WILL BE APPLIED TO ALL OPEN ACCOUNTS AND WILL BE VALID FOR A PERIOD OF 6 MONTHS FROM DATE OF DETERMINATION AND 6 MONTHS RETROACTIVELY</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART VI, LINE 2	<p>IN ADDITION TO THE COMMUNITY HEALTH NEED ASSESSMENT PROCESS DESCRIBED IN PART V, SECTION B, MEMORIAL HEALTH SYSTEM (MHS) HAS ALWAYS REVIEWED A VARIETY OF INFORMATION TO IDENTIFY COMMUNITY NEEDS. THESE INCLUDE HOSPITAL ADMISSIONS AND DISCHARGES, LEADING CAUSES OF MORTALITY AND MORBIDITY IN EACH COUNTY AS REPORTED BY THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH, AND THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTHY PEOPLE 2020. ADDITIONAL INFORMATION IS GLEANED FROM CONSUMER SURVEYS, PATIENT SURVEYS, MEDICAL STAFF SURVEYS, EVALUATIONS FROM COMMUNITY EDUCATION EVENTS, SUPPORT GROUP FEEDBACK, WEBMASTER AND SOCIAL MEDIA QUESTIONS AND FEEDBACK, VOLUNTEER BOARD MEMBER AND COMMUNITY BENEFIT COMMITTEE FEEDBACK, REQUESTS FROM THE COMMUNITY AND GRANT APPLICATIONS TO THE MEMORIAL MEDICAL CENTER FOUNDATION. INFORMATION FROM ALL THESE SOURCES HELPED PRIORITIZE MHS'S COMMUNITY BENEFIT INITIATIVES IN TY2016/FY2017, AND TO ASSURE THAT THOSE INITIATIVES ARE ALIGNED WITH MHS'S MISSION, STATEMENT OF VALUES, STRATEGIC PLAN AND BUDGET. PRIORITIES ARE ESTABLISHED BASED ON OVERALL NEED, LEADING CAUSES OF DEATH, IMPACT ON HEALTH STATUS, ORGANIZATIONAL CORE COMPETENCIES, RESOURCES AND WHEREWITHAL TO MEANINGFULLY ADDRESS THE NEED. EACH MHS AFFILIATE HAS THE FLEXIBILITY TO DEVELOP SPECIFIC COMMUNITY BENEFIT PROGRAMS AND INITIATIVES THAT ARE DESIGNED TO RESPOND TO THE NEEDS OF ITS PARTICULAR COMMUNITY. MHS UNDERSTANDS THAT COLLABORATION WITH OTHER COMMUNITY ORGANIZATIONS IS AN IMPORTANT COMPONENT OF COMMUNITY HEALTH IMPROVEMENT EFFORTS AND RESPONDS TO DIRECT COMMUNITY REQUESTS FOR PROGRAMS AND ASSISTANCE. TO FACILITATE THIS PROCESS, MMC HAS A LINK ON ITS WEBSITE FOR COMMUNITY ORGANIZATIONS TO ELECTRONICALLY REQUEST SUPPORT FOR THEIR PROGRAMS, SERVICES AND INITIATIVES THAT ALIGN WITH IDENTIFIED COMMUNITY HEALTH NEED PRIORITIES.</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 3	<p>MMC, ALMH, TMH, AND PAH PROACTIVELY INFORM PATIENTS ABOUT THEIR FINANCIAL ASSISTANCE POLICY AND THE ELIGIBILITY CRITERIA. A FINANCIAL ASSISTANCE LINK ON EACH HOSPITAL'S WEBSITE GOES TO THE FINANCIAL ASSISTANCE POLICY AND APPLICATION. THE POLICY AND APPLICATION FORM ARE AVAILABLE IN ENGLISH AND SPANISH. FOREIGN LANGUAGE TRANSLATION ASSISTANCE IS AVAILABLE UPON REQUEST. INFORMATION ON THE AVAILABILITY OF FINANCIAL ASSISTANCE IS POSTED AT PRIMARY REGISTRATION SITES, INCLUDING THE EMERGENCY DEPARTMENT. THE "PEACE OF MIND REGARDING PAYMENT" BROCHURE IS AVAILABLE TO EVERY PATIENT AT EVERY VISIT AND IS AVAILABLE IN BOTH ENGLISH AND SPANISH. EMPLOYEES IN PATIENT REGISTRATION, PATIENT FINANCIAL SERVICES AND SOCIAL SERVICES ARE TRAINED TO UNDERSTAND THE FINANCIAL ASSISTANCE POLICY AND KNOW HOW TO DIRECT QUESTIONS TO THE APPROPRIATE HOSPITAL REPRESENTATIVE WHO CAN ANSWER SPECIFIC QUESTIONS ABOUT THE FINANCIAL ASSISTANCE POLICY. THEY ALSO REFER PATIENTS TO MEDICAID COORDINATORS WHO CAN EXPLAIN THE AVAILABILITY OF VARIOUS GOVERNMENT PROGRAMS, SUCH AS MEDICAID OR OTHER STATE PROGRAMS AND ASSIST THE PATIENT WITH QUALIFICATION FOR SUCH PROGRAMS. MMC AND PAH CONTRACT WITH FULL-TIME MEDICAID COORDINATORS. THEIR GOAL IS TO VISIT ALL INPATIENTS WHO ARE IDENTIFIED AS SELF-PAY WITHIN ONE DAY OF ADMISSION. IF AN INPATIENT IS IDENTIFIED AS BEING POTENTIALLY ELIGIBLE FOR MEDICAID OR OTHER GOVERNMENT BENEFITS, THE APPLICATION PROCESS IS STARTED IMMEDIATELY. THE MEDICAID COORDINATORS WILL CONTINUE TO WORK WITH A PATIENT POST-DISCHARGE TO WALK THEM THROUGH THE ENTIRE APPLICATION PROCESS. THEY ALSO CONTACT A SELF-PAY OUTPATIENT WITH OVER \$1,000 IN CHARGES AND OFFER TO HELP THEM WITH THE MEDICAID APPLICATION PROCESS. IF THE MEDICAID COORDINATORS DETERMINE THAT THE PATIENT IS OVER INCOME FOR MEDICAID, THEY CONTACT THE FINANCIAL ASSISTANCE REPRESENTATIVE SO THAT A FINANCIAL ASSISTANCE APPLICATION CAN BE SENT TO THE PATIENT. EVERY HOSPITAL BILLING STATEMENT INCLUDES FINANCIAL ASSISTANCE INFORMATION WITH A PHONE NUMBER TO CALL FOR INFORMATION. PATIENTS ARE ENCOURAGED TO INQUIRE ABOUT FINANCIAL ASSISTANCE AT ANY STAGE OF THE BILLING PROCESS. ALL MHS HOSPITALS STRIVE TO HAVE A CONSISTENT AND COURTEOUS APPROACH TO COLLECTIONS. MHS HOSPITALS WILL NOT REFER ACCOUNTS TO A COLLECTION AGENCY, FILE ANY LAWSUIT, OR GARNISH WAGES AGAINST ANY PARTICULAR PATIENT TO COLLECT MEDICAL DEBT UNTIL THE HOSPITAL VERIFIES THE FOLLOWING REASONABLE BASIS FOR BELIEVING PATIENT OWES THE DEBT, THE HOSPITAL WILL MAKE ALL REASONABLE ATTEMPTS TO BILL THIRD PARTY PAYERS AND CONFIRM ANY REMAINING AMOUNTS ARE TRULY THE FINANCIAL RESPONSIBILITY OF THE PATIENT, WHEN THE PATIENT HAS INDICATED AN INABILITY TO PAY THE HOSPITAL WILL ATTEMPT TO VALIDATE THE INABILITY TO PAY AND THE HOSPITAL WILL OFFER A REASONABLE PAYMENT PLAN AND, THE PATIENT HAS BEEN GIVEN A REASONABLE OPPORTUNITY TO SUBMIT AN APPLICATION FOR FINANCIAL ASSISTANCE. ALL MHS HOSPITALS HAVE A CODE OF CONDUCT POLICY THAT SETS FORTH CERTAIN PRINCIPLES TO WHICH AGENCIES, REPRESENTATIVES AND COLLECTORS ARE EXPECTED TO ADHERE. THE AGENCIES ARE REQUIRED TO COMPLY WITH ALL OF THE RELEVANT TERMS OF THE ILLINOIS FAIR PATIENT BILLING ACT, AND, IN PARTICULAR, SECTION 30(C) WHICH ENUMERATES CERTAIN PREREQUISITE CONDITIONS WHICH MUST BE SATISFIED BEFORE AN AGENCY CAN INITIATE ANY LEGAL ACTION AGAINST A PATIENT WHICH IS RELATED TO A FAILURE BY THAT PATIENT TO PAY A HOSPITAL BILL. THE AGENCIES ARE ALSO REQUIRED TO COMPLY WITH ALL OF THE RELEVANT TERMS OF THE ACA INTERNATIONAL CODE OF ETHICS AND PROFESSIONAL RESPONSIBILITY. ONCE A FINANCIAL ASSISTANCE DETERMINATION IS MADE, ALL COLLECTION EFFORTS CEASE. IF AN ACCOUNT IS AT A COLLECTION AGENCY, THE ACCOUNT IS RETURNED BACK TO THE HOSPITAL FOR FINANCIAL ASSISTANCE PROCESSING. ALL PATIENT COMPLAINTS REGARDING DISSATISFACTION WITH SERVICES RENDERED OR BILLING ISSUES ARE HANDLED PROMPTLY AND IN A COURTEOUS MANNER TO ENSURE THAT CUSTOMER SERVICE REMAINS THE FOCUS OF ANY PATIENT CONCERN. ALL COMPLAINTS ARE CONSIDERED VALID AND PATIENT FEEDBACK IS WELCOME WITH RESPECT TO DISPUTED MATTERS.</p>

Form and Line Reference	Explanation
PART VI, LINE 4	<p>MEMORIAL MEDICAL CENTER (MMC), A NONPROFIT TERTIARY CARE HOSPITAL WITH 500 LICENSED BEDS, IS LOCATED IN THE STATE CAPITOL OF SPRINGFIELD, ILL. MMC IS A TEACHING HOSPITAL FOR SOUTHERN ILLINOIS UNIVERSITY SCHOOL OF MEDICINE, WHICH IS ADJACENT TO THE HOSPITAL CAMPUS. MMC IS A LEVEL 1 TRAUMA CENTER AND MAJOR REGIONAL HEALTHCARE PROVIDER FOR CENTRAL AND SOUTHERN ILLINOIS, WHICH IS LARGELY RURAL. ALTHOUGH MMC SERVES PATIENTS FROM A WIDE RANGE OF COUNTIES, THE MAJORITY OF MMC'S COMMUNITY OUTREACH EFFORTS ARE FOCUSED ON SANGAMON COUNTY, WHERE MMC IS LOCATED. SANGAMON COUNTY (POP. 197,499), IS 877 SQUARE MILES AND IS LOCATED IN THE CENTER OF THE STATE. ALTHOUGH THE MAJORITY OF THE COUNTY IS RURAL, IT INCLUDES THE CITY OF SPRINGFIELD, (POP. 117,000), WHICH IS BOTH THE COUNTY SEAT AND STATE CAPITOL. SANGAMON COUNTY HAS EIGHT FEDERALLY DESIGNATED MEDICALLY UNDERSERVED AREAS (MUAS). THE POPULATION OF SANGAMON COUNTY IS 82.6% WHITE, 12.8% BLACK AND 4.6% OTHER. PERSONS AGE 65 AND OLDER MAKE UP 16.6% OF SANGAMON COUNTY'S POPULATION, WHICH IS HIGHER THAN THE STATE AVERAGE OF 14.6%. THE MEDIAN HOUSEHOLD INCOME IS \$56,742. A TOTAL OF 15.2% OF ALL COUNTY RESIDENTS LIVE BELOW THE FEDERAL POVERTY LEVEL, INCLUDING 24.2% OF ALL CHILDREN AND 6.1% OF SENIORS OVER AGE 65. RESIDENTS WITH A DISABILITY TOTAL 13.8% OF THE POPULATION, COMPARED TO THE STATE AVERAGE OF 10.9%. IN FY2016/FY2017, 7% OF THE PATIENTS SERVED AT MMC RECEIVED PATIENT FINANCIAL ASSISTANCE (UNINSURED), 20.7% OF PATIENTS WERE ON MEDICAID, AND 30.5% RECEIVED MEDICARE. OTHER HOSPITALS IN SANGAMON COUNTY INCLUDE HSHS ST. JOHN'S HOSPITAL, A 430-BED NONPROFIT HOSPITAL AFFILIATED WITH HOSPITAL SISTERS HEALTH SYSTEM, AND VIBRA HOSPITAL (A 50-BED, LONG-TERM, ACUTE-CARE FACILITY). ABRAHAM LINCOLN MEMORIAL HOSPITAL (ALMH) IS A NON-PROFIT 25-BED RURAL CRITICAL ACCESS HOSPITAL LOCATED IN LINCOLN, IL, APPROXIMATELY 30 MILES NORTHWEST OF THE STATE CAPITOL OF SPRINGFIELD. ALMH SERVES THE PEOPLE AND COMMUNITIES OF LOGAN AND EASTERN MASON COUNTIES AND IS LARGELY RURAL, AGRICULTURAL AREA. ALMH IS THE ONLY HOSPITAL IN THE PRIMARY SERVICE AREA OF LOGAN COUNTY (POP. 29,494). RACE/ETHNICITY INCLUDES 89.1% WHITE, 8.2% BLACK AND 2.7% OTHER. BACKGROUND: THE MEDIAN HOUSEHOLD INCOME IS \$49,882. PERSONS AGE 65 AND OLDER MAKE UP 17.3% OF LOGAN COUNTY'S POPULATION. 13.2% OF ALL RESIDENTS LIVE BELOW THE FEDERAL POVERTY LEVEL. THERE ARE NO OTHER HOSPITALS PRESENT IN LOGAN COUNTY. IN FY17, 2.5% OF PATIENTS SERVED AT ALMH RECEIVED UNINSURED/UNDERINSURED FINANCIAL ASSISTANCE, 24.2% OF PATIENTS WERE COVERED BY MEDICAID AND 45.0% OF PATIENTS WERE COVERED BY MEDICARE. TAYLORVILLE MEMORIAL HOSPITAL (TMH) IS A NON-PROFIT 25-BED RURAL CRITICAL ACCESS HOSPITAL LOCATED IN TAYLORVILLE, IL, APPROXIMATELY 27 MILES SOUTHEAST OF THE STATE CAPITOL OF SPRINGFIELD. TMH IS ONE OF TWO HOSPITALS IN THE PRIMARY SERVICE AREA OF CHRISTIAN COUNTY (POP. 34,800). THE OTHER, PANA COMMUNITY HOSPITAL, IS A CRITICAL ACCESS FACILITY IN THE SOUTHEAST CORNER OF THE COUNTY. THE MAJORITY OF THE PATIENTS SERVED BY TMH COME FROM CHRISTIAN COUNTY, WHERE THE HOSPITAL FOCUSES THE MAJORITY OF OUR COMMUNITY OUTREACH EFFORTS AND HEALTH IMPROVEMENT INITIATIVES. CHRISTIAN COUNTY'S RACE/ETHNICITY INCLUDES 96.3% WHITE, 2.1% BLACK, AND 1.6% OTHER. THE MEDIAN HOUSEHOLD INCOME IS \$45,334. THE COUNTY HAS AN AGING POPULATION. PERSONS AGE 65 AND OLDER MAKE UP 17.2% OF CHRISTIAN COUNTY'S POPULATION, VS. 13.5% FOR THE STATE OF ILLINOIS. 14.6% OF ALL PEOPLE LIVE BELOW THE FEDERAL POVERTY LEVEL, INCLUDING 21.9% OF CHILDREN AND 7.8% OF SENIORS. CHRISTIAN COUNTY HAS NINE MEDICALLY UNDERSERVED AREAS. IN FY2017, 1.5% OF THE PATIENTS SERVED AT TMH RECEIVED UNINSURED/UNDERINSURED CHARITY CARE ASSISTANCE, 21.6% OF THE PATIENTS WERE ON MEDICAID AND 52.9% WERE COVERED BY MEDICARE. PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION (PAH) IS A NON-PROFIT 131-LICENSED BED HOSPITAL LOCATED IN JACKSONVILLE, IL, APPROXIMATELY 40 MILES WEST OF SPRINGFIELD. THE MAIN COUNTIES THAT PAH SERVES ARE CASS, MORGAN, SCOTT, MACOUPIN AND GREENE COUNTIES (PAH HAS AT LEAST 25% OF THE MARKET IN THESE ZIP CODES). THERE IS A SMALLER, SECONDARY MARKET WHERE PAH HAS AT LEAST 5%, BUT LESS THAN 25% OF THE MARKET. THE SECONDARY MARKET INCLUDES ZIP CODES IN BROWN, SCHUYLER, AND PIKE COUNTIES. OVER 90% OF CASES COME FROM THE PRIMARY MARKET. PAH PROVIDES ALMOST 90% OF THE EMERGENCY DEPARTMENT VISITS FOR RESIDENTS OF MORGAN COUNTY AND OVER 60% OF THE OUTPATIENT SURGERIES. OF THE TOTAL PATIENTS SERVED BY PAH DURING FY2016/FY2017, 1.6% ARE UNINSURED/RECEIVING CHARITY CARE AND 26.1% ARE ON MEDICAID. IN THE PAH SERVICE AREA, ONE PRECINCT IN MORGAN COUNTY IS A FEDERALLY DESIGNATED MEDICALLY UNDERSERVED POPULATION, THREE TOWNSHIPS IN MACOUPIN ARE MEDICALLY UNDERSERVED AREAS (MUAS), WHILE CASS, GREENE, BROWN AND SCOTT COUNTIES ARE ALL MUAS. PATIENTS IN THE PAH SERVICE AREA SOMETIMES TRAVEL FOR SERVICE TO OTHER HOSPITALS IN THE AREA, THE CLOSEST BEING MMC AND ST. JOHN'S HOSPITAL IN SPRINGFIELD, IL, WHICH ARE</p>

Form and Line Reference	Explanation
PART VI, LINE 4	30 MILES FROM PAH'S PHYSICAL LOCATION IN JACKSONVILLE, IL THE COUNTIES WHICH MAKE UP PAH'S SERVICE AREA ARE ALL RURAL AREAS DEMOGRAPHICS OF THE PRIMARY SERVICE AREAS ARE (ESTIMATED AS OF 2016) MORGAN COUNTY - POPULATION APPROX 34,277, PER CAPITA INCOME \$25,201, MEDIAN HOUSEHOLD INCOME \$47,760, PERCENTAGE OF PERSONS BELOW THE POVERTY LEVEL 15.7%

Form and Line Reference	Explanation
PART VI, LINE 5	<p>EACH MHS HOSPITAL (MMC, PAH, ALMH, AND TMH) HAS A BOARD OF DIRECTORS MADE UP OF MEDICAL, BUSINESS AND COMMUNITY LEADERS WHO RESIDE IN THAT HOSPITAL'S PRIMARY SERVICE AREA. VOLUNTEER BOARD MEMBERS ARE NEITHER EMPLOYEES NOR INDEPENDENT CONTRACTORS NOR FAMILY MEMBERS THERE OF. THEY DONATE NUMEROUS HOURS OF SERVICE IN THEIR OVERSIGHT ROLE, INCLUDING THE COMMUNITY NEEDS ASSESSMENT PROCESS, FUNDRAISING, AND GENERAL STEWARDSHIP. ALL MHS HOSPITALS HAVE OPEN MEDICAL STAFFS THAT ALLOW MEMBERSHIP TO ANYONE WHO MEETS CREDENTIALING REQUIREMENTS. ALL FOUR HOSPITALS PARTICIPATE IN MEDICARE, MEDICAID, CHAMPUS, TRICARE AND OTHER GOVERNMENT PROGRAMS AND ARE DISPROPORTIONATE SHARE MEDICAID HOSPITALS THAT PROVIDE FINANCIAL ASSISTANCE AND SLIDING SCALE DISCOUNTS ACCORDING TO BOARD-APPROVED FINANCIAL ASSISTANCE POLICIES. ALL FOUR HOSPITALS ALSO PROVIDE 24/7 EMERGENCY DEPARTMENTS THAT SERVE AS SAFETY NET PROVIDERS FOR THE UNINSURED AND UNDERINSURED WHO DO NOT HAVE PRIMARY CARE PHYSICIANS. THEY PROVIDE SERVICES TO ALL PEOPLE REGARDLESS OF ABILITY TO PAY. MEMORIAL HEALTH SYSTEM UTILIZES SURPLUS FUNDS TO IMPROVE PATIENT CARE, MEDICAL EDUCATION, RESEARCH AND ACCESS TO HEALTH CARE. MMC SERVES AS THE REGIONAL BURN CENTER FOR CENTRAL AND SOUTHERN ILLINOIS AND IS THE REGIONAL REHABILITATION PROVIDER FOR COMPREHENSIVE INPATIENT AND OUTPATIENT REHABILITATION. MMC'S REGIONAL CANCER CENTER APPLIES ITS RESOURCES AND RESEARCH TO OFFER THE LATEST IN CANCER EDUCATION, DETECTION, TREATMENT AND RESEARCH. MMC'S TRANSPLANT SERVICES HAS COMPLETED MORE THAN 800 KIDNEY OR PANCREAS TRANSPLANTS. MMC'S EMERGENCY DEPARTMENT IS A LEVEL 1 TRAUMA CENTER. MMC COLLABORATES WITH COMMUNITY PROVIDERS TO SERVE LOW INCOME AND UNINSURED POPULATIONS. MMC SUPPORTS PATIENTS FROM TWO FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) IN SANGAMON COUNTY, PROVIDING SERVICES TO FQHC PATIENTS, REGARDLESS OF ABILITY TO PAY. IN FY2017, MHS COMPLETED CONSTRUCTION ON A LARGE FACILITY EXPANSION FOR THE SIU FQHC, WHICH GREATLY INCREASED THE NUMBER OF LOW INCOME PATIENTS THEY SERVE. ALSO, MMC, ST. JOHN'S HOSPITAL AND SIU'S FQHC SUPPORT THE ENOS PARK ACCESS TO CARE COLLABORATIVE, PLACING COMMUNITY HEALTH WORKERS IN AN AT-RISK NEIGHBORHOOD TO ADDRESS HEALTH AND SOCIAL DETERMINANTS FACTORS. MMC ALSO PROVIDES FREE TEMPORARY SUPPLIES OF PHARMACEUTICALS FOR INDIGENT PATIENTS WHO ARE DISCHARGED FROM THE HOSPITAL. MMC ALSO FUNDS PHARMACEUTICAL ACCESS FOR LOW-INCOME PERSONS SERVED BY KUMLER OUTREACH MINISTRIES. IN FY2017, MMC PLEDGED \$500,000 OVER THREE YEARS TO IMPLEMENT A NEW NURSE FAMILY PARTNERSHIP (NFP) PROGRAM FOR AT-RISK FIRST-TIME MOTHERS AND THEIR BABIES, IN COLLABORATION WITH OTHER COMMUNITY ORGANIZATIONS. MMC IS COMMITTED TO HEALTH PROFESSIONS EDUCATION. MHS (THE PARENT OF MMC) PROVIDES SIGNIFICANT FINANCIAL SUPPORT FOR SIU SCHOOL OF MEDICINE, WHICH DOES NOT RECEIVE SUFFICIENT OPERATING SUPPORT FROM THE STATE OF ILLINOIS. MMC SERVES AS A MAJOR TEACHING HOSPITAL FOR SIU MEDICINE (300 2ND-4TH-YEAR MEDICAL STUDENTS AND MORE THAN 300 RESIDENTS AND FELLOWS). MMC IS COLLABORATING WITH THE UNIVERSITY OF ILLINOIS SPRINGFIELD AND UNIVERSITY OF ILLINOIS CHICAGO TO OFFER A LOCAL BACHELOR AND MASTER NURSING PROGRAM. MMC ALSO OFFERS CLINICAL TRAINING SITES FOR OTHER NURSING SCHOOLS AND NUMEROUS ALLIED HEALTH PROGRAMS (RADIOLOGY, PHARMACY, CERTIFIED REGISTERED NURSE ANESTHETISTS, AND OTHERS). MMC SUPPORTS CLINICAL RESEARCH, OFFERING CANCER TRIALS THROUGH THE NATIONAL CLINICAL ONCOLOGY RESEARCH PROGRAM. MMC FUNDS THE LOCAL INSTITUTIONAL REVIEW BOARD FOR CLINICAL RESEARCH TRIALS, ABOUT 450 RESEARCH PROJECTS AND PROTOCOLS ARE OPEN AT MMC AT ANY GIVEN TIME. SURPLUS FUNDS ALSO IMPROVE PATIENT CARE. MHS OPENED A NEW 19-BED INPATIENT HOSPITAL UNIT WHICH IS ATTACHED TO HERITAGE MANOR SKILLED NURSING FACILITY LOCATED IMMEDIATELY NORTH OF THE MMC EMERGENCY DEPARTMENT. THIS FACILITY AUGMENTS OUR EXISTING MEMORIAL HOME SERVICES HOSPICE PROGRAM AND MEETS A SIGNIFICANT DEMAND FOR PALLIATIVE AND END-OF-LIFE PATIENT CARE. DURING TY2016/FY2017, MMC EXPANDED MEMORIAL CARE COORDINATION SERVICES TO HELP PATIENTS WITH COMPLEX MEDICAL NEEDS ACHIEVE LONG-TERM HEALTHCARE GOALS AND ACCESS THE CARE THEY NEED. IN TY2016/FY2017 MMC MAINTAINED COMPREHENSIVE STROKE CENTER CERTIFICATION, THE HIGHEST LEVEL OF JCAHO STROKE CERTIFICATION. MMC CONTINUES TO MAINTAIN A TELESTROKE NETWORK WITH OTHER REGIONAL HOSPITALS. PATIENTS PRESENTING WITH STROKE SYMPTOMS CAN BE DIAGNOSED AND TRIAGED AT THEIR LOCAL HOSPITAL. ALMH IS A RURAL CRITICAL ACCESS HOSPITAL WITH 25 STAFFED BEDS. SERVICES OFFERED INCLUDE 24-HOUR EMERGENCY MEDICINE, GENERAL ACUTE INPATIENT CARE, PAIN MANAGEMENT, ORTHOPEDICS, SURGERY AND FAMILY MATERNITY SUITES. ALMH ALSO OFFERS A FULL RANGE OF OUTPATIENT REHABILITATION AND THERAPY AS WELL AS DIAGNOSTIC TESTING. A FIXED MRI UNIT AND UPGRADED CT SCAN OFFER COMMUNITY MEMBERS CONVENIENT ACCESS TO MANY DIAGNOSTIC TESTS. ALMH OFFERS MEMORIAL JOINTWORKS FOR HIP OR KNEE REPLACEMENT SURGERY, ULTRASOUND GUIDED BIOPSIES AND A HEART FAILURE CLINIC. ALMH PRO</p>



Form and Line Reference	Explanation
PART VI, LINE 5	<p>VIDES FREE COMMUNITY WEEKLY BLOOD PRESSURE SCREENINGS AND A WEEKLY BREASTFEEDING SUPPORT GROUP TO NEW MOTHERS. ALMH OFFERS MEMORIAL WEIGHT LOSS AND WELLNESS CENTER SERVICES IN RESPONSE TO NEEDS FOUND ON THE COMMUNITY HEALTH NEEDS ASSESSMENT. TMH IS A RURAL CRITICAL ACCESS HOSPITAL WITH OCCUPANCY FOR 25 STAFFED ACUTE AND SWING BEDS. SERVICES INCLUDE OBSERVATION SERVICES, A 24-HOUR EMERGENCY DEPARTMENT, OUTPATIENT SURGERY, LABORATORY, REHABILITATION THERAPY, AND RADIOLOGY SERVICES WITH MRI, CT, 3D MAMMOGRAPHY, ECHOCARDIOLOGY, ULTRASOUND /SONOGRAPHY AND NUCLEAR MEDICINE. DURING FY2016/FY2017 TMH INVESTED SURPLUS FUNDS IN UPGRADING THE FIRE PROTECTION SYSTEMS TO PROVIDE A SAFER ENVIRONMENT FOR PATIENTS AND STAFF. TMH ALSO PURCHASED A VEIN VIEWER TO HELP STAFF MORE EASILY VISUALIZE PATIENTS' VEINS WHEN STARTING IVS, REPLACED ELECTROCARDIOGRAM MACHINES, PURCHASED A NEW SURGERY TABLE, UPGRADED COLONOSCOPY EQUIPMENT, REPLACED TELEMETRY SYSTEMS USED TO MONITOR OUR SICKEST PATIENTS' VITAL SIGNS, AND UPGRADED THE NURSE CALL SYSTEM ON THE ACUTE CARE PATIENT UNIT TO IMPROVE COMMUNICATION BETWEEN PATIENTS AND THE NURSING STAFF. PAH, A SOLE COMMUNITY HOSPITAL WITH 103 BEDS, HAS AN ACTIVE MEDICAL STAFF OF 70 PHYSICIANS. SERVICES INCLUDE 24-HOUR EMERGENCY MEDICINE, GENERAL ACUTE INPATIENT CARE, WOUND CARE, ORTHOPEDICS, AND SURGERY, AS WELL AS A FULL RANGE OF OUTPATIENT REHABILITATION, THERAPY AND DIAGNOSTIC TESTING. A FIXED MRI UNIT AND UPGRADED CT SCAN OFFER CONVENIENT ACCESS TO MANY DIAGNOSTIC TESTS. PAH USED SURPLUS FUNDS TO IMPROVE COMMUNITY HEALTH AND ACCESS TO CARE BY OPENING A SPECIALTY CLINIC. ADDITIONALLY THE PASSAVANT RADIATION ONCOLOGY CENTER OPENED IN APRIL 2017. PAH COLLABORATED WITH THE MIA WARE FOUNDATION, PROVIDING FREE MAMMOGRAMS FOR LOW INCOME WOMEN. PAH INCREASED THE COMMUNITY ACCESS TO CANCER SCREENINGS BY PARTNERING WITH THE NATIONAL KIDNEY FOUNDATION TO OFFER THE KIDNEY MOBILE SCREENINGS AND ALSO SPONSORED TWO SKIN CANCER SCREENING EVENTS. PAH ALSO WORKS CLOSELY WITH THE CENTER FOR PSYCHIATRIC HEALTH AND MBH TO PROVIDE A FULL RANGE OF INPATIENT AND OUTPATIENT BEHAVIOR HEALTH SERVICES. THE 10-BED INPATIENT UNIT PROVIDES HOSPITALIZATION AND STABILIZATION FOR ACUTE SYMPTOMS, GREATLY INCREASING MUCH NEEDED ACCESS TO PSYCHIATRIC CARE. PAH ALSO OFFERS COMMUNITY HEALTH CHECKS BIMONTHLY TO THE PUBLIC, SCREENING FOR CHOLESTEROL, BLOOD SUGARS, TRIGLYCERIDES AND BLOOD PRESSURE. ADDITIONALLY, PAH HOSTS SEVERAL SUPPORT GROUPS FOR THE COMMUNITY: BEREAVED PARENTS, ALZHEIMER'S, BREASTFEEDING, DIABETES, GRIEF, GRANDPARENTS RAISING CHILDREN, PARKINSON'S AND NEUROMUSCULAR DISORDERS. A NEW SUPPORT GROUP FOR BEHAVIORAL HEALTH WAS ADDED THIS YEAR. PAH PROVIDES FREE MEDICARE CONSULTING SERVICES TO SENIORS. PAH HAS ALSO COLLABORATED WITH THE MORGAN COUNTY HEALTH DEPARTMENT IN HELPING TO FUND A CLINIC TO DIAGNOSE AND TREAT SEXUALLY TRANSMITTED DISEASES. PAH PROVIDES FINANCIAL SUPPORT TO THIS CLINIC, AS WELL AS PHYSICIANS AND NURSES VOLUNTEERING THEIR TIME TO SEE PATIENTS AT THE CLINIC. PAH ALSO WORKS WITH LOCAL SCHOOLS TO IMPROVE CURRICULUM ON REPRODUCTIVE HEALTH, AND SUPPORTS THE PARTNERSHIP FOR SUBSTANCE MISUSE, A LOCAL COALITION, IN ITS WORK TO ADDRESS ADOLESCENT SUBSTANCE ABUSE.</p>

Form and Line Reference	Explanation
PART VI, LINE 6	<p>MEMORIAL HEALTH SYSTEM (MHS), A 501(C)(3) CORPORATION, IS THE SOLE CORPORATE MEMBER OF ABR AHAM LINCOLN MEMORIAL HOSPITAL (ALMH), A RURAL CRITICAL ACCESS HOSPITAL, TAYLORVILLE MEMORIAL HOSPITAL (TMH), A RURAL CRITICAL ACCESS HOSPITAL, PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION (PAH), A 131 BED HOSPITAL, AND MEMORIAL MEDICAL CENTER (MMC), A 500-BED TERTIARY CARE HOSPITAL THAT OFFERS A FULL RANGE OF INPATIENT AND OUTPATIENT SERVICES. OTHER AFFILIATES INCLUDE MEMORIAL PHYSICIAN SERVICES, A PRIMARY CARE PHYSICIAN NETWORK THAT INCLUDES SEVERAL CLINICS LOCATED IN MEDICALLY UNDERSERVED OR HEALTH MANPOWER SHORTAGE AREAS, MENTAL HEALTH CENTERS OF CENTRAL ILLINOIS DBA "MEMORIAL BEHAVIORAL HEALTH", A MULTI-COUNTY OUTPATIENT MENTAL HEALTH NETWORK THAT PROVIDES SERVICE BASED ON A SLIDING-SCALE FEE SCHEDULE AND FREE CARE TO A WIDE RANGE OF PATIENTS WITH PSYCHIATRIC DISORDERS, MEMORIAL HOME SERVICES, A MULTI-COUNTY HOME CARE AND HOSPICE PROGRAM, A CHILD CARE CENTER, PASSAVANT PHYSICIAN ASSOCIATION, A PHYSICIAN NETWORK LOCATED IN JACKSONVILLE, IL, AND FOUR HOSPITAL FOUNDATIONS, ALL OF WHICH ARE 501(C)(3) ENTITIES. MHS'S AFFILIATES ENGAGE IN A WIDE RANGE OF PROGRAMS AND ACTIVITIES THAT PROMOTE COMMUNITY HEALTH. HEALTH SYSTEM AFFILIATES INTEGRATE SERVICES TO PROVIDE IMPROVED ACCESS AND STREAMLINED TRANSITIONS BETWEEN THE DOCTORS' OFFICES, HOSPITAL, HOME HEALTH AGENCY, NURSING HOME AND MENTAL HEALTH CLINICS. IN ADDITION TO THE HOSPITAL ACTIVITIES PREVIOUSLY DESCRIBED FOR MMC, ALMH, PAH AND TMH, ALL OTHER MHS AFFILIATES' CONTRIBUTIONS TO COMMUNITY BENEFITS CONSIST OF THE FOLLOWING: MEMORIAL PHYSICIAN SERVICES (MPS) IS A PRIMARY CARE NETWORK OF 10 BRANCH CLINICS THAT SUPPORT A VARIETY OF OUTPATIENT SERVICES THROUGHOUT CENTRAL ILLINOIS. PATIENTS MAY BE CARED FOR IN A CLINIC, NURSING HOME, HOSPITAL OR VIRTUAL SETTING. IN JUNE 2017, TO IMPROVE PATIENT ACCESS FOR PATIENTS WITHOUT AN ESTABLISHED PRIMARY CARE RELATIONSHIP, THE MEMORIAL EXPRESSCARE BECAME PART OF MPS TO FACILITATE PATIENT APPOINTMENTS AND THE ESTABLISHMENT OF MEDICAL HOME RELATIONSHIPS WITH THE SE PATIENTS. COMPRISED OF MORE THAN 130 PHYSICIANS, PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES, IT EMPLOYS MORE THAN 410 SUPPORT PERSONNEL AND PROVIDES 325,000+ PATIENT VISITS EACH YEAR. PHYSICIAN OFFICES AND CLINICS ARE LOCATED IN SPRINGFIELD, JACKSONVILLE, LINCOLN, PETERSBURG AND CHATHAM. MPS ALSO HAS AN ON-SITE CLINIC AT A LOCAL NURSING HOME TO IMPROVE ACCESS FOR ELDERLY RESIDENTS. DURING FY2017, TO INCREASE PATIENT ACCESS TO CARE, A WALK-IN CLINIC WAS ESTABLISHED IN A RETAIL SETTING. ALL OF THE MPS PRIMARY CARE CLINICS ARE NCQA DESIGNATED LEVEL 3 PATIENT-CENTERED MEDICAL HOMES. MPS PROVIDES COMMUNITY BENEFITS BY MENTORING AND PROVIDING HEALTH PROFESSION EDUCATIONAL OPPORTUNITIES FOR MEDICAL STUDENTS, ADVANCED PRACTICE NURSES, PHYSICIAN ASSISTANTS AND CERTIFIED MEDICAL ASSISTANTS. MEMORIAL HEALTH VENTURES MANAGES JOINT VENTURES IN WHICH MHS HAS ENTERED WITH OTHER HEALTHCARE PROFESSIONALS AND ORGANIZATIONS. OPERATIONS INCLUDE MHS'S OUTPATIENT SERVICE AND MEMORIAL EXPRESSCARE MENTAL HEALTH CENTERS OF CENTRAL ILLINOIS (DBA MEMORIAL BEHAVIORAL HEALTH (MBH)). IT IS A PRIVATE, NOT-FOR-PROFIT ORGANIZATION PROVIDING HIGH-QUALITY, COMPREHENSIVE BEHAVIORAL HEALTH AND REHABILITATION SERVICES. IT IS ONE OF THE LARGEST PROVIDERS OF BEHAVIORAL HEALTH SERVICES IN CENTRAL ILLINOIS, SERVING MORE THAN 9,000 INDIVIDUALS EACH YEAR IN LOGAN, MAISON, MENARD, MORGAN, SANGAMON AND SCOTT COUNTIES. ESTABLISHED IN 1947, MBH CARES FOR CHILDREN, ADOLESCENTS, AND ADULTS AND HAS FIVE SITES OF CARE LOCATED IN SPRINGFIELD, LINCOLN, AND JACKSONVILLE. BEHAVIORAL SERVICES INCLUDE CRISIS INTERVENTION, PSYCHIATRIC AND MEDICAL SERVICES, SCREENING AND ASSESSMENT, OUTPATIENT THERAPY, CASE MANAGEMENT, GROUP EDUCATION AND SUPPORT, AND EMPLOYMENT SERVICES, AS WELL AS RESIDENTIAL CARE. MBH PROVIDES LEVEL 1 SUBSTANCE USE SERVICES FOR ADULTS IN SPRINGFIELD. MBH ALSO PROVIDES TREATMENT TO CHILDREN AND ADOLESCENTS WITH ATTENTION DEFICIT HYPERACTIVITY DISORDER. ITS PSYCHIATRIC RESPONSE TEAM WORKS WITH FOUR AREA HOSPITAL EMERGENCY DEPARTMENTS. REHABILITATION AND SUPPORT SERVICES FOR INDIVIDUALS WITH A DEVELOPMENTAL DISABILITY INCLUDE COMMUNITY AND ON-SITE EMPLOYMENT, DEVELOPMENTAL TRAINING, COMMUNITY SUPPORT AND 24-HOUR SUPERVISED RESIDENTIAL CARE. MBH ALSO PROVIDES PSYCHIATRIC CRISIS INTERVENTION WITH LOCAL SCHOOLS DEALING WITH SUICIDE OR OTHER TRAUMATIC EVENTS, CRISIS INTERVENTION TRAINING FOR LOCAL LAW ENFORCEMENT DEALING WITH MENTALLY ILL INDIVIDUALS, AND MENTALLY ILL HOMELESS PERSONS' ADVOCACY AND COUNSELING. MBH IS A MEMBER OF THE NATIONAL SUICIDE PREVENTION LIFELINE. IT STAFFS A HOTLINE ANSWERING CALLS FROM INDIVIDUALS IN CRISIS 24/7, 365 DAYS A YEAR. MBH ALSO SPONSORS PROFESSIONAL CONFERENCES ATTENDED BY PROVIDERS THROUGHOUT THE STATE. MBH IS COLLABORATING WITH LOCAL PARTNERS ON THE CHILDREN'S MOSAIC PROJECT TO INCREASE CAPACITY TO PROVIDE COMMUNITY-BASED MENTAL HEALTH SERVICES TO UNSERVED OR UNDER-SERVED CHILDREN.</p>

Form and Line Reference	Explanation
PART VI, LINE 6	<p>N 11 SPRINGFIELD SCHOOLS IN AT-RISK LOCATIONS, PLUS A SCHOOL IN LINCOLN IN FY2017, 2,045 CHILDREN RECEIVED MENTAL HEALTH SCREENINGS IN SCHOOLS, AND 262 CHILDREN RECEIVED MENTAL HEALTH SERVICES IN THE SCHOOL SETTINGS A PARENT SUPPORT GROUP IS OFFERED IN A TARGETED AT-RISK NEIGHBORHOOD MBH ALSO COORDINATED MENTAL HEALTH FIRST AID TRAININGS IN FOUR COUNTIES (SANGAMON, CHRISTIAN, LOGAN AND MORGAN), WHICH TRAINED 795 COMMUNITY MEMBERS, TEACHERS AND FIRST RESPONDERS ABOUT HOW TO RECOGNIZE AND RESPOND TO MENTAL HEALTH ISSUES MEMORIAL HOME SERVICES PROVIDES HOME HEALTH, HOME HOSPICE AND HOME MEDICAL EQUIPMENT SERVICES ACROSS CENTRAL ILLINOIS HOME HEALTH OFFERS INDIVIDUALS ASSISTANCE IN RECOVERING FROM INJURY, SURGERY OR ILLNESS IN THE COMFORT OF THEIR OWN HOME IT PROVIDES HOME NURSING CARE, AS WELL AS HOME THERAPY SERVICES, MATERNAL CHILD NURSING, AND TELEHEALTH HOME MONITORING MEMORIAL HOME SERVICES OFFERS HOME MEDICAL EQUIPMENT AND SUPPLIES, INCLUDING RESPIRATORY EQUIPMENT/SERVICES, WHEELCHAIR AND REHAB TECHNOLOGY AND HOME INFUSION THERAPY MEMORIAL HOME SERVICES ALSO PROVIDES HOME HOSPICE CARE, ASSISTING PATIENTS AND FAMILIES AT END-OF-LIFE, INCLUDING SKILLED NURSING, VOLUNTEER SERVICES, SPIRITUAL AND EMOTIONAL CARE, AS WELL AS BEREAVEMENT SERVICES AFTER THE PASSING OF A LOVED ONE THE MEMORIAL MEDICAL CENTER FOUNDATION (MMCF) PROVIDES GRANTS FOR PATIENT CARE, EDUCATION AND CLINICAL RESEARCH IN FY2017, MMCF AWARDED \$ 544,427 FOR 23 HEALTH-RELATED GRANTS FOR COMMUNITY AND HEALTH-SYSTEM INITIATIVES THAT BENEFIT THE PEOPLE AND COMMUNITIES SERVED BY MEMORIAL SOUTHERN ILLINOIS UNIVERSITY SCHOOL OF MEDICINE RECEIVED FIVE GRANTS, INCLUDING FUNDS FOR SIMULATION TRAINING EQUIPMENT, A LUNG CANCER PATIENT REGISTRY, AND A CONFERENCE ON ALZHEIMER'S DISEASE THE UNIVERSITY OF ILLINOIS AT CHICAGO COLLEGE OF NURSING SPRINGFIELD REGIONALCAMPUS RECEIVED FUNDING FOR A LEARNING LABORATORY TO HELP PATIENTS LEARN BASIC SKILLS, CONDUCT ASSESSMENTS AND PATIENT SIMULATIONS MMCF'S DIABETES PREVENTION PROGRAM RECEIVED FUNDING TO PROVIDE DIABETES EDUCATION AND PREVENTION SERVICES IN THE COMMUNITY ADDITIONAL GRANTS ASSIST VARIOUS DEPARTMENTS WITHIN MMCF IN IMPROVING PATIENT CARE MMCF ALSO ADMINISTERS A CANCER PATIENT ASSISTANCE FUND THAT PROVIDES FUNDING TO PATIENTS FOR UTILITIES, RENT AND OTHER BASIC EXPENSES WHILE UNDERGOING CANCER TREATMENT, AND A TRANSPLANT PATIENT ASSISTANCE FUND THAT HELPS KIDNEY/PANCREAS TRANSPLANT PATIENTS WITH THE COST OF ANTI-REJECTION MEDICATIONS, TRANSPORTATION EXPENSES AND LODGING ANOTHER FUND, SHARING WISHES, HELPS GRANT WISHES OF HOSPICE PATIENTS IN FY2017, MMCF SUPPORTED A COMMUNITY-WIDE WOMEN'S HEALTH FAIR TO PROVIDE A VARIETY OF HEALTH SCREENINGS AND TO EDUCATE WOMEN ABOUT A WIDE RANGE OF HEALTH ISSUES MEMORIAL WEIGHT LOSS AND WELLNESS CENTER RECEIVED FUNDING FOR SCHOLARSHIPS FOR CHILDREN AND FAMILIES TO PARTICIPATE IN THE HEALTHY FAMILIES PROGRAM TAYLORVILLE MEMORIAL HOSPITAL FOUNDATION (TMHF) PROVIDES GRANTS TO SUPPORT PATIENT CARE, EDUCATION AND COMMUNITY HEALTH OUTREACH IN ADDITION TO FACILITATING PARTNERSHIPS AND COLLABORATION TO IMPROVE THE HEALTH OF THE COMMUNITY SERVED BY TMH IN FY2017, TMHF AWARDED OVER \$38,160 IN GRANTS TO THE COMMUNITY AND TMH SPECIFICALLY, \$24,987 IN GRANTS WERE PROVIDED TO SUPPORT PATIENT CARE, INCLUDING DISTRIBUTIONS FROM THE CUPS FUND, A MAMMOGRAPHY ASSISTANCE PROGRAM PROVIDED TO WOMEN IN CHRISTIAN COUNTY WHO WERE UNINSURED OR DO NOT HAVE HEALTH INSURANCE EDUCATION AND PROFESSIONAL CERTIFICATION GRANTS TOTALING \$7,341 WERE AWARDED TO BENEFIT THOSE PURSUING ADVANCED CERTIFICATIONS AND POST-SECONDARY EDUCATION IN NURSING AND OTHER HEALTHCARE RELATED FIELDS JACKSONVILLE CRNA'S IS A GROUP OF CERTIFIED REGISTERED NURSE ANESTHETISTS WHO PROVIDE SERVICES TO PATIENTS AT PAH</p>

# 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 7, REPORTS FILED WITH STATES	IL

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
LINE 6 CONT	<p>PASSAVANT AREA HOSPITAL FOUNDATION (PAHF) SERVES TO ESTABLISH AND MAINTAIN RELATIONSHIPS THAT GENERATE PHILANTHROPIC SUPPORT TO ENHANCE PASSAVANT MEMORIAL AREA HOSPITAL'S (PAH) ABILITY TO PROVIDE EXCELLENCE IN HEALTHCARE UNDER PAHF'S BYLAWS, PAH IS ITS SOLE MEMBER PAHF IS LED BY A 15-MEMBER BOARD OF ELECTED TRUSTEES WITH DAILY OPERATIONS CARRIED OUT BY THE EXECUTIVE DIRECTOR TRUSTEES HAVE THE RESPONSIBILITY TO ALLOCATE CHARITABLE FUNDS IN SUPPORT OF THE HOSPITAL'S PRIORITIES TO PURCHASE NEW MEDICAL EQUIPMENT AND TECHNOLOGY, FUND CAPITAL CONSTRUCTION AND REMODELING PROJECTS, AND IMPROVE PATIENT SERVICES AND COMMUNITY OUTREACH ABRAHAM LINCOLN HEALTHCARE FOUNDATION (ALHF) UNDERWRITES THE OPERATING EXPENSES OF THE HEALTHY COMMUNITIES PARTNERSHIP, WHICH TOTALED MORE THAN \$100,000 IN FY2017 THE HEALTHY COMMUNITIES PARTNERSHIP (HCP) TRANSITIONED TO THE ALMH COMMUNITY HEALTH COLLABORATIVE (CHC) THE GROUP PROVIDES NETWORKING AND COLLABORATION AMONG A VARIETY OF COMMUNITY RESOURCES COMMITTEES ADDRESS ALCOHOL AND DRUG USE INCLUDING OPIOID ABUSE, OBESITY, AND CHRONIC DISEASE MANAGEMENT ON THE LOCAL COMMUNITY LEVEL CHC ACTIVITIES ARE FUNDED BY THE FOUNDATION INCLUDING EVENTS TO PROMOTE SUBSTANCE-FREE AND HEALTHY LIFESTYLES IN SUPPORT OF BRINGING NEW FEDERALLY QUALIFIED HEALTH CENTER TO LOGAN COUNTY, ALHF PROVIDED A GRANT TO LOGAN COUNTY DEPARTMENT OF PUBLIC HEALTH FOR BUILDING RENOVATIONS THAT ALLOWED A 1,500-SQUARE-FOOT CLINIC TO OPEN INSIDE THE HEALTH DEPARTMENT ALHF ALSO PROVIDED FUNDING THAT EXPANDED MEMORIAL BEHAVIORAL HEALTH'S MOSAIC PROGRAM TO LINCOLN JUNIOR HIGH SCHOOL A BEHAVIORAL HEALTH CONSULTANT SCREENS ALL STUDENTS, THOSE WITH IDENTIFIED NEEDS ARE PROVIDED SERVICES AT THE SCHOOL PASSAVANT PHYSICIAN ASSOCIATION (PPA) IS A GROUP OF 5 PHYSICIAN OFFICES THAT OFFER A VARIETY OF SERVICES EAR, NOSE &amp; THROAT, PSYCHIATRIC, INTERNAL MEDICINE, WOUND CARE, AND OBSTETRICS/GYNECOLOGY COMPRISED OF MORE THAN 17 PHYSICIANS AND MID-LEVEL PROVIDERS, IT EMPLOYS MORE THAN 50 PEOPLE AND PROVIDES 25,000+ PATIENT VISITS EACH YEAR PPA PROVIDES COMMUNITY BENEFITS BY PROVIDING COMMUNITY EDUCATION PROGRAMS ON VARIOUS TOPICS, SUCH AS STROKE, DIABETES, DEPRESSION, HOSPICE CARE, AND PATIENT SAFETY</p>

**Additional Data****Software ID:****Software Version:****EIN:** 90-0756744**Name:** MEMORIAL HEALTH SYSTEM GROUP**Form 990 Schedule H, Part V Section A. Hospital Facilities**

<b>Section A. Hospital Facilities</b>  (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? <b>4</b>		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER—24 hours	ER—other	Other (Describe)	Facility reporting group
1	MEMORIAL MEDICAL CENTER 701 NORTH FIRST STREET SPRINGFIELD, IL 62781 HTTPS://WWW.MEMORIALMEDICAL.COM/ 0001487	X	X		X		X	X			
2	ABRAHAM LINCOLN MEMORIAL HOSPITAL 200 STAHLHUT DRIVE LINCOLN, IL 62656 HTTP://WWW.ALMH.ORG/ 0005728	X	X			X		X			
3	TAYLORVILLE MEMORIAL HOSPITAL 201 E PLEASANT TAYLORVILLE, IL 62568 HTTPS://WWW.TAYLORVILLEMEMORIAL.ORG/ 0005447	X	X			X		X			
4	PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION 1600 W WALNUT ST JACKSONVILLE, IL 62650 HTTPS://WWW.PASSAVANTHOSPITAL.COM/ 0001792	X	X					X			

**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, 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.

Form and Line Reference	Explanation
MEMORIAL MEDICAL CENTER	<p>PART V, SECTION B, LINE 5 MEMORIAL MEDICAL CENTER (MMC) CONDUCTED A JOINT COMMUNITY HEALTH NEED ASSESSMENT (CHNA) OF SANGAMON COUNTY IN COLLABORATION WITH SHS ST JOHN'S HOSPITAL AND THE SANGAMON COUNTY DEPARTMENT OF PUBLIC HEALTH. A COMMUNITY ADVISORY COMMITTEE WAS CONVENED TO ASSIST IN REVIEWING AND RANKING SECONDARY DATA ON COMMUNITY HEALTH ISSUES AND TO HELP IDENTIFY COMMUNITY ASSETS AND GAPS. THE FOLLOWING ORGANIZATIONS PARTICIPATED: CENTRAL COUNTIES HEALTH CENTERS AND SIU SCHOOL OF MEDICINE CENTER FOR FAMILY MEDICINE (BOTH FEDERALLY QUALIFIED HEALTH CLINICS IN SANGAMON COUNTY), MENTAL HEALTH CENTERS OF CENTRAL ILLINOIS (SERVING RESIDENTS WITH MENTAL HEALTH NEEDS, PARTICULARLY LOW-INCOME, VULNERABLE AND HOMELESS INDIVIDUALS), EASTSIDE MINISTERIAL ALLIANCE (REPRESENTED BY SERVING JESUS WILLINGLY URBAN MINISTRY, WHICH SERVES LOW-INCOME AND MINORITY RESIDENTS), SPRINGFIELD SCHOOL DISTRICT 186 (HAS 15,000 STUDENTS, INCLUDING THOSE LIVING IN THE MOST AT-RISK NEIGHBORHOODS IN THE COUNTY), SPRINGFIELD URBAN LEAGUE (SERVING 9,000 MINORITY AND LOW-INCOME INDIVIDUALS), UNITED WAY OF CENTRAL ILLINOIS (SERVING ALL RESIDENTS, WITH A FOCUS ON LOW-INCOME AND VULNERABLE POPULATIONS), SANGAMON COUNTY FARM BUREAU (SERVING THOSE LIVING IN RURAL AREAS), THE UNIVERSITY OF ILLINOIS AT SPRINGFIELD'S (UIS) SURVEY RESEARCH OFFICE, SANGAMON COUNTY MEDICAL SOCIETY, AND ILLINOIS DEPARTMENT OF PUBLIC HEALTH, DIVISION OF HEALTH POLICY. THE COMMUNITY ADVISORY COMMITTEE NARROWED A LIST OF 12 PRIORITY HEALTH ISSUES TO NINE TOPICS, WHICH WERE THEN PRESENTED TO THE COMMUNITY AT LARGE THROUGH FIVE COMMUNITY FORUMS AND A COMMUNITY-WIDE SURVEY. THREE FORUMS WERE HELD IN SPRINGFIELD, INCLUDING TWO WITHIN ZIP CODES 62702 AND 62703, WHICH REPRESENT AREAS OF THE CITY WITH POOR HEALTH AND SOCIOECONOMIC INDICATORS AND LARGER MINORITY POPULATIONS. TWO FORUMS TARGETED RURAL AREAS OF THE COUNTY CONGRUENT TO THE COMMUNITY FORUMS, AN ONLINE COMMUNITY SURVEY WAS CONDUCTED BY THE UIS SURVEY RESEARCH OFFICE. HARD COPIES OF THE SURVEY WERE ALSO DISTRIBUTED TO ORGANIZATIONS PARTICIPATING ON THE COMMUNITY ADVISORY COMMITTEE, THROUGH THE HEALTH DEPARTMENT'S WOMEN, INFANT, CHILDREN (WIC) PROGRAM, AND OTHER COMMUNITY ORGANIZATIONS. HARD COPIES WERE ALSO DISTRIBUTED AT THE FIVE COMMUNITY FORUMS. UIS ANALYZED 781 COMPLETED SURVEYS, WHICH RANKED THE NINE PRIORITIES SELECTED BY THE COMMUNITY ADVISORY COMMITTEE. FOLLOWING THE SURVEY, THE PRIORITY OF ACCESS TO CARE WAS SELECTED BY BOTH MMC AND ST. JOHN'S HOSPITAL, AND WE RESEARCHED A WAY TO COLLABORATIVELY ADDRESS THE ISSUE. FOCUSING ON A TARGETED AT-RISK NEIGHBORHOOD WITHIN ZIP CODE 62702, WE GAINED ADDITIONAL COMMUNITY INPUT BY WORKING WITH THE UIS SURVEY RESEARCH PROGRAM TO CONDUCT FOUR FOCUS GROUPS WITHIN THE ENOS PARK NEIGHBORHOOD TO IDENTIFY SPECIFIC ISSUES AFFECTING ACCESS TO CARE. THE FOCUS GROUPS TARGETED SENIORS, YOUNG ADULTS, SINGLE MOTHERS AND LOCAL SOCIAL SERVICE PROVIDERS. A COMPLETE DESCRIPTION OF THE PROCESSES IS PROVIDED IN MMC'S CHNA REPORT.</p>

**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, 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.

Form and Line Reference	Explanation
MEMORIAL MEDICAL CENTER	EPORT AT WWW CHOOSEMEMORIAL ORG/HEALTHYCOMMUNITIES



**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**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, 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.

Form and Line Reference	Explanation
ABRAHAM LINCOLN MEMORIAL HOSPITAL	PART V, SECTION B, LINE 5 ABRAHAM LINCOLN MEMORIAL HOSPITAL COLLABORATED WITH THE LOGAN COUNTY DEPARTMENT OF PUBLIC HEALTH THE CHNA CONVENED AN INTERNAL ADVISORY COMMITTEE CONSISTING OF LEADERSHIP FROM THE HOSPITAL, LOGAN COUNTY DEPARTMENT OF PUBLIC HEALTH, MENTAL HEALTH CENTERS OF CENTRAL ILLINOIS, MEMORIAL PHYSICIAN SERVICES AND ABRAHAM LINCOLN HEALTHCARE FOUNDATION THIS GROUP REVIEWED SECONDARY HEALTH AND SOCIOECONOMIC DATA INDICATORS FOR THE COUNTY AN EXTERNAL ADVISORY COMMITTEE, CONSISTING OF ORGANIZATIONS PARTICIPATING IN LOGAN COUNTY'S HEALTHY COMMUNITIES PARTNERSHIP, OFFERED INPUT INTO IDENTIFIED NEEDS HEALTHY COMMUNITIES PARTNERSHIP (HCP) IS A COMMUNITY HEALTH COALITION THAT WAS ESTABLISHED IN 1996 MORE THAN 30 ORGANIZATIONS, CHURCHES, PRIVATE INDIVIDUALS, AND BUSINESSES ARE REPRESENTED IN THE PARTNERSHIP MEMBERS INCLUDE LOGAN COUNTY DEPARTMENT OF PUBLIC HEALTH, LINCOLN PARK DISTRICT, DEPARTMENT OF HUMAN SERVICES, LOGAN COUNTY HOUSING AUTHORITY, PARISH NURSES, LOGAN COUNTY EMERGENCY MANAGEMENT ASSOCIATION, COMMUNITY ACTION, AND THE UNIVERSITY OF ILLINOIS EXTENSION OFFICE ADDITIONALLY, HEALTHCARE PROVIDERS INCLUDING MEMORIAL PHYSICIAN SERVICES, SPRINGFIELD CLINIC, MENTAL HEALTH CENTERS OF ILLINOIS (DBA MEMORIAL BEHAVIORAL HEALTH), SAFE HAVEN HOSPICE, CHESTNUT HEALTH SYSTEM, AND ILLINOIS INSTITUTE FOR ADDICTION AND RECOVERY ARE PART OF THE HEALTHY COMMUNITIES PARTNERSHIP THE EXTERNAL ADVISORY COMMITTEE NARROWED 26 NEEDS TO 10 TOP ISSUES, THEN RANKED THOSE ISSUES TO IDENTIFY TOP PRIORITIES THESE PRIORITIES WERE THEN ADDRESSED BY INTERNAL ADVISORY COMMITTEE, WHICH RANKED AND SELECTED THE FINAL ISSUES A COMPLETE DESCRIPTION OF THE RANKING PROCESS IS PROVIDED IN THE WRITTEN CHNA REPORT AT WWW.CHOOSMEMORIAL.ORG/HEALTHYCOMMUNITIES

**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**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, 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.

Form and Line Reference	Explanation
TAYLORVILLE MEMORIAL HOSPITAL	PART V, SECTION B, LINE 5 TAYLORVILLE MEMORIAL HOSPITAL'S COMMUNITY HEALTH NEED ASSESSMENT WAS CARRIED OUT IN CONJUNCTION WITH CHRISTIAN COUNTY HEALTH DEPARTMENT'S IPLAN (ILLINOIS PROJECT FOR LOCAL ASSESSMENT OF NEEDS) IPLAN IS REQUIRED OF PUBLIC HEALTH DEPARTMENTS BY THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH DURING THE 2015 COMMUNITY HEALTH NEED ASSESSMENT PROCESS, THE HOSPITAL AND HEALTH DEPARTMENT CREATED AN EXTERNAL ADVISORY TEAM TO PROVIDE INPUT ON PRIORITY HEALTH NEEDS THIS GROUP CONSISTED OF UNITED WAY OF CHRISTIAN COUNTY, SENIOR CITIZENS OF CHRISTIAN COUNTY, CHRISTIAN COUNTY YMCA, TAYLORVILLE MINISTERIAL ASSOCIATION, TAYLORVILLE SCHOOL DISTRICT, AND CHRISTIAN COUNTY MENTAL HEALTH ASSOCIATION THIS GROUP PROVIDED INPUT ON A LIST OF 22 IDENTIFIED PRIORITIES AND RANKED THE LIST, NARROWING IT TO EIGHT TOP ISSUES THE COMMITTEE ALSO PROVIDED INFORMATION ON ASSETS AND GAPS IN THE COMMUNITY IN EACH OF THE IDENTIFIED AREAS A COMPLETE DESCRIPTION OF THE PROCESS IS PROVIDED IN THE WRITTEN CHNA REPORT AT WWW.CHOOSMEMORIAL.ORG/HEALTHYCOMMUNITIES

**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**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, 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.

Form and Line Reference	Explanation
PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION	PART V, SECTION B, LINE 5 PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION (PAH) MET AND RECEIVED INPUT FROM MANY INDIVIDUALS/ORGANIZATIONS IN THE COMMUNITY WHO HAVE KNOWLEDGE AND EXPERTISE IN THE AREAS OF ITS IDENTIFIED NEEDS PAH COLLABORATED WITH PUBLIC HEALTH, PROBATION, LAW ENFORCEMENT, SUBSTANCE ABUSE COUNSELORS, COLLEGE HEALTH OFFICIALS, HIGH SCHOOL ADMINISTRATORS, AND NURSES, TEENS, AND ITS OWN HOSPITAL PERSONNEL A COMPLETE DESCRIPTION OF THE RANKING PROCESS IS PROVIDED IN THE WRITTEN CHNA REPORT AT <a href="http://WWW.CHOOSEMEMORIAL.ORG/HEALTHYCOMMUNITIES">WWW.CHOOSEMEMORIAL.ORG/HEALTHYCOMMUNITIES</a>

**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**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, 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.

Form and Line Reference	Explanation
MEMORIAL MEDICAL CENTER	PART V, SECTION B, LINE 6A MEMORIAL MEDICAL CENTER CONDUCTED THE 2015 SANGAMON COUNTY COMMUNITY HEALTH NEED ASSESSMENT IN COLLABORATION WITH HSHS ST JOHN'S HOSPITAL, A 430- BED NONPROFIT HOSPITAL IN SANGAMON COUNTY

**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**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, 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.

Form and Line Reference	Explanation
MEMORIAL MEDICAL CENTER	PART V, SECTION B, LINE 6B IN ADDITION TO MMC CONDUCTING THE NEED ASSESSMENT WITH HSHS ST JOHN'S HOSPITAL, THE SANGAMON COUNTY DEPARTMENT OF PUBLIC HEALTH RECEIVED PERMISSION FROM THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH (IDPH) TO CONDUCT A PILOT PROJECT TO COMPLETE ITS ILLINOIS PROJECT FOR LOCAL ASSESSMENT OF NEEDS (IPLAN) IN A THREE-YEAR CYCLE TO ALIGN WITH THE HOSPITALS' CHNA REQUIREMENTS, RATHER THAN THE FIVE-YEAR IPLAN CYCLE REQUIRED BY IDPH ASSISTING WITH THE CHNA PROCESS WAS SIU MEDICINE'S DEPARTMENT OF COMMUNITY HEALTH AND SERVICE AND THE UNIVERSITY OF ILLINOIS' SURVEY RESEARCH DEPARTMENT MMC AND HSHS ST JOHN'S HOSPITAL COLLABORATED ON A JOINT COMMUNITY INITIATIVE, BUT EACH HOSPITAL AS WELL AS THE HEALTH DEPARTMENT PRODUCED SEPARATE CHNA REPORTS AND IMPLEMENTATION STRATEGIES

**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**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, 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.

Form and Line Reference	Explanation
ABRAHAM LINCOLN MEMORIAL HOSPITAL	PART V, SECTION B, LINE 6B ALMH CONDUCTED THE LOGAN COUNTY COMMUNITY HEALTH NEED ASSESSMENT IN COLLABORATION WITH THE LOGAN COUNTY DEPARTMENT OF PUBLIC HEALTH THIS ASSISTED THE HEALTH DEPARTMENT IN COMPLETING ITS REQUIRED ILLINOIS PROJECT FOR LOCAL ASSESSMENT OF NEEDS (IPLAN), AS MANDATED EVERY FIVE YEARS BY THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH THE HOSPITAL AND COUNTY HEALTH DEPARTMENT PRODUCED SEPARATE REPORTS AND IMPLEMENTATION STRATEGIES

**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**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, 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.

Form and Line Reference	Explanation
TAYLORVILLE MEMORIAL HOSPITAL	PART V, SECTION B, LINE 6B THE CHRISTIAN COUNTY HEALTH DEPARTMENT CONDUCTED ITS ILLINOIS PLANNING FOR LOCAL ASSESSMENT OF NEED (IPLAN) WITH TMH'S COMMUNITY HEALTH NEED ASSESSMENT PROCESS THIS ASSISTED THE HEALTH DEPARTMENT IN COMPLETING ITS REQUIRED IPLAN, AS MANDATED EVERY FIVE YEARS BY THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH THE HOSPITAL AND COUNTY HEALTH DEPARTMENT PRODUCED SEPARATE REPORTS AND IMPLEMENTATION STRATEGIES

**Form 990 Part V Section C Supplemental Information for Part V, Section B.**

**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, 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.

Form and Line Reference	Explanation
PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION	PART V, SECTION B, LINE 6B PAH COLLABORATED WITH 12 COMMUNITY ORGANIZATIONS THEY WERE MORGAN COUNTY HEALTH DEPARTMENT, ILLINOIS SCHOOL FOR THE DEAF, ILLINOIS SCHOOL FOR THE VISUALLY IMPAIRED, JACKSONVILLE SCHOOL DISTRICT #117, THE WELLS CENTER, PRAIRIELAND UNITED WAY, HEAD START, MENTAL HEALTH CENTERS OF CENTRAL ILLINOIS, MACMURRAY COLLEGE, ILLINOIS COLLEGE, LINCOLN LAND COMMUNITY COLLEGE, AND JACKSONVILLE AREA CENTER FOR INDEPENDENT LIVING



**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, 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.

Form and Line Reference	Explanation
MEMORIAL MEDICAL CENTER	<p>PART V, SECTION B, LINE 11 MEMORIAL MEDICAL CENTER'S (MMC) COMMUNITY SURVEY IN SANGAMON C</p> <p>OUNTY RANKED NINE HEALTH PRIORITIES IDENTIFIED BY THE COMMUNITY ADVISORY COMMITTEE IN ORD</p> <p>ER THEY ARE 1 MENTAL HEALTH2 CHILD ABUSE3 OVERWEIGHT/OBESITY4 ACCESS TO CARE5 HEART DISEA</p> <p>SE 6 DIABETES7 DENTAL CARE 8 FOOD INSECURITY9 ASTHMA MMC PRESENTED THE NINE PRIORITIES FRO</p> <p>M THE COMMUNITY SURVEY TO AN INTERNAL ADVISORY COMMITTEE THIS GROUP USED THE DEFINED CRIT</p> <p>ERIA OF TRIPLE AIM IMPACT, MAGNITUDE OF THE ISSUE, SERIOUSNESS OF THE ISSUE, AND FEASIBILI TY</p> <p>TO ADDRESS THE ISSUE GIVEN AVAILABLE RESOURCES MMC SELECTED THREE FINAL PRIORITIES AFT ER</p> <p>REVIEWING INPUT FROM THE COMMUNITY ADVISORY COMMITTEE, COMMUNITY FORUMS, THE COMMUNITY</p> <p>SURVEY, AND MMC'S INTERNAL ADVISORY TEAM THESE PRIORITIES WILL BE ADDRESSED IN THE IMPLEM</p> <p>ENTATION STRATEGY OVER THE NEXT THREE YEARS, FROM FY2016-FY2018 THE PRIORITIES ARE ACCES S</p> <p>TO CARE, MENTAL HEALTH AND OBESITY OUTCOMES FROM THE TY2016/FY2017 IMPLEMENTATION STRAT</p> <p>EGY INCLUDE THE FOLLOWING 1 ACCESS TO CARE IN COLLABORATION WITH ST JOHN'S HOSPITAL AND</p> <p>SIU CENTER FOR FAMILY MEDICINE FQHC, AN ACCESS PROGRAM WAS CREATED IN ENOS PARK, A VULNER</p> <p>ABLE NEIGHBORHOOD IN ZIP CODE 62702 A NEW COMMUNITY HEALTH WORKER PROGRAM SERVED 136</p> <p>CLIE NTS IN THE YEAR TWO, CONNECTING THEM TO 599 PRIMARY CARE APPOINTMENTS, 172 MENTAL</p> <p>HEALTH A PPOINTMENTS AND 46 DENTAL TREATMENTS, AS WELL AS 479 REFERRALS TO OTHER SOCIAL</p> <p>SERVICES T RANSPORTATION WAS PROVIDED TO MANY OF THESE BY APPOINTMENT ALSO IMPROVED WAS</p> <p>ACCESS TO HE ALTHIER FOODS, BETTER HOUSING, AND EMPLOYMENT OPPORTUNITIES RELATIONSHIPS</p> <p>WITH NEIGHBORHO OD POLICE OFFICERS IS IMPROVING , CRIME IS DECREASING, AND POLICE REPORT A</p> <p>22% REDUCTION I N CALLS FROM THE ENOS PARK NEIGHBORHOOD IN THE FIRST TWO YEARS OF THE</p> <p>PROGRAM A TOTAL OF 640 NEIGHBORHOOD RESIDENTS WERE IMPACTED, INCLUDING 43 CHILDREN IN A</p> <p>SUMMER ENRICHMENT PRO GRAM THIRTY-NINE PAROLEES WERE SERVED BY THE COMMUNITY HEALTH</p> <p>WORKERS, RESULTING IN ZERO RECIDIVISM IN THIS GROUP COLLABORATION WITH THE MOSAIC</p> <p>CHILDREN'S MENTAL HEALTH PROJECT H AS PLACED A BEHAVIORAL HEALTH CONSULTANT WITHIN THE</p> <p>NEIGHBORHOOD ELEMENTARY SCHOOL A STEE RING COMMITTEE MEETS REGULARLY, AND AN ACTIVE</p> <p>COMMUNITY ADVISORY COMMITTEE MADE UP OF NEIG HBORHOOD RESIDENTS MEETS MONTHLY</p> <p>EDUCATION WAS ALSO OFFERED TO LOCAL HEALTH AND SOCIAL SE RVICE ORGANIZATIONS AS</p> <p>COLLABORATION INCREASED ACCESS TO CARE WAS ALSO IMPROVED BY MMC PR OVIDING FINANCIAL</p> <p>SUPPORT FOR A 30,315 SQUARE FOOT EXPANSION OF THE SIU CENTER FOR FAMILY MEDICINE FQHC,</p> <p>WHICH OPENED IN 2016 THE EXPANSION OF SPACE HAS ALLOWED THE FQHC TO HIRE A DDITIONAL</p> <p>PROVIDERS MMC ALSO IMPROVED ACCESS TO CARE THROUGH FINANCIAL SUPPORT OF SIU SCH OOL OF</p> <p>MEDICINE AND SERVING AS A TEACHING HOSPITAL FOR THE EDUCATION OF NEW PHYSICIANS (NE ARLY</p> <p>HALF SELECT PRIMARY CARE FOR THEIR RESIDENCIES) ACCESS TO NECESSARY MEDICATIONS WAS</p> <p>INCREASED BY SUPPORT OF KUMLER OUTREACH MINISTRIES' PHARMACEUTICAL ASSISTANCE PROGRAM</p> <p>FOR PEOPLE WHO CANNOT AFFORD TO PA</p>

**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, 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.

Form and Line Reference	Explanation
MEMORIAL MEDICAL CENTER	<p>Y FOR PRESCRIPTION MEDICATIONS 2 MENTAL HEALTH MMC IS PROVIDING SIGNIFICANT FINANCIAL SUPPORT TO THE CHILDREN'S MOSAIC PROJECT OF MENTAL HEALTH CENTERS OF ILLINOIS (DBA MEMORIAL BEHAVIORAL HEALTH OR MBH) TO INCREASE THE NUMBER OF CHILD-SERVING SITES WITH THE CAPACITY TO CONDUCT SOCIAL/EMOTIONAL SCREENINGS AND IDENTIFY CHILDREN IN DISTRESS MOSAIC PROVIDES MENTAL HEALTH SERVICES ON-SITE TO 11 SPRINGFIELD PUBLIC SCHOOLS IN DISTRICT 186 MOSAIC COMPLETED 2,045 SCREENING IN FY2017, AND 262 CHILDREN RECEIVED ON-SITE INTERVENTIONS IN THE SCHOOL SETTING MMC IS ALSO COLLABORATING WITH MBH AND THE THREE OTHER MEMORIAL HEALTH SYSTEM HOSPITALS TO OFFER MENTAL HEALTH FIRST AID, AN EVIDENCE-BASED PROGRAM, TO LOCAL COMMUNITIES MMC FUNDED THE COST TO BRING NATIONAL INSTRUCTORS TO CENTRAL ILLINOIS, A TOTAL OF 27 INDIVIDUALS WERE TRAINED AND CERTIFIED TO TEACH MENTAL HEALTH FIRST AID IN SANGAMON, LOGAN, MORGAN AND CHRISTIAN COUNTIES, AND 20 INDIVIDUALS ALSO RECEIVED ADDITIONAL CERTIFICATION IN YOUTH MENTAL HEALTH FIRST AID IN FY2017, 795 TEACHERS, FIRST RESPONDERS AND COMMUNITY MEMBERS COMPLETED MENTAL HEALTH FIRST AID 3 OBESITY MMC EXPANDED ACCESS TO THE MEMORIAL WEIGHT LOSS AND WELLNESS CENTER BY IMPLEMENTING THE PROGRAM AT ALMH (LOGAN COUNTY) AND PAH (MORGAN COUNTY) ALSO, MEMORIAL DIABETES SERVICES WAS ADDED AT TMH (CHRISTIAN COUNTY) TO SERVE RURAL RESIDENTS THE WEIGHT LOSS AND WELLNESS CENTER IS BASED ON THE NATIONALLY RECOGNIZED, EVIDENCE-BASED MODEL OF GEISINGER HEALTH SYSTEM IT INCLUDES A MEDICAL (NON-SURGICAL) WEIGHT LOSS PROGRAM, ACCREDITED BARIATRIC SURGERY PROGRAM, DIABETES SERVICES, OUTPATIENT NUTRITION SERVICES, AND FITNESS IT PROVIDES PHYSICIANS A COMPREHENSIVE RESOURCE FOR THEIR PATIENTS TO OBTAIN INDIVIDUALIZED COUNSELING AND EDUCATION THERE IS NO OTHER PROGRAM OFFERING THIS SPECIALIZED APPROACH IN CENTRAL ILLINOIS ADDITIONALLY, THE MEMORIAL WEIGHT LOSS AND WELLNESS CENTER ADDED A PEDIATRIC AND FAMILY COMPONENT TO THE PROGRAM IN SANGAMON COUNTY, WHICH HAS BEEN REQUESTED BY PHYSICIANS AND COMMUNITY MEMBERS MMC IS ALSO COLLABORATING WITH THE SPRINGFIELD YMCA TO ESTABLISH THE CENTER FOR DISEASE CONTROL'S DIABETES PREVENTION PROGRAM, WHICH FOCUSES ON HEALTHY EATING AND PHYSICAL ACTIVITY TO PREVENT PEOPLE WITH PRE-DIABETES FROM DEVELOPING THE DISEASE MMC IS FINANCIALLY SUPPORTING THE YMCA'S WORK ON COMMUNITY HEALTH AND OBESITY INITIATIVES, SUPPORTS A COMMUNITY GARDEN AND EDUCATION PROGRAM AT A LOW-INCOME APARTMENT COMPLEX, AND SUPPORTS GIRLS ON THE RUN OF CENTRAL ILLINOIS MMC DID NOT SELECT THE FOLLOWING ISSUES AS ITS FINAL PRIORITIES 1 CHILD ABUSE - CONSIDERING FEASIBILITY, THIS ISSUE IS NOT A CORE COMPETENCY FOR OUR HOSPITAL TO ADDRESS MMC WILL PARTICIPATE ON COMMUNITY INITIATIVES TO ADDRESS THIS ISSUE, BUT IS NOT POSITIONED TO LEAD SUCH AN INITIATIVE 2 HEART/CARDIOVASCULAR DISEASE - MMC IS ALREADY VERY INVOLVED IN ADDRESSING CARDIOVASCULAR ISSUES, BOTH WITHIN ITS PATIENT POPULATION AND IN THE COMMUNITY AT LARGE DATA SHOWS THAT CAR</p>

**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, 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.

Form and Line Reference	Explanation
MEMORIAL MEDICAL CENTER	<p>DIOVASCULAR INDICATORS FOR SANGAMON COUNTY ARE GRADUALLY IMPROVING OVER TIME MMC WILL CON TINUE TO ADDRESS CARDIOVASCULAR ISSUES, BUT IT WAS FELT THAT A FOCUS ON OBESITY MIGHT BE A WAY TO ADDRESS A SIGNIFICANT CONTRIBUTING FACTOR 3 DIABETES IS A SIGNIFICANT ISSUE IN SAN GAMON COUNTY AND IMPACTS MANY PEOPLE MMC IS ALREADY ADDRESSING DIABETES BUT, LIKE CARDIO VASCULAR DISEASE, IT WAS DETERMINED THAT SELECTING OBESITY AS A PRIORITY RATHER THAN DIABE TES WOULD BE A WAY TO ADDRESS A SIGNIFICANT CONTRIBUTING FACTOR 4 DENTAL CARE DID NOT RAN K HIGH IN FEASIBILITY FOR MMC, EITHER IN EXPERTISE OR RESOURCES THE COMMUNITY DOES HAVE A FEDERALLY QUALIFIED HEALTH CENTER THAT OFFERS DENTAL SERVICES 5 FOOD INSECURITY DID NOT R ANK AS HIGH A PRIORITY FOR THE HOSPITAL TO ADDRESS AS THE OTHER ISSUES IT WAS FELT THAT I T WOULD BE MORE FEASIBLE TO ADDRESS THIS THROUGH A BROADER COMMUNITY COLLABORATIVE 6 ASTHM A, ALTHOUGH AN IMPORTANT ISSUE, DID NOT RANK AS HIGH USING THE DEFINED CRITERIA AS DID THE OTHER SELECTED PRIORITIES ADDITIONALLY, OTHER COMMUNITY ORGANIZATIONS (HSHS ST JOHN'S H OSPITAL, THE COUNTY HEALTH DEPARTMENT AND SIU SCHOOL OF MEDICINE) ARE WORKING ON THIS ISSU E</p>

**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, 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.

Form and Line Reference	Explanation
ABRAHAM LINCOLN MEMORIAL HOSPITAL	<p>PART V, SECTION B, LINE 11 FOR ALMH, THE LOGAN COUNTY CHNA EXTERNAL ADVISORY COMMITTEE IDENTIFIED THE FOLLOWING AS TOP PRIORITY HEALTH NEEDS 1 CHRONIC DISEASE MANAGEMENT (DIABETE S/CARDIOVASCULAR DISEASE)2 OBESITY3 INCREASED DRUG USE IN TEENS4 PREGNANT WOMEN SMOKING5 A CCESS TO HEALTHCARE6 INCREASING CHILD ABUSE RATE7 MENTAL HEALTH8 DRUG ADDICTION/HEROIN USE 9 BULLYING10 TEEN BIRTH RATEFOUR FINAL PRIORITIES WERE SELECTED BY ALMH AND ARE ADDRESSED IN AN IMPLEMENTATION STRATEGY OUTCOMES FOR TY2016/FY2017 INCLUDE THE FOLLOWING 1 OBESITY - THE IMPLEMENTATION STRATEGY IDENTIFIES THE EXPANSION OF THE MEMORIAL WEIGHT LOSS AND WE LLNESS CENTER, AN EVIDENCE-BASED PROGRAM, INCREASING ACCESS TO THESE SERVICES TO PEOPLE IN LOGAN COUNTY IN FY17, LOCAL PHYSICIANS MADE 54 REFERRALS TO THIS PROGRAM PATIENTS IN TH E MEDICAL WEIGHT LOSS PROGRAM ACHIEVED AN AVERAGE OF 12% MAINTAINED WEIGHT LOSS AT 15 MONT HS FOLLOWING THE PROGRAM, BARIATRIC SURGICAL PATIENTS LOST AN AVERAGE OF 31 1% EXCESS WEIG HT AT ONE YEAR POST-OP ADDITIONALLY, ALMH IS WORKING WITH LOGAN COUNTY SCHOOLS TO OFFER T HE CENTER FOR DISEASE CONTROL'S CATCH PROGRAM TO ADDRESS CHILDHOOD OBESITY EIGHT NEW SCHO OLS JOINED THE PROGRAM IN FY17, FOR A TOTAL OF 15 SCHOOLS PARTICIPATING IN LOGAN COUNTY AS WELL AS TWO EARLY CHILDHOOD PROGRAMS, IMPACTING 3,000 STUDENTS ALL SCHOOLS RECEIVE EQUIP MENT AND EDUCATIONAL MATERIALS FOR THE PROGRAM, PHYSICAL EDUCATION TEACHERS WERE TRAINED, AND ALMH PROVIDES ONGOING PROGRAM SUPPORT IN THE SCHOOLS MEASURES SHOW THAT CATCH LANGUAG E AND LEARNING IS BECOMING A PART OF SCHOOL CULTURE ALMH IS ALSO CONDUCTING PUBLIC EDUCAT ION CAMPAIGNS IN THE COMMUNITY AND SCHOOLS USING THE 5-2-1-0 MESSAGE TO PROMOTE HEALTHY BE HAVIORS FOR CHILDREN AND FAMILIES ALMH SUPPORTS THE GIRLS ON THE RUN PROGRAM WITH LOCAL S CHOOLS THE HOSPITAL IS ALSO WORKING TO INCREASE ACCESS TO OUTDOOR TRAILS OR PHYSICAL ACTI VITY WORK WAS COMPLETED IN FY17 ON A NEW WELLNESS TRAIL AT THE HOSPITAL CAMPUS, MORE THAN 5,000 MILES WERE CLOCKED ON THE TRAIL USING A TRAIL COUNTER ALMH IS ALSO WORKING TO INCR EASE THE NUMBER OF MOTHERS WHO BREASTFEED THEIR INFANTS, INCLUDING EDUCATION AND A SUPPORT GROUP WIC (WOMEN, INFANTS AND CHILDREN) PROGRAM AT LOGAN COUNTY DEPARTMENT OF PUBLIC HEA LTH REPORTED A 5% INCREASE IN BREASTFEEDING AT 6 MONTHS OF AGE AND A 7 5% INCREASE BREASTF EEDING AT 12 MONTHS OF AGE ALMH ALSO OPENED A NEW SATURDAY FARMERS MARKET, OPEN FROM MAY TO OCTOBER ATTENDANCE HAS GROWN TO 16,000 PEOPLE, WITH AVERAGE WEEKLY ATTENDANCE OF 695 ALMH COMPLETED 172 FREE LIPID PROFILES/BLOOD GLUCOSE SCREENINGS AND 266 BLOOD PRESSURE/BMI SCREENINGS ALSO, 23 ACTIVITIES TARGETING CHILDREN TO LEARN ABOUT THE BENEFITS OF EXERCIS E AND EATING FRESH PRODUCE THE 2016 ILLINOIS YOUTH SURVEY REPORTED AN INCREASE OF 5 PERCE NTAGE POINTS OF FRUIT AND VEGETABLE CONSUMPTION IN 8TH TO 10TH GRADERS SINCE 2014 THE ILL INOIS YOUTH SURVEY ALSO SHOWED THAT THE SAME CLASS SURVEYED IN 2014 HAD A 6% DECREASE IN O BESITY VIA A SELF-REPORTED BMI</p>

**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, 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.

Form and Line Reference	Explanation
ABRAHAM LINCOLN MEMORIAL HOSPITAL	<p>OF &gt;30 2 CHRONIC DISEASE MANAGEMENT (CARDIOVASCULAR DISEASE/DIABETES) - ALMH PROVIDES DIA BETES EDUCATION THROUGH A DIABETES SUPPORT GROUP, OFFERED AT THE SENIOR CENTER, AND AN AVE RAGE OF 5 PEOPLE ATTENDED ALMH ALSO OFFERS AN ANNUAL WOMEN'S HEALTH EDUCATION EVENT THAT FOCUSES ON AWARENESS OF NUTRITION, PHYSICAL ACTIVITIES AND PREVENTATIVE BEHAVIORS THE ATT ENDANCE OF 150 SURPASSED THE GOAL OF 65 PEOPLE, 62% OF SURVEYED PARTICIPANTS REPORTED THEY ARE TRYING TO IMPROVE THEIR HEALTHY BEHAVIORS AFTER THE EVENT, 82% OF ATTENDEES REPORTED INCREASED AWARENESS TO DRINK WATER, AND 58% REPORTED AWARENESS TO EAT MORE FRUITS AND VEGE TABLES FREE CHOLESTEROL AND PULSE OXIMETER SCREENINGS, AS WELL AS DIABETES EDUCATION ARE OFFERED AT THE ANNUAL COMMUNITY WELLNESS EXPO, WHICH WAS ATTENDED BY 550 PEOPLE IN FY2017</p> <p>3 ACCESS TO HEALTHCARE - ALMH COLLABORATED WITH THE LOGAN COUNTY DEPARTMENT OF PUBLIC HEAL TH AND SIU CENTER FOR FAMILY MEDICINE TO OPEN A NEW FEDERALLY QUALIFIED HEALTH CENTER, INC REASING ACCESS TO CARE THE ABRAHAM LINCOLN HEALTHCARE FOUNDATION PROVIDED A GRANT TO RENO VATE SPACE AT THE HEALTH DEPARTMENT FOR THE NEW CLINIC SPACE ALMH ALSO PROVIDES PHARMACEU TICAL ASSISTANCE FOR PATIENTS DISCHARGED FROM THE EMERGENCY DEPARTMENT OR INPATIENT CARE W HO CANNOT AFFORD TO FILL THEIR PRESCRIBED MEDICATIONS ALMH ALSO HELPS INCREASE ACCESS TO HEALTHCARE BY TRAINING THE NEXT GENERATION OF HEALTHCARE PROVIDERS THROUGH CLINICAL EDUCAT ION ROTATIONS FOR NURSING AND ALLIED HEALTH STUDENTS ALMH IS ALSO INCREASING ACCESS TO CO NCUSSION EDUCATION AND CARE BY OFFERING FREE BASELINE NEUROLOGICAL TESTING TO ATHLETES AGE S 10 AND OLDER, IN COLLABORATION WITH LOCAL SCHOOLS, SPORTS PROGRAMS AND COLLEGES, 842 BAS ELINE SCREENINGS HAVE BEEN CONDUCTED, AS WELL AS 83 POST-INJURY SCREENINGS</p> <p>4 MENTAL HEALT H - ALMH COLLABORATED WITH THE THREE OTHER MEMORIAL HEALTH SYSTEM HOSPITALS AND MBH TO OFF ER MENTAL HEALTH FIRST AID TRAINING TO THE COMMUNITIES IT SERVES, 49 PEOPLE IN LOGAN COUNT Y COMPLETED THE TRAINING IN FY2017 ALMH ALSO COLLABORATED WITH LINCOLN JUNIOR HIGH SCHOOL AND MBH TO BRING THE MOSAIC PROGRAM TO THE SCHOOL A BEHAVIORAL HEALTH CONSULTANT SCREENS ALL STUDENTS, THOSE WITH IDENTIFIED NEEDS ARE PROVIDED SERVICES AT THE SCHOOL THIRTEEN S TUDENTS RECEIVED SERVICES IN THE FIRST YEAR OF THE PROGRAM THE FOLLOWING PRIORITIES WERE N OT SELECTED FOR THE FOLLOWING REASONS -TEEN BIRTH RATE WAS ELIMINATED FROM FURTHER CONSID ERATION BECAUSE IT DOES NOT HAVE AS GREAT AN OVERALL IMPACT ON POPULATION HEALTH AS SOME O F THE OTHER NEEDS -INCREASED DRUG USE AND INCREASING CHILD ABUSE RATES ARE GREAT CONCERNS FOR OUR COMMUNITIES, BUT AS A HOSPITAL, ALMH IS NOT BEST EQUIPPED TO MEET THAT NEED HOWEV ER, THE LOCAL HEALTH COALITTON, HEALTHY COMMUNITIES PARTNERSHIP, WILL BE SUPPORTING EFFORT S OF ITS PARTNER ORGANIZATIONS TO ADDRESS THESE ISSUES -THE HIGH RATE OF LOGAN COUNTY WOM EN WHO SMOKE DURING PREGNANCY IS ALARMING THE ISSUE IS BEING ADDRESSED BY THE LOGAN COUNT Y DEPARTMENT OF PUBLIC HEALTH</p>

**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, 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.

Form and Line Reference	Explanation
ABRAHAM LINCOLN MEMORIAL HOSPITAL	ALMH WILL SUPPORT ITS EFFORTS THROUGH THE HEALTHY COMMUNITIES PARTNERSHIP -BULLYING WAS N OT CHOSEN AS A PRIORITY AS THE PROGRAM IS BEING ADDRESSED IN LOCAL SCHOOLS

**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, 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.

Form and Line Reference	Explanation
TAYLORVILLE MEMORIAL HOSPITAL	<p>PART V, SECTION B, LINE 11 THE CHNA FOR CHRISTIAN COUNTY AND TMH IDENTIFIED EIGHT TOP PRI ORITIES ACCESS TO MENTAL HEALTH SERVICES, ACCESS TO PEDIATRIC DENTAL SERVICES, OBESITY, H EART DISEASE, LUNG CANCER, COLORECTAL CANCER, DIABETES, AND BREAST CANCER THREE FINAL PRI ORITIES WERE SELECTED BY TMH AND ARE ADDRESSED IN ITS TY2016/FY2017 IMPLEMENTATION STRATEG Y, WITH THE FOLLOWING OUTCOMES 1 OBESITY - THE IMPLEMENTATION STRATEGY IDENTIFIED CONDUCT ING A FEASIBILITY STUDY TO SEE WHETHER THE MEMORIAL WEIGHT LOSS AND WELLNESS CENTER, AN EV IDENCE-BASED PROGRAM, SHOULD BE ADDED TO SERVICES OFFERED BY TMH TO INCREASE ACCESS TO THI S CARE FOR PEOPLE IN CHRISTIAN COUNTY ALTHOUGH THAT PROGRAM WILL NOT BE IMPLEMENTED AT TM H AT THIS TIME, TMH DID IMPLEMENT A NEW DIABETES SELF-MANAGEMENT EDUCATION PROGRAM, OFFERI NG SIX CLASSES IN FY2017 TWENTY PEOPLE PARTICIPATED IN THE NEW PROGRAM, WITH 14 REACHING THEIR GOALS TMH ALSO STARTED WORKING WITH THE LOCAL YMCA TO IMPLEMENT THE CDC'S DIABETES PREVENTION PROGRAM ADDITIONALLY, TMH SPONSORED GIRLS ON THE RUN OF CENTRAL ILLINOIS 2 ME NTAL HEALTH - TMH COLLABORATED WITH THE THREE OTHER MEMORIAL HEALTH SYSTEM HOSPITALS AND M BH TO OFFER ITS COMMUNITY ACCESS TO MENTAL HEALTH FIRST AID (MHFA) IN 2016, TWENTY-SEVEN PEOPLE BECAME CERTIFIED TRAINERS IN THIS NATIONAL PROGRAM, WITH FOUR OF THEM FROM CHRISTIA N COUNTY THESE TRAINERS OFFERED MHFA COURSES TO THE CHRISTIAN COUNTY COMMUNITY, WITH 76 P EOPLE PARTICIPATING TMH ALSO STAFFS AND PROVIDES PROGRAM SUPPORT FOR SENIOR LIFE SOLUTION S, IN COLLABORATION WITH CHRISTIAN COUNTY MENTAL HEALTH, WHICH SUPPORTS SENIORS IN DEALING WITH DEPRESSION AND ANXIETY IN FY2017 THERE WERE 10 PARTICIPANTS PROGRAM OUTCOMES INCLU DED LOWER GENERALIZED ANXIETY FOR PARTICIPANTS AND NONE RETURNED TO THE EMERGENCY DEPARTME NT FOR MENTAL HEALTH ISSUES 3 ACCESS TO CARE - TMH MADE A CHANGE TO ITS PRIORITIES AND IM PLEMENTATION STRATEGY FOR FY2017 TMH BROADENED THE PRIORITY OF PEDIATRIC DENTAL CARE TO A CCESS TO CARE TMH DISCUSSED THIS CHANGE WITH ITS CHNA COMMUNITY ADVISORY COMMITTEE, WHICH AGREED THAT ACCESS TO CARE SHOULD BE ADDED AS A PRIORITY THIS CHANGE WAS APPROVED BY THE TMH BOARD THE GOALS FOR ACCESS TO PEDIATRIC DENTAL SERVICES ARE INCLUDED AS AN OBJECTIVE WITHIN THAT PRIORITY IN FY2017, A PILOT PROJECT WAS STARTED THAT INCLUDES ACCESS TO DENT AL CARE AND TRANSPORTATION FROM SCHOOL FOR CHILDREN IDENTIFIED IN NEED OF SERVICES FIVE C HILDREN RECEIVED URGENTLY NEEDED DENTAL CARE ALSO IN FY2017, A NEW FEDERALLY QUALIFIED HE ALTH CENTER OPENED IN CHRISTIAN COUNTY, TMH COLLABORATED WITH IT TO EDUCATE THE COMMUNITY ABOUT ACCESS TO THIS NEW SERVICE ALSO INCLUDED UNDER ACCESS TO CARE IS COLLABORATION WITH THE CHRISTIAN COUNTY COALITION TO DEVELOP AN ACTION PLAN TO ADDRESS TOBACCO, ALCOHOL AND OTHER DRUG USE BY YOUTH IN CHRISTIAN COUNTY PROGRAMS OFFERED LAST YEAR INCLUDED THE COP, THE CONVICT AND THE KID, AN END THE TREND RALLY ATTENDED BY 125 PEOPLE, FAMILIES ANONYMOUS , AND NARCAN DONATIONS TO LOCA</p>

**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, 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.

Form and Line Reference	Explanation
TAYLORVILLE MEMORIAL HOSPITAL	<p>L LAW ENFORCEMENT WORK ON THE LOCAL ACTION PLAN CONTINUES TMH DID NOT SELECT THE FOLLOWI NG PRIORITIES FROM ITS MOST RECENT CHNA FOR THE FOLLOWING REASONS -HEART DISEASE AND DIAB ETES WERE ELIMINATED FROM FURTHER CONSIDERATION BECAUSE THE ADVISORY GROUP MEMBERS FELT TH AT EFFORTS TO IMPROVE TREATMENT OF OBESITY WOULD ALSO IMPACT THE INCIDENCE AND MORBIDITY O F HEART DISEASE AND DIABETES -LUNG CANCER WAS NOT CHOSEN BECAUSE, ALTHOUGH IT WAS RANKED AS A HIGH PRIORITY BY THE ADVISORY GROUP, IT WAS PERCEIVED BY THE ADVISORY GROUP THAT THER E WOULD BE LITTLE OPPORTUNITY TO MAKE ADDITIONAL IMPACT BEYOND WHAT IS ALREADY BEING DONE BY THE CHRISTIAN COUNTY HEALTH DEPARTMENT -COLORECTAL CANCER WAS NOT CHOSEN BECAUSE IT CON SISTENTLY RANKED AS A LOWER PRIORITY AMONG THE ADVISORY GROUP MEMBERS TMH CURRENTLY OFFER S ADVANCED COLONOSCOPY SERVICES, AND ANNUAL COLORECTAL CANCER EDUCATION FOR THE COMMUNITY -BREAST CANCER WAS NOT CHOSEN BECAUSE IT WAS RANKED AS A LOWER PRIORITY AMONG THE ADVISOR Y GROUP MEMBERS FREE MAMMOGRAMS ARE AVAILABLE TO LOW INCOME WOMEN WHO QUALIFY FOR THE ILL INOIS BREAST AND CERVICAL CANCER PROGRAM AND THE CUPS FOR THE CURE FUND AT TMH IS ALSO AVA ILABLE TO OFF-SET COSTS OF MAMMOGRAPHY FOR OTHER WOMEN</p>



**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, 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.

Form and Line Reference	Explanation
PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION	<p>PART V, SECTION B, LINE 11 IN REVIEW OF THE SURVEY DATA, PAH IDENTIFIED 9 PRIORITIES THE Y WERE ACCESS TO CARE, MENTAL HEALTH, EARLY SEXUAL ACTIVITY/TEEN PREGNANCY, OBESITY, DENT AL CARE, SUBSTANCE MISUSE, COLON CANCER, SEXUALLY TRANSMITTED DISEASES, AND TOBACCO ACCES S TO CARE, MENTAL HEALTH, AND OBESITY WERE CHOSEN AS THE FINAL PRIORITIES OUTCOMES FOR TY 2016/FY2017 INCLUDE THE FOLLOWING MENTAL HEALTH - IN FY2017, PAH CONTINUED EFFORTS TO INC REASE ACCESS TO THE INPATIENT PSYCHIATRIC UNIT AND REDUCE BOARD DAYS IN THE EMERGENCY ROOM THE 10 BED INPATIENT BEHAVIORAL HEALTH UNIT AVERAGED 7 6 PATIENTS DAILY WITH AN 89% UTIL IZATION RATE BOARD DAYS IN THE EMERGENCY ROOM DECREASED TO 0 53 DAYS ON AVERAGE CONTINUE D EFFORTS TO REDUCE THE STIGMA OF MENTAL HEALTH AND IMPROVE UNDERSTANDING OF REFERRALS TO AVAILABLE COMMUNITY RESOURCES ARE ONGOING SUPPORT OF COMMUNITY EFFORTS INCLUDE THE MORGAN SCOTT SUICIDE PREVENTION TASK FORCE AND MENTAL HEALTH FIRST AID (MHFA), WHICH IS AN EVIDE NCE-BASED PROGRAM THAT OFFERS A FIVE-DAY INTENSIVE TRAINING SESSION TO COMMUNITY MEMBERS T O BECOME CERTIFIED MHFA TRAINERS THESE CERTIFIED TRAINERS IN TURN GO OUT IN THE COMMUNITY TO PROVIDE AN EIGHT-HOUR EDUCATION SESSION TO COMMUNITY MEMBERS SUCH AS TEACHERS, POLICE, FIRST RESPONDERS, CHURCHES, YOUTH LEADERS AND OTHERS TO TEACH THEM HOW TO IDENTIFY MENTAL HEALTH ISSUES, HOW TO REFER PEOPLE TO RESOURCES, AND ENCOURAGE COMMUNITY SUPPORT OF THOSE STRUGGLING WITH ISSUES THAT MAY CONTRIBUTE TO MENTAL ILLNESS THE SUBSTANCE ABUSE AND MEN TAL HEALTH SERVICES ADMINISTRATION (SAMHSA), THE FEDERAL AGENCY THAT LEADS PUBLIC HEALTH E FFORTS TO ADVANCE THE BEHAVIORAL HEALTH OF THE NATION, ENDORSES MHFA AND RECENTLY ESTABLIS HED GRANT FUNDING FOR MHFA AS PART OF THE PRESIDENT'S INITIATIVE TO INCREASE ACCESS TO MEN TAL HEALTH SERVICES MHFA IS ON THE NATIONAL REGISTRY OF EVIDENCE BASED PRACTICES (NREPP) ALL INTERVENTIONS ON THE REGISTRY HAVE BEEN INDEPENDENTLY ASSESSED AND RATED FOR QUALITY OF RESEARCH AND READINESS FOR DISSEMINATION MHFA HAS BEEN SHOWN TO INCREASE UNDERSTANDING OF MENTAL HEALTH DISORDERS, KNOWLEDGE OF AVAILABLE RESOURCES, AND CONFIDENCE IN AND LIKEL IHOOD TO HELP AN INDIVIDUAL IN DISTRESS IN FY2017, PAH DEVELOPED A LOCALIZED COMMUNICATIO N PLAN TO CREATE AWARENESS AND PROMOTE AVAILABLE MHFA COURSES THIS PLAN INCLUDED THE UTIL IZATION OF PRESS RELEASES, MAILINGS, AND SOCIAL MEDIA SO FAR, 13 TRAININGS HAVE BEEN HELD IN MORGAN COUNTY WITH 277 MHFAIDERS TRAINED OBESITY - MMC AND PAH CONTINUE WORKING TOGETH ER TO IMPLEMENT THE MEMORIAL WEIGHT LOSS AND WELLNESS CENTER PROGRAM AT PAH, EXPANDING ACC ESS TO THE PROGRAM INTO MORGAN COUNTY IN FY2017, THE PROGRAM WAS EXPANDED TO FIVE DAYS PE R WEEK PROVIDING ADDITIONAL ACCESS AND SHORTER WAIT TIMES FOR PATIENTS FOR FY2017, THE PR OGRAM RECEIVED 87 PATIENT REFERRALS MEDICAL WEIGHT LOSS PATIENTS HAVE LOST AN AVERAGE OF 8% OF TOTAL BODY WEIGHT WITHIN 12 MONTHS PAH IS WORKING TO IMPROVE ATTITUDES ABOUT HEALTH Y LIFESTYLES THROUGH MONTHLY E</p>

**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, 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.

Form and Line Reference	Explanation
PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION	<p> DUCATION PROGRAMS WITH 5TH GRADE SCHOOL CHILDREN USING THE 5-2-1-0 CURRICULUM, AN EVIDENCE BASED HEALTHY LIFESTYLES CURRICULUM URGING STUDENTS TO EAT FIVE SERVINGS OF FRUITS AND VE GETABLES, LIMIT SCREEN TIME TO TWO HOURS OR LESS, EXERCISE AT LEAST ONE HOUR EVERY DAY AND HAVE ZERO SUGARY DRINKS PAH IS ALSO SPONSORING THE WALKING FOR WELLNESS PROGRAM AT THE J ACKSONVILLE HIGH SCHOOL BOWL AND THE FIRST CHRISTIAN CHURCH AT THE BOWL, WALKERS ENJOY A HEATED LOCATION FOR DAILY WALKING EXERCISE ON DAYS WHEN SCHOOL IS IN SESSION, NOVEMBER THR OUGH APRIL THE FIRST CHRISTIAN CHURCH OFFERS A CLIMATE CONTROLLED ENVIRONMENT FOR WALKING YEAR AROUND ADDITIONALLY, PAH PROVIDES FINANCIAL SUPPORT FOR GIRLS ON THE RUN(GOTR) IN S CHOOOLS LOCATED WITHIN PAH'S SERVICE AREA FOR FY2017, 6 MORGAN COUNTY SCHOOLS ENROLLED IN GOTR (58 GIRLS), THE WALKING FOR WELLNESS PROGRAM DREW OVER 8,000 ENCOUNTERS COMBINED BETW EEN THE JACKSONVILLE BOWL AND FIRST CHRISTIAN CHURCH SITES, AND 5-2-1-0 MESSAGES WERE GIVE N AT THE YMCA ON A MONTHLY BASIS AND INCORPORATED INTO COMMUNITY EVENTS AND HEALTH FAIRS A CCESS TO CARE - PAH, IN COLLABORATION WITH THE MORGAN COUNTY HEALTH DEPARTMENT AND SOUTHER N ILLINOIS UNIVERSITY SCHOOL OF MEDICINE OPENED A FEDERALLY QUALIFIED HEALTH CENTER (FQHC) IN 2016 PAH PROVIDES LEADERSHIP, PHYSICIAN COVERAGE AND FINANCIAL SUPPORT TOWARDS OPERAT ION OF THE SIU CENTER FOR FAMILY MEDICINE IN MORGAN COUNTY FOR FY2017, THE FQHC AVERAGED 4 48 PATIENTS PER DAY, TOTALING 1,625 VISITS IN ADDITION, PAH CONTINUES TO PROVIDE FINANC IAL SUPPORT FOR THE OPERATIONS OF A WALK-IN STD CLINIC RUN BY THE MORGAN COUNTY HEALTH DEP ARTMENT WITHOUT PAH'S SUPPORT, THE CLINIC WOULD NOT BE ABLE TO OFFER SERVICES FOR FY2017 , 201 CLIENTS WERE COUNSELED, 590 TESTS COMPLETED AND SCREENED WITH 38 POSITIVE RESULTS AN D 103 TREATMENTS PAH ALSO PROVIDES FINANCIAL SUPPORT FOR THE WEST CENTRAL MASS TRANSIT WH ICH PROVIDES RIDES TO COMMUNITY MEMBERS TO AND FROM PAH ACCESS TO DENTAL CARE WAS NOT CHOS EN BECAUSE PAH DOES NOT HAVE THE EXPERTISE TO ADDRESS THE ISSUE COLON CANCER WAS NOT CHOS EN BECAUSE IT CONSISTENTLY RANKED AS A LOW PRIORITY AMONG COMMUNITY MEMBERS PAH CURRENTLY OFFERS ADVANCED COLONOSCOPY SERVICES, ANNUAL COLORECTAL CANCER EDUCATION FOR THE COMMUNIT Y, AND PARTNERS WITH A LOCAL CANCER FOUNDATION TO PROVIDE FREE COLORECTAL SCREENINGS TO CO MMUNITY MEMBERS EACH YEAR SUBSTANCE MISUSE WAS NOT CHOSEN BECAUSE IT DID NOT RANK AS A HI GH PRIORITY AMONG THE ADVISORY COMMITTEE, IN THE COMMUNITY FORUM, OR ON THE SURVEY IT WAS PERCEIVED BY THE ADVISORY COMMITTEE THAT THERE WOULD BE LITTLE OPPORTUNITY TO MAKE ADDITI ONAL IMPACT BEYOND WHAT IS BEING DONE THROUGH THE PARTNERSHIP FOR A HEALTHY COMMUNITY, WHI CH IS A COLLABORATION OF LOCAL LAW ENFORCEMENT, EDUCATION INSTITUTIONS, HEALTH PROVIDERS, AND THE WELLS CENTER - A DRUG AND ALCOHOL TREATMENT FACILITY EARLY SEXUAL ACTIVITY/TEEN P REGNANCY WAS NOT CHOSEN BECAUSE THE MORGAN COUNTY HEALTH DEPARTMENT IS ALREADY ADDRESSING THIS DISPARITY IN THE SCHOOLS, </p>

**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, 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.

Form and Line Reference	Explanation
PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION	AND IT WOULD BE A DUPLICATION OF SERVICES TOBACCO RANKED SIGNIFICANTLY LOWER THAN OTHER PRIORITIES IN THE FORUM AND THE SURVEY IT WAS COMMUNICATED THAT IT WOULD BE DIFFICULT TO MAKE A SIGNIFICANT IMPACT AS THE MORGAN COUNTY HEALTH DEPARTMENT IS PARTNERING WITH THE IL LINOIS QUITLINE TO OFFER SMOKING CESSATION PRODUCTS SEXUALLY TRANSMITTED DISEASES WILL BE ADDRESSED AS AN ACCESS TO CARE INITIATIVE IN PARTNERSHIP WITH THE HEALTH DEPARTMENT, RATHER THAN A STAND-ALONE PRIORITY PAH WILL CONTINUE TO SUPPORT THE HEALTH DEPARTMENT'S STD CLINIC WHICH WAS REOPENED IN 2014 USING FUNDS ALLOCATED BY THE HOSPITAL THIS NEED CONTINUES TO BE MET THROUGH THIS PARTNERSHIP ESTABLISHED AS A RESULT OF THE 2012 CHNA

Section D. 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 - MEMORIAL PHYSICIAN SERVICES-KOKE MILL 3132 OLD JACKSONVILLE RD SPRINGFIELD, IL 62704	MPS PHYSICIAN
2 - MEMORIAL PHYS SVCS-JACKSONVILLE 15 FOUNDERS LANE SUITE 100 JACKSONVILLE, IL 62650	MPS PHYSICIAN
3 - MEMORIAL PHYSICIAN SERVICES-LINCOLN 515 NORTH COLLEGE STREET LINCOLN, IL 62526	MPS PHYSICIAN
4 - MEMORIAL EXPRESSCARE AT SOUTH SIXTH 2950 SOUTH SIXTH STREET SPRINGFIELD, IL 62703	ANCILLARY SERVICES
5 - MEMORIAL EXPRESSCARE AT NORTH DIRKSEN 3220 ATLANTA STREET SPRINGFIELD, IL 62702	ANCILLARY SERVICES
6 - MEMORIAL EXPRESSCARE AT KOKE MILL 3132 OLD JACKSONVILLE RD SPRINGFIELD, IL 62704	ANCILLARY SERVICES
7 - MEMORIAL PHYSICIAN SERVICES-VINE STREET 3225 HEDLEY RD SPRINGFIELD, IL 62711	MPS PHYSICIAN
8 - MEMORIAL PHYSICIAN SERVICES-CHATHAM 101 EAST PLUMMER CHATHAM, IL 62629	MPS PHYSICIAN
9 - SPORTSCARE AT YMCA 4550 WEST ILES SPRINGFIELD, IL 62711	OUTPATIENT SERVICES
10 - MEMORIAL EXPRESSCARE AT CHATHAM 101 EAST PLUMMER CHATHAM, IL 62629	ANCILLARY SERVICES
11 - MEMORIAL PHYS SVCS-WOMEN'S HEALTHCARE 747 NORTH RUTLEDGE SPRINGFIELD, IL 62701	MPS PHYSICIAN
12 - MEMORIAL PHYSICIAN SERVICES-PETERSBURG 1 CENTRE DRIVE PETERSBURG, IL 62675	MPS PHYSICIAN
13 - MEMORIAL PHYS SVCS-CAPITAL HEALTHCARE 2603 SOUTH SIXTH SPRINGFIELD, IL 62703	MPS PHYSICIAN
14 - MEMORIAL INDUSTRIAL REHAB 775 ENGINEERING DRIVE SPRINGFIELD, IL 62703	OUTPATIENT SERVICES
15 - MEMORIAL PHYSICIAN SVCS-NORTH DIRKSEN 3220 ATLANTA STREET SPRINGFIELD, IL 62707	MPS PHYSICIAN

**Form 990 Schedule H, Part V Section D. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

**Section D. 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)
16 - SPINEWORKS PAIN CENTER 501 NORTH FIRST STREET SPRINGFIELD, IL 62702	OUTPATIENT SERVICES
17 - MEMORIAL PHYSICIAN SERVICES-SOUTH SIXTH 2950 SOUTH SIXTH STREET SPRINGFIELD, IL 62703	MPS PHYSICIAN
18 - MEMORIAL PHYSICIAN SVCS-MACARTHUR 2115 SOUTH MACARTHUR BLVD SPRINGFIELD, IL 62704	MPS PHYSICIAN
19 - WOUND HEALING CENTER 901 NORTH FIRST STREET SPRINGFIELD, IL 62702	OUTPATIENT SERVICES
20 - MEMORIAL MD SMARTVISIT 701 NORTH FIRST STREET SPRINGFIELD, IL 62781	VIRTUAL CARE

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As Filed Data -

DLN: 93493226009978

Schedule I  
(Form 990)

OMB No 1545-0047

2016

Open to Public Inspection

Department of the Treasury  
Internal Revenue Service

Grants and Other Assistance to Organizations,  
Governments and Individuals in the United States  
Complete if the organization answered "Yes," on Form 990, Part IV, line 21 or 22.  
▶ Attach to Form 990.  
▶ Information about Schedule I (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

Name of the organization  
MEMORIAL HEALTH SYSTEM GROUP

Employer identification number  
90-0756744

Part I

General Information on Grants and Assistance

- 1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . . . 

☒ Yes ☐ No
- 2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States

Part II

Grants and Other Assistance to Domestic Organizations and Domestic Governments. Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than \$5,000. Part II can be duplicated if additional space is needed.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
See Additional Data Table							
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table . . . . . 13

3 Enter total number of other organizations listed in the line 1 table . . . . . 1

**Part III** **Grants and Other Assistance to Domestic Individuals.** Complete if the organization answered "Yes" on Form 990, Part IV, line 22

Part III can be duplicated if additional space is needed

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
See Additional Data Table					
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					

**Part IV** **Supplemental Information.** Provide the information required in Part I, line 2, Part III, column (b), and any other additional information.

Return Reference	Explanation
PART I, LINE 2	MEMORIAL HEALTH SYSTEM (MHS) PROVIDES GRANTS AND ASSISTANCE PRIMARILY TO LOCALLY MANAGED 501(C)(3) ORGANIZATIONS OR INDIVIDUALS WHO MEET THE CRITERIA FOR GRANTS AND/OR ASSISTANCE REQUESTS TO SUPPORT INITIATIVES IN LINE WITH MHS'S COMMUNITY HEALTH NEED ASSESSMENT PRIORITIES RECEIVE SPECIAL CONSIDERATION MHS AFFILIATES UTILIZE A COMBINATION OF METHODS TO ENSURE FUNDS ARE AWARDED TO ELIGIBLE APPLICANTS AND THE FUNDS ARE USED FOR ITS INTENDED PURPOSE THROUGH VARIOUS REPORTING AND MONITORING ACTIVITIES

Additional Data

Software ID:  
Software Version:  
EIN: 90-0756744  
Name: MEMORIAL HEALTH SYSTEM GROUP

Form 990,Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
ENOS PARK NEIGHBORHOOD IMPROVEMENT ASSOCIATION 1015 N 7TH STREET SPRINGFIELD,IL 62702	37-1288358	501(C)(3)	37,226				NEIGHBORHOOD AND COMMUNITY REDEVELOPMENT
ILLINOIS HOSPITAL RESEARCH AND EDUCATION FOUNDATION 1151 EAST WARRENVILLE ROAD NAPERVILLE,IL 60566	23-7421930	501(C)(3)	125,731				TO ADDRESS THE DISPARATE AND NEGATIVE EFFECTS OF THE ILLINOIS MEDICAID PROGRAM EXPERIENCED BY HOSPITALS AND HEALTHCARE SYSTEMS IN ILLINOIS



Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
KUMLER OUTREACH MINISTRIES 303 NORTH GRAND AVE EAST SPRINGFIELD, IL 62702	37-0695489	501(C)(3)	9,500				PHARMACEUTICAL ASSISTANCE
ILLINOIS COLLEGE 1101 WEST COLLEGE AVENUE JACKSONVILLE, IL 62650	37-0661211	501(C)(3)	25,000				COMMUNITY BUILDING NURSING PROGRAM

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MIDWEST HEALTHCARE QUALITY ALLIANCE LLC 701 NORTH FIRST STREET SPRINGFIELD, IL 62781	46-4411631		28,141				HEALTHCARE SAFETY SYMPOSIUM AND SECOND VICTIM WORKSHOP
MEMORIAL HOME SERVICES 701 NORTH FIRST STREET SPRINGFIELD, IL 62781	37-0714225	501(C)(3)	22,732				PROVIDE GENERAL SUPPORT AND BLANKET WARMER

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MEMORIAL MEDICAL CENTER 701 NORTH FIRST STREET SPRINGFIELD, IL 62781	37-0661220	501(C)(3)	468,901				PROVIDE DIABETES EDUCATION SCHOLARSHIPS, INFLUENCING COMMITMENT TO BSN COMPLETION, EKG DIGITAL TRANSMISSION EQUIPMENT, MEDICAL-SURGICAL CERTIFICATION AND REVIEW COURSE, ACUTE CARE NURSING CONFERENCE, CRITICAL CARE NURSING CERTIFICATION, SPECIALTY CERTIFICATION AND REVIEW COURSE, CARDIOVASCULAR SYMPOSIUM, EMPLOYEE CERTIFICATION PROGRAM, BIRTHING SIMULATOR, TELEHEALTH MONITORING EQUIPMENT, GENERAL SUPPORT, EQUIPMENT AND SUPPLIES, SUPPORT FOR EDUCATION, PATIENT CARE EDUCATIONAL MATERIALS AND SUPPLIES
MENTAL HEALTH CENTERS OF CENTRAL ILLINOIS 710 NORTH EIGHTH STREET SPRINGFIELD, IL 62702	37-0646367	501(C)(3)	19,468				PROVIDE GENERAL SUPPORT

**Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.**

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION 1600 WEST WALNUT STREET JACKSONVILLE, IL 62650	37-0661230	501(C)(3)	107,358				PROVIDE GENERAL SUPPORT, REHABILITATION EQUIPMENT AND SUPPLIES, PLANT OPERATIONS EQUIPMENT AND SUPPLIES, COMMUNITY HEALTH IMPROVEMENT, LIFELINE SUPPORT, AND COMMUNITY BUILDING JOINT MEDICAL PROGRAM
SIU PHYSICIANS & SURGEONS INC DBA SIU HEALTHCARE PO BOX 19639 SPRINGFIELD, IL 62794	36-4143823	501(C)(3)	1,900,349				MEMORIAL MEDICAL CENTER ENTERED INTO AN ELECTRONIC HEALTH RECORD DONATION AGREEMENT WITH SIU HEALTHCARE TO PROVIDE FUNDING TO ASSIST SIU HEALTHCARE WITH THE IMPLEMENTATION OF THE ALLSCRIPTS TOUCHWORKS ELECTRONIC HEALTH RECORD SIU HEALTHCARE ELECTED TO TRANSITION TO THE ALLSCRIPTS ELECTRONIC HEALTH RECORD IN COLLABORATION WITH MEMORIAL PHYSICIAN SERVICES, AN AFFILIATE OF MEMORIAL HEALTH SYSTEM, AND THE SPRINGFIELD CLINIC, LLP UPON COMPLETION, THIS COLLABORATION AMONG THE MAJOR PHYSICIAN GROUPS IN THE COMMUNITY WILL IMPROVE THE COORDINATION OF CARE FOR ALL PATIENTS THROUGHOUT THE REGION

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
SIU SCHOOL OF MEDICINE 801 NORTH RUTLEDGE SPRINGFIELD, IL 62702	37-6005961	501(C)(3)	255,032				PROVIDE GENERAL SUPPORT, TREATMENT OF PATIENTS WITH STAGE 1 NS CELL LUNG CANCER, POINT OF CARE ULTRASOUND SIMULATOR, AND ALZHEIMER'S CONFERENCE FOR HEALTHCARE PROVIDERS AND COMMUNITY
TAYLORVILLE MEMORIAL HOSPITAL 201 E PLEASANT ST TAYLORVILLE, IL 62568	37-0661250	501(C)(3)	22,098				ASSIST WITH MEDICAL TECHNOLOGIES AND PATIENT SERVICES

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
UNIVERSITY OF ILLINOIS-SPRINGFIELD ONE UNIVERISTY PLAZA SPRINGFIELD, IL 62703	37-6000511	501(C)(3)	69,305				COLLEGE OF NURSING LEARNING LAB
MACMURRAY COLLEGE 447 E COLLEGE AVENUE JACKSONVILLE, IL 62650	37-0661217	501(C)(3)	8,000				NURSING EDUCATION

**Form 990, Schedule I, Part III, Grants and Other Assistance to Domestic Individuals.**

(a)Type of grant or assistance	(b)Number of recipients	(c)Amount of cash grant	(d)Amount of non-cash assistance	(e)Method of valuation (book, FMV, appraisal, other)	(f)Description of non-cash assistance
EDUCATIONAL GRANTS - MEMORIAL MEDICAL CENTER'S EDUCATIONAL GRANT PROGRAM PROVIDES THE OPPORTUNITY FOR BOTH EMPLOYEES AND EXTERNAL CANDIDATES TO PURSUE ADDITIONAL EDUCATION IN EXCHANGE FOR A WORK COMMITMENT ONCE THE EDUCATION IS COMPLETED EDUCATIONAL GRANTS ARE AVAILABLE TO THOSE PURSUING HEALTH CARE CAREERS THAT ARE DEEMED CRITICAL TO THE ORGANIZATION'S PRESENT OR PROJECTED STAFFING NEEDS (I E , NURSING, RADIOLOGY, ETC ) GRANT APPLICATIONS FOR ALL OTHER CAREERS WILL BE REVIEWED ON A CASE-BY-CASE BASIS WITH A FINAL DETERMINATION TO BE MADE BY THE CHIEF HUMAN RESOURCES OFFICER	95	559,929			
TUITION REIMBURSEMENT - FUNDING FOR THE EDUCATION OF MEMORIAL MEDICAL CENTER'S EMPLOYEES IS BASED UPON THE NEEDS OF THE ORGANIZATION AS WELL AS THE EMPLOYEE'S EDUCATIONAL GOALS EMPLOYEES WILL BE AWARDED TUITION REIMBURSEMENT BASED ON THE EMPLOYEE'S PRESENT JOB SKILL NEEDS OR TO PREPARE THE EMPLOYEE FOR FUTURE ADVANCEMENT WITHIN MEMORIAL HEALTH SYSTEM THE TUITION REIMBURSEMENT PROCESS REQUIRES EMPLOYEES TO RECEIVE PRIOR APPROVAL FROM THEIR MANAGERS FOR THE COURSEWORK	128	323,229			
PRESCRIPTION DRUGS FOR PATIENTS	54	4,654			
SHELTER AND UTILITY ASSISTANCE FOR PATIENTS	75	39,682			
DIRECT CASH ASSISTANCE TO PATIENTS	110	41,442			

Form 990, Schedule I, Part III, Grants and Other Assistance to Domestic Individuals.					
(a)Type of grant or assistance	(b)Number of recipients	(c)Amount of cash grant	(d)Amount of non-cash assistance	(e)Method of valuation (book, FMV, appraisal, other)	(f)Description of non-cash assistance
TRANSPORTATION ASSISTANCE FOR PATIENTS	77	13,178			
EMPLOYEE ASSISTANCE WITH CATASTROPHIC EVENTS	36	20,473			
SCHOLARSHIPS FOR EMPLOYEES	19	40,145			
SCHOLARSHIPS	4	6,000			
TAYLORVILLE CUPS ASSISTANCE	15	3,000			



Form 990, Schedule I, Part III, Grants and Other Assistance to Domestic Individuals.					
(a)Type of grant or assistance	(b)Number of recipients	(c)Amount of cash grant	(d)Amount of non-cash assistance	(e)Method of valuation (book, FMV, appraisal, other)	(f)Description of non-cash assistance
PASSAVANT CARES PROGRAM	3	3,649			

Schedule J  
(Form 990)

Department of the Treasury  
Internal Revenue Service

OMB No 1545-0047

2015  
Open to Public Inspection

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23.  
▶ Attach to Form 990.

▶ Information about Schedule J (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

Name of the organization  
MEMORIAL HEALTH SYSTEM GROUP

Employer identification number  
90-0756744

Part I Questions Regarding Compensation

	Yes	No
<b>1a</b> Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items. <div><div><input type="checkbox"/> First-class or charter travel</div><div><input type="checkbox"/> Travel for companions</div><div><input type="checkbox"/> Tax idemnification and gross-up payments</div><div><input type="checkbox"/> Discretionary spending account</div><div><input type="checkbox"/> Housing allowance or residence for personal use</div><div><input type="checkbox"/> Payments for business use of personal residence</div><div><input type="checkbox"/> Health or social club dues or initiation fees</div><div><input type="checkbox"/> Personal services (e g , maid, chauffeur, chef)</div></div>		
<b>b</b> If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain		
<b>2</b> Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?		
<b>3</b> Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III. <div><div><input type="checkbox"/> Compensation committee</div><div><input type="checkbox"/> Independent compensation consultant</div><div><input type="checkbox"/> Form 990 of other organizations</div><div><input type="checkbox"/> Written employment contract</div><div><input type="checkbox"/> Compensation survey or study</div><div><input type="checkbox"/> Approval by the board or compensation committee</div></div>		
<b>4</b> During the year, did any person listed on Form 990, Part VII, Section A, line 1a with respect to the filing organization or a related organization: <b>a</b> Receive a severance payment or change-of-control payment?		No
<b>b</b> Participate in, or receive payment from, a supplemental nonqualified retirement plan?	Yes	
<b>c</b> Participate in, or receive payment from, an equity-based compensation arrangement? If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.		No
<b>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</b>		
<b>5</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of: <b>a</b> The organization?		No
<b>b</b> Any related organization? If "Yes," on line 5a or 5b, describe in Part III.		No
<b>6</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of: <b>a</b> The organization?	Yes	
<b>b</b> Any related organization? If "Yes," on line 6a or 6b, describe in Part III.	Yes	
<b>7</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III.		No
<b>8</b> Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III.		No
<b>9</b> If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?		

**Part II Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees.** Use duplicate copies if additional space is needed.

For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that are not listed on Form 990, Part VII.

**Note.** The sum of columns (B)(i)-(iii) for each listed individual must equal the total amount of Form 990, Part VII, Section A, line 1a, applicable column (D) and (E) amounts for that individual.

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column(B) reported as deferred on prior Form 990
	(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
See Additional Data Table							

**Part III** **Supplemental Information**

Provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 3, 4a, 4b, 4c, 5a, 5b, 6a, 6b, 7, and 8, and for Part II. Also complete this part for any additional information.

Return Reference	Explanation
See Additional Data	

Additional Data

Software ID:  
Software Version:  
EIN: 90-0756744  
Name: MEMORIAL HEALTH SYSTEM GROUP

Part III, Supplemental Information

Return Reference	Explanation
PART I, LINE 3	COMPENSATION AND BENEFITS RECEIVED BY EDGAR CURTIS, PRESIDENT AND CEO OF MEMORIAL HEALTH SYSTEM, WAS COMPRISED OF THE FOLLOWING COMPONENTS, BASE COMPENSATION, INCENTIVE COMPENSATION, OTHER COMPENSATION, RETIREMENT/DEFERRED COMPENSATION AND OTHER NONTAXABLE BENEFITS MEMORIAL HEALTH SYSTEM, A RELATED ORGANIZATION OF MEMORIAL HEALTH SYSTEM GROUP, USES THE FOLLOWING TO ESTABLISH THE COMPENSATION OF THE ORGANIZATION'S CEO/EXECUTIVE DIRECTOR 1) COMPENSATION COMMITTEE, 2) INDEPENDENT COMPENSATION CONSULTANT, 3) COMPENSATION SURVEY OR STUDY, AND 4) APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE BASE COMPENSATION LEVELS WERE SET BY THE LEADERSHIP COMPENSATION COMMITTEE, A COMMITTEE OF THE MHS BOARD CONSISTING ENTIRELY OF MHS BOARD MEMBERS WHO ARE INDEPENDENT AND FREE OF ANY CONFLICTS OF INTEREST, AT THE 50TH PERCENTILE OF THE RELEVANT COMPENSATION RANGE, AS DETERMINED BY THE INDEPENDENT COMPENSATION CONSULTANTS INCENTIVE COMPENSATION WAS CONTINGENT ON THE ACHIEVEMENT OF FOUR SPECIFIC PERFORMANCE METRICS OF MHS, AS DEFINED BY THE MHS BOARD OTHER COMPENSATION IS COMPRISED PRIMARILY OF DEFERRED COMPENSATION PAYOUTS OF \$1,165,816 (COLUMN (B)(III)) MADE DURING THE YEAR FOR COMPENSATION PREVIOUSLY EARNED IN PRIOR YEARS, PAID TIME OFF BANK CASHED IN AND PAID TIME OFF DONATED BACK TO MEMORIAL MEDICAL CENTER FOUNDATION'S ANNUAL FUNDRAISING CAMPAIGN RETIREMENT COMPENSATION REFLECTS AN INCREASE IN RETIREMENT BENEFITS OWED BY MHS UPON RETIREMENT OF MR CURTIS NORMAL RETIREMENT COMPENSATION FOR THE YEAR IS REPORTED IN COLUMN (C) LASTLY, NONTAXABLE BENEFITS REFLECT THE VALUE OF HEALTH (MEDICAL, DENTAL, LIFE INSURANCE) BENEFITS RECEIVED DURING THE YEAR

Part III, Supplemental Information

Return Reference	Explanation
PART I, LINE 4B	THE FOLLOWING LISTED INDIVIDUALS PARTICIPATE IN ONE OR MORE NONQUALIFIED DEFERRED COMPENSATION PLANS OF MHS BOHAN, BOURNE, CALLAHAN, CURTIS, DALPOAS, DOWELL, EARLY, ENGLAND, EVANS, FLORENCE, GOVINDAIAH, GRAHAM HALE, HANSEN, JOHNSON, JONES, KASA, KAY, KEIM, KIRIAKOS, MIZEUR, MOORE, PRATER, RAHN, ROGERS, ROSZHART, SALVACION, SCHEIBLER-VENTRESS, SCHMIDT, SCOTT, SHEAFF, SHEEDY, LILLPOP, AND WAHAB MHS CREDITS ANNUAL CONTRIBUTION AMOUNTS TO THESE PLANS, AND THESE AMOUNTS SERVE TO PROVIDE SUPPLEMENTAL RETIREMENT INCOME TO THESE INDIVIDUALS ALL CREDITED AMOUNTS ARE REVIEWED AND APPROVED BY A COMMITTEE OF THE MHS BOARD AS PART OF REASONABLE TOTAL COMPENSATION ALL AMOUNTS CREDITED ARE UNVESTED WHILE THE EXECUTIVE IS REQUIRED TO PROVIDE SUBSTANTIAL FUTURE SERVICES, AND THEN ARE TAXED IN FULL WHEN THE SERVICE PERIOD IS COMPLETED AND THE AMOUNTS BECOME VESTED ALL AMOUNTS CREDITED TO THESE EXECUTIVES UNDER THESE PLANS ARE INCLUDED IN COLUMN (C) AS UNVESTED, NONTAXABLE DEFERRED COMPENSATION WHEN FIRST CREDITED, AND THEN ARE AGAIN INCLUDED IN COLUMN (B)(III) WHEN THE AMOUNTS BECOME VESTED AND ARE SUBJECT TO TAX THE FOLLOWING CURRENT OR FORMER OFFICERS, KEY EMPLOYEES, AND HIGHEST COMPENSATED EMPLOYEES RECEIVED DEFERRED COMPENSATION PAYOUTS IN THE CALENDAR YEAR FROM THE ORGANIZATION OR A RELATED ORGANIZATION, MEMORIAL HEALTH SYSTEM JAMES BOHAN, M D \$95,283, EDGAR CURTIS \$1,165,816, DOLAN DALPAOS \$27,852, J TRAVIS DOWELL \$24,945, KEVIN ENGLAND, \$8,840, NICOLE FLORENCE, M D , \$32,006, MARSHALL HALE, M D , \$64,873, MARK HANSEN, M D , \$214,059, ROBERT KAY, \$300,647, STEVEN LILLPOP, M D , \$118,691, TRACY MIZEUR, M D , \$33,611, MARSHA PRATER, PH D , \$157,825, FERDINAND SALVACION, M D , \$76,435, CHRISTINA SCHEIBLER-VENTRESS, M D , \$39,063, AND MICHAEL SHEEDY, M D \$39,086 TO BECOME ENTITLED TO THE BENEFITS PROVIDED, EACH COVERED EMPLOYEE MUST MEET SUBSTANTIAL REQUIREMENTS RELATING TO FURTHER EMPLOYMENT UNTIL THOSE REQUIREMENTS ARE SATISFIED, IF EVER, THE EMPLOYEE IS NOT ENTITLED TO THESE AMOUNTS IF THE EMPLOYEE WERE TO HAVE TERMINATED EMPLOYMENT VOLUNTARILY IN THE YEAR TO WHICH THIS RETURN APPLIES AND NOT MET THESE SUBSTANTIAL REQUIREMENTS, THESE SUPPLEMENTAL RETIREMENT BENEFITS WOULD HAVE BEEN FORFEITED THESE SUPPLEMENTAL RETIREMENT BENEFITS ARE PART OF A RETIREMENT PROGRAM THAT PROVIDES RETIREMENT INCOME FOR ALL YEARS OF SERVICE THAT THE EMPLOYEE PROVIDES TO THE ORGANIZATION ACCORDINGLY, ANY RETIREMENT BENEFITS SHOULD BE VIEWED AS APPLYING TO THE ENTIRE LENGTH OF THE EMPLOYEE'S SERVICE THE LEADERSHIP COMPENSATION COMMITTEE OF THE MHS BOARD APPROVES ALL RETIREMENT BENEFITS, TOGETHER WITH ALL OTHER FORMS OF COMPENSATION AND BENEFITS FOR THESE AND OTHER SENIOR LEADERS, IN A MANNER INTENDED TO QUALIFY FOR THE "REBUTTABLE PRESUMPTION OF REASONABLENESS" UNDER FEDERAL INCOME TAX LAW

**Part III, Supplemental Information**

Return Reference	Explanation
PART I, LINE 6	AN INCENTIVE BONUS IS PAID TO ELIGIBLE EXECUTIVES BASED ON MEMORIAL HEALTH SYSTEM CONSOLIDATED ORGANIZATION'S PERFORMANCE IN THE FOLLOWING AREAS 1) OPERATING INCOME, 2) QUALITY, 3) PATIENT SATISFACTION, AND 4) EMPLOYEE SATISFACTION

**Part III, Supplemental Information**

Return Reference	Explanation
SCHEDULE J, PART II, COLUMN (D)	MEMORIAL HEALTH SYSTEM PROVIDES A POSTRETIREMENT HEALTH CARE INSURANCE REIMBURSEMENT PLAN TO CERTAIN EXECUTIVES AND PHYSICIANS TO REIMBURSE HEALTH INSURANCE COSTS INCURRED BY THE RETIREES AND THEIR SPOUSES. THE SERVICE COST OF THE PLAN IS REPORTED ON SCHEDULE J, PART II, COLUMN (D) AS A NONTAXABLE BENEFIT. SCHEDULE J, PART II, COLUMN (D) ALSO INCLUDES OTHER NONTAXABLE BENEFITS SUCH AS MEDICAL, DENTAL, AND LIFE INSURANCE.



Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

(A) Name and Title	(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
	(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1PAUL KASA MD BOARD MEMBER ALMH (THRU JAN 17)/MPS	(i)	277,202	29,704	11,495	41,803	40,463	400,667
	(ii)	-	-	-	-	-	-
		0	0	0	0	0	0
1AMIR JOHN WAHAB MD BOARD MEMBER ALMH	(i)	454,158	48,690	24,558	65,222	47,332	639,960
	(ii)	-	-	-	-	-	-
		0	0	0	0	0	0
2TRACY A MIZEUR MD BOARD MEMBER ALMH (FROM FEB 17)	(i)	239,988	12,724	33,911	53,010	8,590	348,223
	(ii)	-	-	-	-	-	-
		0	0	0	0	0	0
3MARK HANSEN MD BOARD MEMBER MPS	(i)	347,340	29,039	235,274	53,238	47,259	712,150
	(ii)	-	-	-	-	-	-
		0	0	0	0	0	0
4MARSHALL HALE MD CHAIR MPS	(i)	385,675	41,680	94,219	70,762	51,901	644,237
	(ii)	-	-	-	-	-	-
		0	0	0	0	0	0
5J TRAVIS DOWELL PRESIDENT MPS & VP MPS	(i)	0	0	0	0	0	0
	(ii)	-	-	-	-	-	-
		233,971	58,493	37,330	50,143	10,078	390,015
6JANICE GAMBACH PRESIDENT SRS, ADMIN MBH	(i)	0	0	0	0	0	0
	(ii)	-	-	-	-	-	-
		180,087	22,922	5,997	14,438	9,496	232,940
7JAMESON ROSZHART BRDMEM MHV/BRDMEM MHSVC/VPAMBNET	(i)	0	0	0	0	0	0
	(ii)	-	-	-	-	-	-
		193,542	50,000	5,193	37,263	23,129	309,127
8HARRY SCHMIDT BRD MEM MHSVC/ PRES PAH CRNA	(i)	182,623	51,550	4,775	76,554	2,320	317,822
	(ii)	-	-	-	-	-	-
		9,728	0	191	3,629	93	13,641
9R SCOTT KIRIAKOS SVPCLININTMMC/BRDMMEMHV/CHAIR MHSVC	(i)	327,037	116,052	13,751	110,033	16,174	583,047
	(ii)	-	-	-	-	-	-
		0	0	0	0	0	0
10DOLAN DALPOAS PRESIDENT ALMH/BRDMEM MHSVC/CEOALMH	(i)	0	0	0	0	0	0
	(ii)	-	-	-	-	-	-
		262,800	65,700	48,514	53,242	391	430,647
11KIMBERLY BOURNE PRES TMH&TMHF/BRDMMEMMHSVC/CEOTMH	(i)	0	0	0	0	0	0
	(ii)	-	-	-	-	-	-
		225,106	57,750	12,810	48,741	22,611	367,018
12KATHRYN KEIM SEC/TREAS MHV(FROM JAN 17)/VPFINANCE	(i)	149,149	28,125	2,659	18,490	20,428	218,851
	(ii)	-	-	-	-	-	-
		0	0	0	0	0	0
13DOUGLAS RAHN DBA BRDMMEMMHSVC&PRESPAHCRNA (THRUDEC16)	(i)	0	0	0	0	0	0
	(ii)	-	-	-	-	-	-
		317,537	80,342	99,361	75,538	17,882	590,660
14EDGAR CURTIS PRES&CEOMHS/PRESMMC/BRDMMEMPS	(i)	0	0	0	0	0	0
	(ii)	-	-	-	-	-	-
		804,321	355,031	1,269,360	288,601	20,823	2,738,136
15ROBERT KAY SVPCFOSECTREASMHSVCMPSMHV (THRUDEC16)	(i)	0	0	0	0	0	0
	(ii)	-	-	-	-	-	-
		436,222	155,263	319,398	204,169	22,611	1,137,663
16KEVIN ENGLAND VP BUS DEVELOP/VC/PRES MHV/VC MHSVC	(i)	0	0	0	0	0	0
	(ii)	-	-	-	-	-	-
		226,882	73,515	34,323	143,137	30,053	507,910
17CHARLES CALLAHAN PHD EVPCOOMMC/CHRMHV/MPSBRDMEM/PRESMHSVC	(i)	486,975	173,632	77,638	93,101	25,790	857,136
	(ii)	-	-	-	-	-	-
		0	0	0	0	0	0
18BABU ELADASARI MD PAH BRDMEM (THRU AUG 17), PPA PHYS	(i)	0	0	4,813	289	0	5,102
	(ii)	-	-	-	-	-	-
		266,815	0	65,157	15,900	19,444	367,316
19STEVEN LILLOPOP MD BRDMEM PAH	(i)	578,165	62,997	151,126	84,540	48,875	925,703
	(ii)	-	-	-	-	-	-
		0	0	0	0	0	0

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
21ANTHONY GRIFFIN MD BRDMEM PAH (FROM JAN 17)	(i)	284,463	25,854	37,234	44,412	30,463	422,426	0
	(ii)	0	0	0	0	0	0	0
1ELENA KEZELIS EXEC DIR MMC	(i)	166,482	21,700	4,319	16,407	24,105	233,013	0
	(ii)	0	0	0	0	0	0	0
2MARSHA PRATER PHD SVP & CNO MMC	(i)	301,995	0	175,509	216,073	8,725	702,302	0
	(ii)	0	0	0	0	0	0	0
3LINDA JONES DNS VP OPERATIONS MMC	(i)	256,622	64,693	31,172	57,739	7,336	417,562	0
	(ii)	0	0	0	0	0	0	0
4DREW EARLY ADMINEDMMC (THRUNOV16)/VPOPERATIONS	(i)	194,997	25,313	4,898	17,791	25,452	268,451	0
	(ii)	0	0	0	0	0	0	0
5ANNA EVANS JD GEN COUNSEL/VP INT AUDIT & COMPL MHS	(i)	0	0	0	0	0	0	0
	(ii)	326,509	0	6,774	192,378	25,189	550,850	0
6RAJESH GOVINDAIAH MD SVP & CMO MHS	(i)	0	0	0	0	0	0	0
	(ii)	416,199	147,144	26,005	76,208	8,339	673,895	0
7DAVID GRAHAM MD SVP & CIO MHS	(i)	0	0	0	0	0	0	0
	(ii)	396,746	140,599	17,798	152,590	17,805	725,538	0
8MITCHELL JOHNSON SVP & CHIEF STRATEGY OFFICER MHS	(i)	0	0	0	0	0	0	0
	(ii)	287,314	102,705	15,178	105,167	19,764	530,128	0
9ROBERT SCOTT VP & CHRO MHS	(i)	0	0	0	0	0	0	0
	(ii)	269,417	68,537	17,966	43,367	18,945	418,232	0
10JENNIFER HARRIS ADMIN PERIOPERATIVE SERVICES	(i)	187,816	23,813	152	12,617	10,915	235,313	0
	(ii)	0	0	0	0	0	0	0
11MITCHELL ROGERS ADMIN CARDIOVASCULAR SERVICES	(i)	213,751	54,075	20,572	37,824	3,281	329,503	0
	(ii)	0	0	0	0	0	0	0
12CHARLES SHEAFF MD CMO PAH	(i)	252,744	40,544	0	25,269	22,156	340,713	0
	(ii)	64,356	0	0	3,861	0	68,217	0
13RANDALL MOORE DIRECTOR PERIOP SERVICES PAH	(i)	254,219	7,328	0	23,193	47,250	331,990	0
	(ii)	0	0	0	0	0	0	0
14FERDINAND SALVACION MD PHYSICIAN MMC	(i)	484,528	36,309	99,476	91,393	37,668	749,374	69,240
	(ii)	0	0	0	0	0	0	0
15JAMES BOHAN MD PHYSICIAN MPS	(i)	390,931	45,941	117,913	70,644	22,434	647,863	0
	(ii)	0	0	0	0	0	0	0
CHRISTINA SCHEIBLER- 16VENTRESS MD PHYSICIAN MPS	(i)	427,748	49,508	58,167	68,666	30,073	634,162	40,581
	(ii)	0	0	0	0	0	0	0
17MICHAEL E SHEEDY MD PHYSICIAN MPS	(i)	420,305	47,565	64,065	69,115	44,172	645,222	39,086
	(ii)	0	0	0	0	0	0	0
18NICOLE A FLORENCE MD PHYSICIAN MPS	(i)	429,141	46,024	50,576	73,532	40,760	640,033	0
	(ii)	0	0	0	0	0	0	0

Schedule L  
(Form 990 or 990-EZ)

Department of the Treasury  
Internal Revenue Service

Transactions with Interested Persons

▶ Complete if the organization answered  
"Yes" on Form 990, Part IV, lines 25a, 25b, 26, 27, 28a, 28b, or 28c,  
or Form 990-EZ, Part V, line 38a or 40b.  
▶ Attach to Form 990 or Form 990-EZ.  
▶ Information about Schedule L (Form 990 or 990-EZ) and its instructions is at  
[www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization  
MEMORIAL HEALTH SYSTEM GROUP

Employer identification number  
90-0756744

Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only)  
Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b

1	(a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected?	
				Yes	No

2 Enter the amount of tax incurred by organization managers or disqualified persons during the year under section 4958 . . . . . ▶ \$

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization . . . . . ▶ \$

Part II Loans to and/or From Interested Persons.  
Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a, or Form 990, Part IV, line 26, or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
			To	From			Yes	No	Yes	No	Yes	No
Total						▶ \$						

Part III Grants or Assistance Benefiting Interested Persons.  
Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance
(1) MITCHELL ROGERS	KEY EMPLOYEE	14,750	EDUCATIONAL GRANT	EDUCATION

**Part IV Business Transactions Involving Interested Persons.**

Complete if the organization answered "Yes" on Form 990, Part IV, line 28a, 28b, or 28c.

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
See Additional Data Table					

**Part V Supplemental Information**

Provide additional information for responses to questions on Schedule L (see instructions)

Return Reference	Explanation
SCH L, PART IV, BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS	(A) NAME OF PERSON MADELINE CALLAHAN(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION EMPLOYEE, DAUGHTER OF CHIEF OPERATING OFFICER OF MHS AND MMC(C) AMOUNT OF TRANSACTION \$38,956 (D) MEMORIAL MEDICAL CENTER PAID COMPENSATION AND BENEFITS OF \$38,956 TO MADELINE CALLAHAN RELATED TO EMPLOYMENT SERVICES FOR THE FISCAL YEAR ENDED 9/30/2017 MADELINE CALLAHAN IS THE DAUGHTER OF CHARLES CALLAHAN, CHIEF OPERATING OFFICER THE COMPENSATION PAID WAS NEGOTIATED AT ARM'S LENGTH AND REPRESENTS FAIR MARKET VALUE FOR THE SERVICES PROVIDED (E) SHARING OF ORGANIZATION REVENUES? = NO
(A) NAME OF PERSON SPRINGFIELD ELECTRIC SUPPLY	(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION BOARD MEMBER IS OWNER OF SPRINGFIELD ELECTRIC SUPPLY(C) AMOUNT OF TRANSACTION \$110,161 (D) MEMORIAL MEDICAL CENTER PAID FEES TO SPRINGFIELD ELECTRIC SUPPLY FOR GOODS AND SERVICES FOR THE YEAR ENDED SEPTEMBER 30, 2017 IN THE AMOUNT OF \$110,161 RANDALL S GERMEAAD IS CHAIRMAN OF MEMORIAL MEDICAL CENTER'S BOARD OF DIRECTORS AND AN OWNER OF SPRINGFIELD ELECTRIC SUPPLY ALL FEES ARE NEGOTIATED AT FAIR MARKET VALUE FOR THE SERVICES PROVIDED (E) SHARING OF ORGANIZATION REVENUES? = NO
(A) NAME OF PERSON CLINICAL RADIOLOGISTS, SC	(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION BOARD MEMBER IS DIRECTOR, SHAREHOLDER AT CLINCIAL RADIOLOGISTS, SC(C) AMOUNT OF TRANSACTION \$690,435 (D) MEMORIAL MEDICAL CENTER PAID FEES TO CLINICAL RADIOLOGISTS, SC FOR THE YEAR ENDED SEPTEMBER 30, 2017 IN THE AMOUNT OF \$690,435 KEVIN J COAKLEY, M D IS A DIRECTOR & SHAREHOLDER AT CLINICAL RADIOLOGISTS AS WELL AS A MMC BOARD MEMBER ALL FEES ARE NEGOTIATED AT FAIR MARKET VALUE FOR THE SERVICES PROVIDED (E) SHARING OF ORGANIZATION REVENUES? = NO
(A) NAME OF PERSON SHERYL ROBERTS	(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION EMPLOYEE, DAUGHTER OF PAH BOARD MEMBER(C) AMOUNT OF TRANSACTION \$119,398 (D) PASSAVANT MEMORIAL AREA HOSPITAL PAID COMPENSATION AND BENEFITS OF \$119,398 TO SHERYL ROBERTS RELATED TO EMPLOYMENT SERVICES FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 2017 SHERYL ROBERTS IS THE DAUGHTER OF NANCY SPANGENBERG, MEMBER OF PASSAVANT MEMORIAL AREA HOSPITAL'S BOARD OF DIRECTORS THE COMPENSATION PAID WAS NEGOTIATED AT ARM'S LENGTH AND REPRESENTS FAIR MARKET VALUE FOR THE SERVICES PROVIDED (E) SHARING OF ORGANIZATION REVENUES? = NO
(A) NAME OF PERSON AMANDA CHUKIN	(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION EMPLOYEE, DAUGHTER OF PAH BOARD MEMBER(C) AMOUNT OF TRANSACTION \$24,111 (D) PASSAVANT MEMORIAL AREA HOSPITAL PAID COMPENSATION AND BENEFITS OF \$24,111 TO AMANDA CHUKIN RELATED TO EMPLOYMENT SERVICES FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 2017 AMANDA CHUKIN IS THE DAUGHTER OF GARY SCOTT, MEMBER OF PASSAVANT MEMORIAL AREA HOSPITAL'S BOARD OF DIRECTORS THE COMPENSATION PAID WAS NEGOTIATED AT ARM'S LENGTH AND REPRESENTS FAIR MARKET VALUE FOR THE SERVICES PROVIDED (E) SHARING OF ORGANIZATION REVENUES? = NO

Additional Data

Software ID:  
Software Version:  
EIN: 90-0756744  
Name: MEMORIAL HEALTH SYSTEM GROUP

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
MADELINE CALLAHAN	SEE PART V	38,956	SEE PART V		No
SPRINGFIELD ELECTRIC SUPPLY	SEE PART V	110,161	SEE PART V		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons					
(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
CLINICAL RADIOLOGISTS SC	SEE PART V	690,435	SEE PART V		No
SHERYL ROBERTS	SEE PART V	119,398	SEE PART V		No

**Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons**

<b>(a)</b> Name of interested person	<b>(b)</b> Relationship between interested person and the organization	<b>(c)</b> Amount of transaction	<b>(d)</b> Description of transaction	<b>(e)</b> Sharing of organization's revenues?	
				<b>Yes</b>	<b>No</b>
AMANDA CHUKIN	SEE PART V	24,111	SEE PART V		No

SCHEDULE M  
(Form 990)

Department of the Treasury  
Internal Revenue Service

Noncash Contributions

►Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.  
►Attach to Form 990.  
►Information about Schedule M (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990)

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization  
MEMORIAL HEALTH SYSTEM GROUP

Employer identification number  
90-0756744

Part I

Types of Property

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art—Works of art . . . .				
2 Art—Historical treasures .				
3 Art—Fractional interests . .				
4 Books and publications . .				
5 Clothing and household goods . . . . .				
6 Cars and other vehicles . .				
7 Boats and planes . . . . .				
8 Intellectual property . . . .				
9 Securities—Publicly traded .	X	1	5,135	AVG OF HIGH & LOW PRICE
10 Securities—Closely held stock .				
11 Securities—Partnership, LLC, or trust interests . . . . .				
12 Securities—Miscellaneous . .				
13 Qualified conservation contribution—Historic structures . . . . .				
14 Qualified conservation contribution—Other . . . .				
15 Real estate—Residential . .				
16 Real estate—Commercial . .				
17 Real estate—Other . . . .	X	3	3,029,753	APPRAISAL VALUE
18 Collectibles . . . . .				
19 Food inventory . . . . .				
20 Drugs and medical supplies .				
21 Taxidermy . . . . .				
22 Historical artifacts . . . . .				
23 Scientific specimens . . . .				
24 Archeological artifacts . . .				
25 Other ► ( _____ )				
26 Other ► ( _____ )				
27 Other ► ( _____ )				
28 Other ► ( _____ )				

29

Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement

29

0

30a

During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least three years from the date of the initial contribution, and which is not required to be used for exempt purposes for the entire holding period?

30a

Yes

No

b

If "Yes," describe the arrangement in Part II

31

Does the organization have a gift acceptance policy that requires the review of any non-standard contributions?

31

Yes

No

32a

Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions?

32a

Yes

No

b

If "Yes," describe in Part II

33

If the organization did not report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II



**Part II Supplemental Information.**

Provide the information required by Part I, lines 30b, 32b, and 33, and whether the organization is reporting in Part I, column (b), the number of contributions, the number of items received, or a combination of both. Also complete this part for any additional information.

Return Reference	Explanation
PART I, COLUMN (B)	THE NUMBER REPORTED IN COLUMN (B) REPRESENTS THE NUMBER OF CONTRIBUTIONS DURING THE TAX YEAR
PART I, LINE 32B	MEMORIAL MEDICAL CENTER FOUNDATION HAS AN ACCOUNT WITH A LOCAL BROKER THAT RECEIVES AND SELLS DONATIONS OF STOCK THE BROKER SELLS THE STOCK WHEN DIRECTED AND SENDS MMC FOUNDATION A CHECK FOR THE PROCEEDS

<b>SCHEDULE O</b> (Form 990 or 990-EZ)  <small>Department of the Treasury Internal Revenue Service</small>	<b>Supplemental Information to Form 990 or 990-EZ</b> Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information. ▶ Attach to Form 990 or 990-EZ. ▶ Information about Schedule O (Form 990 or 990-EZ) and its instructions is at <a href="http://www.irs.gov/form990">www.irs.gov/form990</a> .	<small>OMB No 1545-0047</small> <b>2016</b> <b>Open to Public Inspection</b>
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Name of the organization MEMORIAL HEALTH SYSTEM GROUP	Employer identification number  90-0756744
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**990 Schedule O, Supplemental Information**

Return Reference	Explanation
PART IV, LINE 24A	ONE SCHEDULE K WAS COMPLETED AT THE PARENT (MEMORIAL HEALTH SYSTEM) LEVEL ONLY EACH AFFILIATE IS SHOWING ITS ALLOCATION OF THE LIABILITY ON THE BALANCE SHEET AS INTERCOMPANY DEBT TO MEMORIAL HEALTH SYSTEM, AS CAN BE SEEN ON THIS GROUP RETURN

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 2	DIANE RUTLEDGE, PH D AND LYNNE BARKMEIER, M D 'S SPOUSE HAVE A BUSINESS RELATIONSHIP NINA HARRIS AND MITCHELL JOHNSON HAVE A BUSINESS RELATIONSHIP TODD WISE AND DIANE RUTLEDGE, PH D HAVE A BUSINESS RELATIONSHIP

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, SECTION A, LINE 6	MEMORIAL HEALTH SYSTEM IS THE SOLE CORPORATE MEMBER OF THE AFFILIATES REPORTED IN THIS GROUP RETURN EXCLUDING SPRINGFIELD RESIDENTIAL SERVICES, MEMORIAL MEDICAL CENTER FOUNDATION, JACKSONVILLE CRNA'S, PASSAVANT AREA HOSPITAL FOUNDATION AND TAYLORVILLE MEMORIAL HOSPITAL FOUNDATION. MEMORIAL HEALTH SYSTEM CORPORATION CONTAINS 100 INDIVIDUAL MEMBERS WHO ELECT THE BOARD OF DIRECTORS. SPRINGFIELD RESIDENTIAL SERVICES HAS A SELF-PERPETUATING BOARD OF DIRECTORS WHOSE MEMBERSHIP SHALL BE APPROVED BY OR BE MEMBERS OF THE BOARD OF DIRECTORS FOR MENTAL HEALTH CENTERS OF CENTRAL ILLINOIS. MEMORIAL MEDICAL CENTER FOUNDATION'S MEMBERS ARE ITS BOARD OF DIRECTORS. MEMORIAL MEDICAL CENTER FOUNDATION'S BOARD OF DIRECTORS CONTAINS 15 DIRECTORS. JACKSONVILLE CRNA'S AND PASSAVANT AREA HOSPITAL FOUNDATION'S SOLE CORPORATE MEMBER IS PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION, WHICH IS INCLUDED IN THE GROUP RETURN. TAYLORVILLE MEMORIAL HOSPITAL FOUNDATION HAS NO CORPORATE MEMBERS. TAYLORVILLE MEMORIAL HOSPITAL FOUNDATION'S BOARD OF DIRECTORS, WHICH CONTAINS 20 DIRECTORS, MANAGES AND CONTROLS THE PROPERTY AND BUSINESS.

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A	THE CORPORATE MEMBER OF THE CORPORATION ELECTS THE BOARD OF DIRECTORS

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B	<p>THE BYLAWS OF THE CORPORATION REQUIRE THE ADVANCE APPROVAL OF THE CORPORATE MEMBER FOR CORPORATE, ADMINISTRATIVE AND OPERATIONAL ACTIONS WHICH INCLUDE, BUT ARE NOT LIMITED TO, THE BORROWING OF ANY SUM, THE PRINCIPAL OF WHICH EXCEEDS \$500,000, OR WHICH HAS A STATED TERM OF GREATER THAN ONE YEAR, OR WHICH IS SECURED BY A MORTGAGE OF ALL OR ANY PORTION OF THE CORPORATION'S REAL PROPERTY OR THE CREATION OF A SECURITY INTEREST IN THE CORPORATION'S ASSETS, INCLUDING PERSONAL PROPERTY AND REVENUES, FOR THE BENEFIT OF THE LENDER, LESSOR OR VENDOR, OR THE DEFEASANCE, ADVANCE PAYMENT OR CANCELLATION OF ANY OUTSTANDING DEBT OF THE CATEGORY DESCRIBED HEREIN, ANY VOLUNTARY DISSOLUTION, MERGER, CONSOLIDATION, SALE OR TRANSFER OF SUBSTANTIALLY ALL OF THE CORPORATION'S ASSETS (DEFINED AS 10% OR MORE), OR ANY CREATION OF A SUBSIDIARY OR AFFILIATE CORPORATION OF THE CORPORATION, ANY APPLICATION TO THE ILLINOIS HEALTH FACILITIES PLANNING BOARD FOR A PERMIT OR CERTIFICATE OF NEED FOR A PROPOSED ACTIVITY, WHETHER OR NOT INVOLVING A CAPITAL EXPENDITURE, THE APPROVAL OF ALL ANNUAL AND LONG-TERM CAPITAL OR OPERATIONAL BUDGETS OF THE CORPORATION, ANY AMENDMENT TO THE ARTICLES OF INCORPORATION OR BYLAWS OF THE CORPORATION, APPROVAL OF ANY NEW OR CHANGES TO EXISTING LONG-TERM OR MASTER INSTITUTIONAL PLAN, THE SALE OF ANY OF THE CORPORATION'S REAL PROPERTY OR INTEREST THEREIN OR PURCHASES OF ADDITIONAL REAL ESTATE, AND THE APPROVAL OF CAPITAL EXPENDITURES IN EXCESS OF \$15 MILLION. PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION'S, JACKSONVILLE CRNA'S, AND PASSAVANT AREA HOSPITAL FOUNDATION'S BYLAWS STATE CORPORATE MEMBERS SHALL ELECT THE DIRECTORS OF THE CORPORATION IN CONJUNCTION WITH THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS. THE CORPORATE MEMBER WILL WORK WITH THE BOARD OF DIRECTORS TO ELECT THE PRESIDENT AND CHIEF EXECUTIVE OFFICER. THE CORPORATE MEMBER WILL APPROVE OF THE CAPITAL AND OPERATING BUDGETS, STRATEGIC PLANS, AND APPROVE ANY VOLUNTARY DISSOLUTION, MERGER, OR CONSOLIDATION. CORPORATE MEMBERS APPROVE ANY AMENDMENT TO BYLAWS OR ARTICLES OF INCORPORATION. IN ADDITION, MEMBERS HAVE THE POWER TO REMOVE THE PRESIDENT WITH MUTUAL AGREEMENT OF THE BOARD OF DIRECTORS OR THE REMOVAL OF ANY DIRECTOR WITH CAUSE. THE CORPORATE MEMBER HAS APPROVAL POWER FOR THE CAPITAL EXPENDITURES OVER \$1,000,000, GUARANTY OF DEBT GREATER THAN \$250,000, WITH OR WITHOUT A MORTGAGE, OR OTHER TRANSACTIONS MATERIAL IN NATURE WITH AFFILIATE CORPORATIONS. CORPORATE MEMBERS HAVE THE POWER TO APPROVE INDEPENDENT AUDITORS, APPROVE CONTRACTS TO PROVIDE HEALTHCARE TO BENEFICIARIES OF MANAGED CARE CONTRACTS AND APPROVAL OF APPLICATIONS TO THE ILL HEALTH FACILITIES PLANNING BOARD. MEMBERS ALSO APPROVE SALES /TRANSFERS OF ASSETS TO NON-AFFILIATE ENTITIES, IF ASSETS ARE OVER \$500,000. CORPORATE MEMBERS APPROVE OF SIGNIFICANT CHANGES IN THE CORPORATION'S INSURANCE AND CONTRACTS INVOLVING GOODS/SERVICES WITH A VALUE OVER \$1,000,000 FOR CAPITAL OR \$1,500,000 IN AGGREGATE FOR OPERATING AND CAPITAL BUDGETS, N</p>

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B	OT PREVIOUSLY APPROVED CORPORATE MEMBERS APPROVE OF PHYSICIAN SERVICE CONTRACTS OVER \$400 ,000, APPROVE REAL ESTATE TRANSACTIONS, AND APPROVE ANY CHANGES TO MASTER OR LONG-TERM INS TITUTIONAL PLANS

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	A DRAFT COPY OF THE MHS GROUP FORM 990 AND ALL ATTACHMENTS IS PROVIDED TO ALL OF THE MEMORIAL HEALTH SYSTEM BOARD OF DIRECTORS AND A BOARD COMMITTEE PRIOR TO FILING PRESENTATIONS ARE MADE TO THE AFFILIATE MEMBERS' BOARDS IN THE SAME TIME FRAME, ALTHOUGH COPIES OF THE COMPLETE FORM 990 AND ALL ATTACHMENTS ARE NOT PROVIDED PRIOR TO THOSE MEETINGS, EXCEPT TO BOARD MEMBERS WHO REQUEST COMPLETE COPIES ALL QUESTIONS AND COMMENTS ARISING FROM THESE REVIEWS ARE ADDRESSED PRIOR TO SUBMISSION OF THE RETURN TO THE APPROPRIATE TAXING AUTHORITIES



**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	ALL OFFICERS, DIRECTORS AND KEY EMPLOYEES OF THE CORPORATION ARE REQUIRED TO REVIEW THE CONFLICT OF INTEREST POLICY AND COMPLETE A SPECIFIC DISCLOSURE STATEMENT WHICH IS ATTACHED TO THE POLICY MEMORIAL HEALTH SYSTEM AND ITS SUBORDINATES MONITORS AND ENFORCES ITS CONFLICT OF INTEREST POLICY BY IDENTIFYING ANY POTENTIAL CONFLICTS AT THE TIME EACH MEETING AGENDA IS PREPARED ANY OFFICER OR DIRECTOR WHO HAS A CONFLICT IS NOTIFIED OF SUCH CONFLICT, AS WELL AS THEIR OBLIGATION TO ABSTAIN FROM THE DISCUSSION AND VOTE ON ANY CONFLICTED ISSUES(S) SUCH ABSTENTION(S), IF REQUIRED, ARE DOCUMENTED IN THE MINUTES OF EACH MEETING BOARD MEMBERS ARE ALSO REQUIRED TO UPDATE THEIR CONFLICT OF INTEREST DISCLOSURE STATEMENTS PROMPTLY IN THE EVENT OF ANY CHANGE IN PERSONAL OR BUSINESS ACTIVITIES THAT WOULD REQUIRE SUCH DISCLOSURE

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15	<p>THE MEMORIAL HEALTH SYSTEM BOARD OF DIRECTORS HAS APPOINTED A LEADERSHIP COMPENSATION COMMITTEE MADE UP OF INDEPENDENT MEMBERS OF THE BOARD OF DIRECTORS AND HAS DELEGATED TO IT THE RESPONSIBILITY OF ADMINISTERING, OVERSEEING AND APPROVING ALL FORMS OF COMPENSATION AND BENEFITS PROVIDED TO EXECUTIVE LEADERSHIP, INCLUDING THE CHIEF EXECUTIVE OFFICER AND THE CHIEF FINANCIAL OFFICER. THE BOARD HAS ADOPTED A LEADERSHIP COMPENSATION PHILOSOPHY STATEMENT DESCRIBING THE ROLE AND RESPONSIBILITIES OF THE COMMITTEE. THIS PHILOSOPHY EXPRESSLY STATES THE COMMITTEE'S INTENT, ON BEHALF OF THE CORPORATION, TO TAKE ALL THE STEPS NECESSARY TO QUALIFY FOR THE REBUTTABLE PRESUMPTION OF REASONABLENESS UNDER THE FEDERAL INCOME TAX LAW INTERMEDIATE SANCTIONS RULES. THE COMMITTEE ANALYZES EVERY ELEMENT OF COMPENSATION (INCLUDING CURRENT, INCENTIVE AND DEFERRED COMPENSATION) AND BENEFITS (INCLUDING QUALIFIED AND NON-QUALIFIED BENEFITS). THE COMMITTEE CONDUCTS ITS REVIEW AND APPROVAL PROCESS AT LEAST ANNUALLY, AND APPROVES COMPENSATION AND BENEFITS ONLY TO THE EXTENT THAT THE COMMITTEE HAS CONCLUDED THAT THE COMPENSATION AND BENEFITS CONSTITUTE NO MORE THAN REASONABLE COMPENSATION FOR EACH EXECUTIVE. IN CONNECTION WITH THE MOST RECENT REVIEW AND APPROVAL PROCESS, THE COMMITTEE RECEIVED PROFESSIONAL ADVICE FROM AN INDEPENDENT CONSULTANT AND OUTSIDE LEGAL COUNSEL. THE COMMITTEE CONSISTS ENTIRELY OF DISINTERESTED MEMBERS OF THE BOARD OR DISINTERESTED COMMITTEE MEMBERS WHO UNDER STATE CORPORATE LAW MAY SERVE ON SUCH A COMMITTEE. THE COMMITTEE WORKS WITH ITS COMPENSATION CONSULTANT TO PREPARE AND REVIEW IN ADVANCE COMPREHENSIVE DATA SHOWING THE COMPENSATION PROVIDED BY SIMILARLY SITUATED ORGANIZATIONS FOR FUNCTIONALLY SIMILAR POSITIONS. THE COMMITTEE ALSO PREPARES A TIMELY AND THOROUGH WRITTEN RECORD OF ITS PROCEDURAL CRITERIA NECESSARY TO QUALIFY FOR THE REBUTTABLE PRESUMPTION OF REASONABLENESS UNDER THE FEDERAL INCOME TAX LAW INTERMEDIATE SANCTIONS RULES.</p>

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	THE GOVERNING DOCUMENTS OF MEMORIAL HEALTH SYSTEM AND ITS SUBORDINATES, SUCH AS ARTICLES OF INCORPORATION AND ANY AMENDMENTS THERETO, ARE AVAILABLE TO THE GENERAL PUBLIC THROUGH THE ILLINOIS SECRETARY OF STATE'S OFFICE. THESE GOVERNING DOCUMENTS, AS WELL AS THE BYLAWS, CONFLICT OF INTEREST POLICY AND FINANCIAL STATEMENTS, ARE AVAILABLE UPON REQUEST. THESE DOCUMENTS ARE AVAILABLE FOR THE SAME PERIOD OF TIME AS SET FORTH IN IRC SECTION 6104(D).

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART IX, LINE 11G	<p>PHYSICIAN SERVICES PROGRAM SERVICE EXPENSES 86,444,657 MANAGEMENT AND GENERAL EXPENSES 1,440,648 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 87,885,305 CONTRACT LABOR PROGRAM SERVICE EXPENSES 3,923,828 MANAGEMENT AND GENERAL EXPENSES 341,704 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 4,265,532 PURCHASED SERVICES PROGRAM SERVICE EXPENSES 26,657,823 MANAGEMENT AND GENERAL EXPENSES 7,441,214 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 34,099,037 PROFESSIONAL FEES PROGRAM SERVICE EXPENSES 1,142,534 MANAGEMENT AND GENERAL EXPENSES 1,513,099 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 2,655,633</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	CHANGE IN MINIMUM PENSION LIABILITY 33,438,122 TRANSFERS TO RELATED ORGANIZATIONS -16,867,252 BOOK/TAX DIFFERENCE -809,097 OTHER -2,547,629 NONOPERATING NET PERIOD BENEFIT COST -8,258,838

SCHEDULE R  
(Form 990)

Department of the Treasury  
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.

▶ Attach to Form 990.▶ Information about Schedule R (Form 990) and its instructions is at [www.irs.gov/form990](http://www.irs.gov/form990).

OMB No 1545-0047

2016

Open to Public Inspection

Name of the organization  
MEMORIAL HEALTH SYSTEM GROUP

Employer identification number  
90-0756744

Part I Identification of Disregarded Entities Complete if the organization answered "Yes" on Form 990, Part IV, line 33.					
(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) HEALTHCARE NETWORK PROPERTIES LLC 701 NORTH FIRST STREET SPRINGFIELD, IL 62781 37-1379377	OWNS MEDICAL OFFICE BUILDINGS	IL	4,040,884	0	MEMORIAL PHYSICIAN SERVICES
(2) MEMORIAL EXPRESSCARE LLC 701 NORTH FIRST STREET SPRINGFIELD, IL 62781 26-3400528	PROVIDES NON-EMERGENCY CARE SEVEN DAYS A WEEK WITHOUT APPOINTMENT	IL	5,907,489	1,682,139	MEMORIAL HEALTH VENTURES

Part II Identification of Related Tax-Exempt Organizations Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.							
(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) ABRAHAM LINCOLN HEALTHCARE FOUNDATION 200 STAHLHUT DR  LINCOLN, IL 62656 36-3492268	GRANTS TO OTHER CHARITABLE ORGANIZATIONS AND HOSPITALS	IL	501(C)(3)	170(B)(1)(A)(VI)	MEMORIAL HEALTH SYSTEM	Yes	
(2) MENTAL HEALTH CENTERS OF CENTRAL ILLINOIS 710 NORTH EIGHTH ST  SPRINGFIELD, IL 62702 37-0646367	TRAINING, PSYCHIATRIC, AND RESIDENT SERVICES FOR MENTALLY ILL AND DISABLED	IL	501(C)(3)	170(B)(1)(A)(VI)	MEMORIAL HEALTH SYSTEM	Yes	
(3) MEMORIAL HEALTH SYSTEM 701 NORTH FIRST ST  SPRINGFIELD, IL 62781 37-1110690	UMBRELLA	IL	501(C)(3)	509(A)(3)TYPE II	N/A		No

**Part III Identification of Related Organizations Taxable as a Partnership** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a partnership during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income(related, unrelated, excluded from tax under sections 512- 514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	

**Part IV Identification of Related Organizations Taxable as a Corporation or Trust** Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related organizations treated as a corporation or trust during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity?	
								Yes	No
<b>(1)</b> MEMORIAL HOME SERVICES OF CENTRAL ILLINOIS INC 701 NORTH FIRST STREET SPRINGFIELD, IL 62781 37-1190216	PROVIDE DURABLE MEDICAL EQUIPMENT AND SUPPLIES TO PATIENTS	IL	MEMORIAL HOME SERVICES	C	10,328,055	11,482,369	100 000 %	Yes	
<b>(2)</b> PASSAVANT PHYSICIAN ASSOCIATION 1600 WEST WALNUT STREET JACKSONVILLE, IL 62650 26-1200566	PHYSICIAN SERVICES	IL	PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION	C	3,598,336	968,901	100 000 %	Yes	
<b>(3)</b> CHARITABLE REMAINDER TRUSTS (2)	TRUST	IL							No

**Part V Transactions With Related Organizations** Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.**Note.** Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule**1** During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?

	Yes	No
<b>a</b> Receipt of <b>(i)</b> interest, <b>(ii)</b> annuities, <b>(iii)</b> royalties, or <b>(iv)</b> rent from a controlled entity . . . . .	<b>1a</b> Yes	
<b>b</b> Gift, grant, or capital contribution to related organization(s) . . . . .	<b>1b</b> Yes	
<b>c</b> Gift, grant, or capital contribution from related organization(s) . . . . .	<b>1c</b> Yes	
<b>d</b> Loans or loan guarantees to or for related organization(s) . . . . .	<b>1d</b>	No
<b>e</b> Loans or loan guarantees by related organization(s) . . . . .	<b>1e</b>	No
<b>f</b> Dividends from related organization(s) . . . . .	<b>1f</b> Yes	
<b>g</b> Sale of assets to related organization(s) . . . . .	<b>1g</b> Yes	
<b>h</b> Purchase of assets from related organization(s) . . . . .	<b>1h</b> Yes	
<b>i</b> Exchange of assets with related organization(s) . . . . .	<b>1i</b>	No
<b>j</b> Lease of facilities, equipment, or other assets to related organization(s) . . . . .	<b>1j</b> Yes	
<b>k</b> Lease of facilities, equipment, or other assets from related organization(s) . . . . .	<b>1k</b> Yes	
<b>l</b> Performance of services or membership or fundraising solicitations for related organization(s) . . . . .	<b>1l</b> Yes	
<b>m</b> Performance of services or membership or fundraising solicitations by related organization(s) . . . . .	<b>1m</b> Yes	
<b>n</b> Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) . . . . .	<b>1n</b> Yes	
<b>o</b> Sharing of paid employees with related organization(s) . . . . .	<b>1o</b> Yes	
<b>p</b> Reimbursement paid to related organization(s) for expenses . . . . .	<b>1p</b> Yes	
<b>q</b> Reimbursement paid by related organization(s) for expenses . . . . .	<b>1q</b> Yes	
<b>r</b> Other transfer of cash or property to related organization(s) . . . . .	<b>1r</b> Yes	
<b>s</b> Other transfer of cash or property from related organization(s) . . . . .	<b>1s</b> Yes	

**2** If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) MEMORIAL HOME SERVICES OF CENTRAL ILLINOIS INC	O	376,979	COST BASIS
(2) MEMORIAL HOME SERVICES OF CENTRAL ILLINOIS INC	K	184,154	COST - RENTAL EQUIPMENT
(3) MEMORIAL HOME SERVICES OF CENTRAL ILLINOIS INC	H	170,022	COST BASIS
(4) MEMORIAL HOME SERVICES OF CENTRAL ILLINOIS INC	F	1,000,000	COST BASIS
(5) PASSAVANT PHYSICIAN ASSOCIATION	R	3,895,253	FMV



Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization. See instructions regarding exclusion for certain investment partnerships.

[illegible]

**Part VII**   **Supplemental Information**

Provide additional information for responses to questions on Schedule R (see instructions)