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Form 990

Return of Organization Exempt From Income Tax

OMB No 1545-0047

2017

Open to Public Inspection

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

Do not enter social security numbers on this form as it may be made public

Information about Form 990 and its instructions is at [www.irs.gov/form990](#)

Department of the Treasury
Internal Revenue Service

A For the 2017 calendar year, or tax year beginning 10-01-2017 , and ending 09-30-2018

B Check if applicable

☐ Address change

☐ Name change

☐ Initial return

☐ Final return/terminated

☐ Amended return

☐ Application pending

C Name of organization

MEMORIAL HEALTH SYSTEM GROUP

Doing business as

Number and street (or P O box if mail is not delivered to street address)

701 NORTH FIRST STREET

Room/suite

City or town, state or province, country, and ZIP or foreign postal code

SPRINGFIELD, IL 62781

F Name and address of principal officer

EDGAR J CURTIS

701 NORTH FIRST STREET

SPRINGFIELD, IL 62781

H(a) Is this a group return for subordinates?

☒ Yes ☐ No

H(b) Are all subordinates included?

☐ Yes ☒ No

If "No," attach a list (see instructions)

H(c) Group exemption number

5670

I Tax-exempt status

☒ 501(c)(3) ☐ 501(c) () (Insert no) ☐ 4947(a)(1) or ☐ 527

J Website: WWW.CHOOSEMEMORIAL.ORG

K Form of organization

☒ Corporation ☐ Trust ☐ Association ☐ Other

L Year of formation

M State of legal domicile

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities

TO IMPROVE THE HEALTH OF THE PEOPLE AND COMMUNITIES WE SERVE

2 Check this box if the organization discontinued its operations or disposed of more than 25% of its net assets

☐

3 Number of voting members of the governing body (Part VI, line 1a)

142

4 Number of independent voting members of the governing body (Part VI, line 1b)

103

5 Total number of individuals employed in calendar year 2017 (Part V, line 2a)

7,834

6 Total number of volunteers (estimate if necessary)

2,119

7a Total unrelated business revenue from Part VIII, column (C), line 12

6,711,253

7b Net unrelated business taxable income from Form 990-T, line 34

0

Revenue

8 Contributions and grants (Part VIII, line 1h)

7,060,951

9 Program service revenue (Part VIII, line 2g)

957,546,002

10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)

26,402,713

11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)

21,856,624

12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)

1,012,866,290

Expenses

13 Grants and similar amounts paid (Part IX, column (A), lines 1–3)

5,021,831

14 Benefits paid to or for members (Part IX, column (A), line 4)

0

15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)

414,587,059

16a Professional fundraising fees (Part IX, column (A), line 11e)

0

16b Total fundraising expenses (Part IX, column (D), line 25)

381,592

17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)

534,707,759

18 Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)

954,316,649

19 Revenue less expenses Subtract line 18 from line 12

58,549,641

Net Assets or Fund Balances

20 Total assets (Part X, line 16)

1,375,133,634

21 Total liabilities (Part X, line 26)

531,999,515

22 Net assets or fund balances Subtract line 21 from line 20

843,134,119

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge

Sign Here

Signature of officer

KATHRYN J KEIM SR VICE PRESIDENT & CFO

Type or print name and title

2019-08-14

Date

Paid Preparer Use Only

Print/Type preparer's name

Firm's name ERNST & YOUNG US LLP

Firm's address 155 N WACKER DRIVE

CHICAGO, IL 60606

Preparer's signature

Firm's EIN 34-6565596

Phone no (312) 879-2000

Check if self-employed

PTIN P01622613

May the IRS discuss this return with the preparer shown above? (see instructions)

☒ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions.

Cat No 11282Y

Form 990 (2017)

Part III Statement of Program Service AccomplishmentsCheck 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

4a	(Code)	(Expenses \$ 729,408,192	including grants of \$ 4,111,933)	(Revenue \$ 917,051,570)
See Additional Data				

4b	(Code)	(Expenses \$ 71,811,851	including grants of \$ 43,518)	(Revenue \$ 48,865,804)
See Additional Data				

4c	(Code)	(Expenses \$ 8,726,046	including grants of \$)	(Revenue \$ 7,685,403)
See Additional Data				

(Code)	(Expenses \$ 1,574,466	including grants of \$ 1,574,466)	(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 FY2018, MMCF PROVIDED \$881,644 IN GRANTS TO ORGANIZATIONS. THIS INCLUDED OVER \$471,000 IN GRANTS TO MEMORIAL HEALTH SYSTEM AFFILIATES, OVER \$333,000 IN GRANTS TO SOUTHERN ILLINOIS UNIVERSITY SCHOOL OF MEDICINE, AND \$77,130 IN GRANTS TO THE COMMUNITY NONPROFITS. MMCF PROVIDED \$222,005 IN GRANTS TO INDIVIDUALS. THESE GRANTS INCLUDE PATIENT ASSISTANCE TOTALING ALMOST \$98,000, EDUCATIONAL GRANTS AND CERTIFICATION REIMBURSEMENTS OF \$111,651, AND ASSISTANCE TO EMPLOYEES WITH CATASTROPHIC EVENTS OF \$12,764. IN FY2018, TMHF AWARDED \$124,733 IN GRANTS TO THE COMMUNITY AND TMH. SPECIFICALLY, \$103,069 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 AND ALSO HELPED TO PURCHASE NEW TELEMETRY MONITORING EQUIPMENT FOR CARDIAC REHAB AND VESTIBULAR GOGGLES FOR PHYSICAL THERAPY. EDUCATION AND PROFESSIONAL CERTIFICATION GRANTS TOTALING \$21,664 WERE AWARDED TO BENEFIT THOSE PURSUING ADVANCED CERTIFICATIONS AND POST-SECONDARY EDUCATION IN NURSING AND OTHER HEALTHCARE RELATED FIELDS. IN FY2018, PAHF PROVIDED \$282,705 IN GRANTS AND OTHER ASSISTANCE. A TOTAL OF \$179,432 WAS GRANTED TO PAHF, \$16,522 FOR GENERAL SUPPORT, \$100,000 FOR ECO STRESS MACHINE, \$18,626 FOR COMMUNITY HEALTH IMPROVEMENT, \$31,251 FOR LIFELINE PROGRAM SUPPORT AND \$13,033 FOR EMS TRAINING COURSES AND EQUIPMENT. THE PURPOSE OF THE EMS GRANTS WAS TO STRENGTHEN FIRST RESPONDER CAPACITY IN THE VOLUNTEER EMS AGENCIES. \$100,000 WAS GRANTED TO SIU WOMEN'S HEALTHCARE TO ESTABLISH A FACILITY TO OFFER WOMEN GREATER ACCESS TO OBSTETRIC AND GYNCOLOGIC CARE. INCLUDING HEALTHCARE RELATED TO HIGH-RISK PREGNANCIES. \$3,273 WAS GRANTED TO AINSLEY'S ANGELS FOR CHILDREN ASSISTANCE. IN ADDITION, COMMUNITIES IN PAH'S FIVE-COUNTY SERVICE AREA ALSO BENEFITED FROM FREE CANCER AND HEALTH SCREENINGS. PAHF PROVIDED \$63,379 IN GRANTS TO INDIVIDUALS. THESE GRANTS INCLUDE EDUCATIONAL GRANTS AND CERTIFICATION REIMBURSEMENTS OF \$48,850 AND ASSISTANCE TO EMPLOYEES OF \$14,529.

4d	Other program services (Describe in Schedule O)			
	(Expenses \$ 1,574,466	including grants of \$ 1,574,466)	(Revenue \$)	

4e	Total program service expenses	811,520,555
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Part IV Checklist of Required Schedules

	Yes	No
1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A	1 Yes	
2 Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?	2 Yes	
3 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	3	No
4 Section 501(c)(3) organizations. 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	4 Yes	
5 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	5	No
6 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	6	No
7 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	7	No
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III	8	No
9 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	9	No
10 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	10 Yes	
11 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		
a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI	11a Yes	
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	11b	No
c 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	11c	No
d 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	11d Yes	
e Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	11e Yes	
f 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	11f Yes	
12a Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII	12a	No
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	12b Yes	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	13	No
14a Did the organization maintain an office, employees, or agents outside of the United States?	14a	No
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	14b	No
15 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	15	No
16 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	16	No
17 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)	17	No
18 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	18 Yes	
19 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	19 Yes	

Part IV Checklist of Required Schedules (continued)

	Yes	No
20a Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	20a Yes	
b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b Yes	
21 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? <i>If "Yes," complete Schedule I, Parts I and II</i>	21 Yes	
22 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? <i>If "Yes," complete Schedule I, Parts I and III</i>	22 Yes	
23 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? <i>If "Yes," complete Schedule J</i>	23 Yes	
24a 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? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i>	24a	No
b Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b	
c 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	
d Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d	
25a Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations. Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i>	25a	No
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? <i>If "Yes," complete Schedule L, Part I</i>	25b	No
26 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? <i>If "Yes," complete Schedule L, Part II</i>	26	No
27 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? <i>If "Yes," complete Schedule L, Part III</i>	27	No
28 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) a A current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>	28a	No
b A family member of a current or former officer, director, trustee, or key employee? <i>If "Yes," complete Schedule L, Part IV</i>	28b Yes	
c 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? <i>If "Yes," complete Schedule L, Part IV</i>	28c Yes	
29 Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i>	29 Yes	
30 Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i>	30	No
31 Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i>	31	No
32 Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i>	32	No
33 Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? <i>If "Yes," complete Schedule R, Part I</i>	33 Yes	
34 Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i>	34 Yes	
35a Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a Yes	
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)? <i>If "Yes," complete Schedule R, Part V, line 2</i>	35b Yes	
36 Section 501(c)(3) organizations. Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i>	36	No
37 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? <i>If "Yes," complete Schedule R, Part VI</i>	37 Yes	
38 Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? Note. All Form 990 filers are required to complete Schedule O	38 Yes	

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

		Yes	No
1a	Enter the number reported in Box 3 of Form 1096 Enter -0- if not applicable	1a	435
b	Enter the number of Forms W-2G included in line 1a Enter -0- if not applicable	1b	0
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c	Yes
2a	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	2a	7,834
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	2b	Yes
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?	3a	Yes
b	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O	3b	Yes
4a	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)?	4a	No
b	If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)		
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a	No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b	No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	5c	
6a	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?	6a	Yes
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b	Yes
7	Organizations that may receive deductible contributions under section 170(c).		
a	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?	7a	Yes
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b	Yes
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c	No
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d	
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e	No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f	No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g	
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h	
8	Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	8	
9a	Did the sponsoring organization make any taxable distributions under section 4966?	9a	
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	9b	
10	Section 501(c)(7) organizations. Enter		
a	Initiation fees and capital contributions included on Part VIII, line 12	10a	
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b	
11	Section 501(c)(12) organizations. Enter		
a	Gross income from members or shareholders	11a	
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)	11b	
12a	Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?	12a	
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b	
13	Section 501(c)(29) qualified nonprofit health insurance issuers.		
a	Is the organization licensed to issue qualified health plans in more than one state? Note. See the instructions for additional information the organization must report on Schedule O	13a	
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	13b	
c	Enter the amount of reserves on hand	13c	
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a	No
b	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O	14b	

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 instructionsCheck if Schedule O contains a response or note to any line in this Part VI ☒**Section A. Governing Body and Management**

		Yes	No
1a Enter the number of voting members of the governing body at the end of the tax year	1a 142		
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 Enter the number of voting members included in line 1a, above, who are independent	1b 103		
2 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?	2	Yes	
3 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?	3		No
4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4		No
5 Did the organization become aware during the year of a significant diversion of the organization's assets?	5		No
6 Did the organization have members or stockholders?	6	Yes	
7a 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?	7a	Yes	
b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b	Yes	
8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following			
a The governing body?	8a	Yes	
b Each committee with authority to act on behalf of the governing body?	8b	Yes	
9 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	9		No

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

	Yes	No
10a Did the organization have local chapters, branches, or affiliates?	10a	No
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?	10b	
11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	11a	Yes
b Describe in Schedule O the process, if any, used by the organization to review this Form 990		
12a Did the organization have a written conflict of interest policy? If "No," go to line 13	12a	Yes
b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	Yes
c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done	12c	Yes
13 Did the organization have a written whistleblower policy?	13	Yes
14 Did the organization have a written document retention and destruction policy?	14	Yes
15 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?		
a The organization's CEO, Executive Director, or top management official	15a	Yes
b Other officers or key employees of the organization	15b	Yes
If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions)		
16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a	Yes
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?	16b	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. <input type="checkbox"/> Own website <input type="checkbox"/> Another's website <input checked="" type="checkbox"/> Upon request <input type="checkbox"/> 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 KATHRYN J KEIM SENIOR VP & CFO 701 NORTH FIRST STREET SPRINGFIELD, IL 62781 (217) 788-3830	

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

1a Complete this table for all persons required to be listed. Report compensation for the calendar year ending with or within the organization's tax year.

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation Enter -0- in columns (D), (E), and (F) if no compensation was paid
- List all of the organization's **current** key employees, if any See instructions for definition of "key employee "
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than \$100,000 from the organization and any related organizations
- List all of the organization's **former** officers, key employees, or highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations

List persons in the following order: individual trustees or directors; institutional trustees; officers; key employees; highest compensated employees; and former such persons

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

[illegible]

[illegible]

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 ▶ 345

Section B. Independent Contractors

(A) Name and business address	(B) Description of services	(C) Compensation
SIU SCHOOL OF MEDICINE PO BOX 19607 SPRINGFIELD, IL 627949607	PHYSICIAN SERVICES	35,782,882
HAROLD O'SHEA BUILDERS INC 3401 CONSTITUTION DR SPRINGFIELD, IL 62711	CONSTRUCTION	12,373,604
SPRINGFIELD CLINIC PO BOX 19260 SPRINGFIELD, IL 627049260	PHYSICIAN SERVICES	8,880,146
CERNER CORPORATION PO BOX 959156 ST LOUIS, MO 631959156	HEALTH INFORMATION TECHNOLOGY	6,836,622
MID-AMERICA EMERGENCY PHYSICIANS INC KERBER ECKBRAECKEL LLP SPRINGFIELD, IL 62701	ER STAFFING	5,895,169

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 ▶ 118	
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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	17,636			
	b	Membership dues . . .	1b				
	c	Fundraising events . . .	1c	282,929			
	d	Related organizations	1d	876,474			
	e	Government grants (contributions)	1e	595,160			
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	4,361,851			
	g	Noncash contributions included in lines 1a-1f \$		2,245,940			
	h	Total. Add lines 1a-1f		6,134,050			
Program Service Revenue			Business Code				
	2a	PATIENT SERVICE REV	900099	903,790,190	903,790,190		
	b	PROGRAM RELATED REV	900099	60,094,544	60,094,544		
	c	HOSPICE SERVICES	621610	5,938,236	5,938,236		
	d	HOME HEALTH SERVICES	621610	3,989,130	3,989,130		
	e	PARTNERSHIP LOSS	621399	-2,292,762	-2,292,762		
	f	All other program service revenue		2,077,130	2,077,130		
	g	Total. Add lines 2a-2f		973,596,468			
Other Revenue	3		Investment income (including dividends, interest, and other similar amounts)	9,773,889		9,773,889	
	4		Income from investment of tax-exempt bond proceeds				
	5		Royalties				
	6a	(i) Real	(ii) Personal				
	b	Less rental expenses					
	c	Rental income or (loss)					
	d	Net rental income or (loss)		820,399	21,562	798,837	
	7a	(i) Securities	(ii) Other				
	b	Less cost or other basis and sales expenses					
	c	Gain or (loss)					
	d	Net gain or (loss)		52,450,541		52,450,541	
	8a	Gross income from fundraising events (not including \$ 282,929 of contributions reported on line 1c) See Part IV, line 18					
		a		445,643			
		b	Less direct expenses	289,654			
c	Net income or (loss) from fundraising events		155,989		155,989		
9a	Gross income from gaming activities See Part IV, line 19						
	a		17,648				
	b	Less direct expenses	10,440				
c	Net income or (loss) from gaming activities		7,208		7,208		
10a	Gross sales of inventory, less returns and allowances						
	a						
	b	Less cost of goods sold					
c	Net income or (loss) from sales of inventory						
Miscellaneous Revenue		Business Code					
11a	REFERENCE LAB REVENUE	621500	5,375,945		5,375,945		
b	CAFETERIA REVENUE	722320	5,314,342		250,366	5,063,976	
c	PROMPT PAY INTEREST	622110	3,732,051			3,732,051	
d	All other revenue		3,050,289		1,063,380	1,986,909	
e	Total. Add lines 11a-11d		17,472,627				
12	Total revenue. See Instructions		1,060,411,171	973,596,468	6,711,253	73,969,400	

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
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21.	4,269,958	4,269,958		
2 Grants and other assistance to domestic individuals. See Part IV, line 22.	1,459,959	1,459,959		
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.				
4 Benefits paid to or for members.				
5 Compensation of current officers, directors, trustees, and key employees.	8,822,626	6,857,267	1,926,004	39,355
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B).	175,540	60,793	114,747	
7 Other salaries and wages.	319,872,153	281,810,539	37,827,332	234,282
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).	18,655,415	16,472,913	2,180,709	1,793
9 Other employee benefits.	52,765,184	46,081,090	6,645,200	38,894
10 Payroll taxes.	23,042,076	19,835,226	3,189,229	17,621
11 Fees for services (non-employees):				
a Management.				
b Legal.	1,250,232		1,250,232	
c Accounting.	76,118		76,118	
d Lobbying.	161,767		161,767	
e Professional fundraising services. See Part IV, line 17.				
f Investment management fees.	878,578		878,578	
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	130,538,414	117,798,035	12,740,379	
12 Advertising and promotion.	1,910,389	692,718	1,217,671	
13 Office expenses.	16,885,546	12,973,355	3,897,698	14,493
14 Information technology.	16,332,490	14,070,774	2,261,716	
15 Royalties.				
16 Occupancy.	15,836,602	14,307,926	1,528,676	
17 Travel.	968,986	769,871	199,115	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials.				
19 Conferences, conventions, and meetings.	766,016	217,843	548,173	
20 Interest.	13,077,614	13,077,614		
21 Payments to affiliates.				
22 Depreciation, depletion, and amortization.	49,204,244	38,194,441	11,009,803	
23 Insurance.	3,503,392	30,985	3,472,407	
24 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):				
a PATIENT SERV SUPPLIES	96,139,581	96,139,581		
b MANAGEMENT FEE	53,916,759		53,916,759	
c PHARMACEUTICAL SUPPLIES	38,495,526	38,495,526		
d PURCHASED MEDICAL SERVI	36,375,390	36,375,390		
e All other expenses	59,411,899	51,528,751	7,847,994	35,154
25 Total functional expenses. Add lines 1 through 24e.	964,792,454	811,520,555	152,890,307	381,592
26 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 SheetCheck if Schedule O contains a response or note to any line in this Part IX ☐

				(A) Beginning of year		(B) End of year
Assets	1	Cash—non-interest-bearing		10,967,227	1	5,491,351
	2	Savings and temporary cash investments		162,218,021	2	119,815,046
	3	Pledges and grants receivable, net		194,207	3	236,310
	4	Accounts receivable, net		214,675,686	4	169,800,007
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L			5	
	6	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			6	
	7	Notes and loans receivable, net		11,713,043	7	12,051,228
	8	Inventories for sale or use		12,904,693	8	14,129,432
	9	Prepaid expenses and deferred charges		8,488,612	9	8,463,207
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D.	10a 847,947,910			
	b	Less: accumulated depreciation	10b 466,566,530	380,137,646	10c	381,381,380
	11	Investments—publicly traded securities		437,640,201	11	589,450,250
	12	Investments—other securities. See Part IV, line 11		27,806,561	12	28,904,291
	13	Investments—program-related. See Part IV, line 11		10,984,263	13	9,280,544
	14	Intangible assets			14	
	15	Other assets. See Part IV, line 11		97,403,474	15	94,431,045
16	Total assets. Add lines 1 through 15 (must equal line 34)		1,375,133,634	16	1,433,434,091	
Liabilities	17	Accounts payable and accrued expenses		92,295,289	17	100,842,730
	18	Grants payable		657,251	18	528,509
	19	Deferred revenue		426,803	19	1,127,920
	20	Tax-exempt bond liabilities			20	
	21	Escrow or custodial account liability. Complete Part IV of Schedule D			21	
	22	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			22	
	23	Secured mortgages and notes payable to unrelated third parties		46,409,923	23	30,000,000
	24	Unsecured notes and loans payable to unrelated third parties			24	
	25	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		392,210,249	25	382,406,031
	26	Total liabilities. Add lines 17 through 25		531,999,515	26	514,905,190
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.					
	27	Unrestricted net assets		747,635,845	27	824,153,662
	28	Temporarily restricted net assets		68,965,415	28	68,063,650
	29	Permanently restricted net assets		26,532,859	29	26,311,589
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.					
	30	Capital stock or trust principal, or current funds			30	
	31	Paid-in or capital surplus, or land, building or equipment fund			31	
	32	Retained earnings, endowment, accumulated income, or other funds			32	
33	Total net assets or fund balances		843,134,119	33	918,528,901	
34	Total liabilities and net assets/fund balances		1,375,133,634	34	1,433,434,091	

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	1,060,411,171
2	Total expenses (must equal Part IX, column (A), line 25)	2	964,792,454
3	Revenue less expenses Subtract line 2 from line 1	3	95,618,717
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	843,134,119
5	Net unrealized gains (losses) on investments	5	-25,792,916
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	5,568,981
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	918,528,901

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

	Yes	No
1 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		
2a 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 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 type="checkbox"/> Consolidated basis <input checked="" type="checkbox"/> Both consolidated and separate basis	Yes	
c 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	
3a 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 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 (2017)

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 140,174 PATIENT DAYS, 29,532 DISCHARGES, AND 642,227 OUTPATIENT VISITS WERE PROVIDED BY THE HOSPITALS IN FY2018 \$12 MILLION IN CHARITY CARE WAS PROVIDED AND THE HOSPITALS WROTE OFF AN ADDITIONAL \$13 MILLION IN BAD DEBT FOR CARE PROVIDED JACKSONVILLE CRNA PROVIDES PROFESSIONAL CERTIFIED REGISTERED NURSE ANESTHETIST SERVICES TO THE COMMUNITIES IN THE PAH SERVICE AREA FOR FY 2018, SERVICES WERE PROVIDED FOR 5,589 CASES DURING FY2018, MMC RECEIVED THE AMERICAN HOSPITAL ASSOCIATION'S NOVA AWARD FOR THE COLLABORATIVE WORK DONE WITH ST JOHN'S HOSPITAL AND SOUTHERN ILLINOIS UNIVERSITY'S CENTER FOR FAMILY MEDICINE IN THE ENOS PARK NEIGHBORHOOD THE AWARD WAS PRESENTED AT THE AHA'S LEADERSHIP SUMMIT IN SAN DIEGO IN JULY 2018 MEMORIAL HEALTH SYSTEM ALSO WON THE ILLINOIS HOSPITAL ASSOCIATION'S OUTSTANDING ACHIEVEMENT AWARD FOR A LEAN SIX SIGMA PROJECT ON MANAGING AGGRESSIVE BEHAVIOR IN THE EMERGENCY DEPARTMENT AT TMH MMC ALSO RECEIVED RE-DESIGNATIONS FROM BLUE CROSS BLUE SHIELD FOR HEART CARE AND FROM THE AMERICAN HEART ASSOCIATION FOR THE HEART FAILURE PROGRAM ALMH ALSO RECEIVED THE PATHWAY TO EXCELLENCE IN NURSING AWARD IN FY2018, PAH COMPLETED THE RENOVATIONS ON A 20 BED PATIENT UNIT, AND BEGAN RENOVATIONS FOR A BEHAVIORAL HEALTH PARTIAL HOSPITALIZATION PROGRAM ADDITIONALLY, RENOVATIONS ON THE MAIN ENTRANCE WERE COMPLETED, IMPROVING THE ACCESS AND SAFETY FOR OUR PATIENTS AND VISITORS IN FY2018, THE ALMH NURSING STAFF, NURSING ADMINISTRATION AND HOSPITALIST PARTNERS IDENTIFIED A NEED FOR MORE INTENSIVE TRAINING BASED ON ACUITY OF PATIENTS ALMH WAS SEEING IN THE SWING BED PROGRAM THE ALMH NURSING STAFF WAS TRAINED AND COMPLETED COMPETENCIES ON TRACHEOSTOMY CARE, WOUND VAC'S AND LIFE VEST DURING FY2018, THE DIABETES SELF-MANAGEMENT PROGRAM CONTINUED CARING FOR PATIENTS AT TMH IN FY 2018, 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 PROVIDER 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. MPS ALSO OFFERS FOUR WALK-IN EXPRESS CARE LOCATIONS TO IMPROVE PATIENT ACCESS, AS WELL AS A WALK-IN CLINIC IN A RETAIL SETTING. MPS PROVIDED 296,767 PRIMARY CARE PATIENT VISITS AND 80,081 URGENT CARE VISITS FOR FY 2018. 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. ALL OF THE MPS PRIMARY CARE CLINICS ARE NCQA DESIGNATED LEVEL 3 PATIENT CENTERED MEDICAL HOMES.

Form 990, Part III, Line 4c:

AMBULATORY & OTHER MEMORIAL HEALTH SYSTEM OPERATES THREE AMBULATORY AFFILIATES THAT ARE INCLUDED IN THE GROUP 990 RETURN MEMORIAL HOME SERVICES (MHSVC), MEMORIAL HEALTH VENTURES (MHV), AND SPRINGFIELD RESIDENTIAL SERVICES (SRS) 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 FY2018, MEMORIAL HOSPICE AT HERITAGE, A 19 BED SKILLED NURSING UNIT, CONTINUED TO HELP MEET THE UNIQUE NEEDS OF HOSPICE PATIENTS AND FAMILIES WHO MAY NEED A FACILITY SETTING FOR END-OF-LIFE CARE SRS PROVIDES HOUSING FACILITIES AND SERVICES TO NON-ELDERLY ADULTS DIAGNOSED WITH MENTAL ILLNESSES BY MEANS OF CONSTRUCTING A HUD HOUSING PROJECT

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 (THRU JAN 18)	0 70 0 70	X						0	0	0
AMIR JOHN WAHAB MD BOARD MEMBER ALMH	50 00 0 00	X						567,208	0	151,975
GREG EIMER BOARD MEMBER ALMH	0 70 0 00	X						0	0	0
BRUCE CARMITCHEL BOARD MEMBER ALMH	0 70 0 00	X						0	0	0
ANDREW HAYES BOARD MEMBER ALMH	0 70 0 70	X						0	0	0
TRACY MIZEUR MD BOARD MEMBER ALMH	50 00 0 00	X						257,940	0	65,382
DON SIELAFF BOARD MEMBER ALMH	0 70 0 00	X						0	0	0
RONALD SCHILLING BOARD MEMBER ALMH	0 70 0 00	X						0	0	0
CHRISTOPHER GRAUE BOARD MEMBER ALMH (FROM FEB 18)	0 70 0 00	X						0	0	0
JUNE HARNACKE BRDMEMALMH(THRUJAN18)/TREASALMH	0 70 0 00	X		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			
KEITH SNYDER TREASALMH(THRUJAN18)/SECALMH	0 70 0 00	X		X				0	0	0
DAVID IRWIN SECALMH(THRUJAN18)/CHRELECTALMH	0 70 0 00	X		X				0	0	0
WILLIAM BATES CHRALMH(THRUJAN18)/IMMEDPASTCHRALMH	0 70 0 00	X		X				0	0	0
DAVID CAMPBELL CHRELECTALMH(THRUJAN18)/CHRALMH	0 70 0 70	X		X				0	0	0
DERON POWELL IMDPASTCHRALMH(THRUJAN18)/BRDMEMALMH	0 70 0 70	X		X				0	0	0
SUSAN KOCH EDD BOARD MEMBER MMC	0 70 0 70	X						0	0	0
LYNNE BARKMEIER MD BOARD MEMBER MMC	0 70 0 00	X						0	0	0
JOSEPH HURWITZ BOARD MEMBER MMC (THRU DEC 17)	0 70 0 70	X						0	0	0
RICHARD LEVI BOARD MEMBER MMC (FROM JAN 18)	0 70 0 70	X						0	0	0
KEVIN COAKLEY MD BOARD MEMBER MMC	0 70 0 00	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			
NINA HARRIS BOARD MEMBER MMC	0 70 0 70	X						0	0	0
SERGIO PECORI BOARD MEMBER MMC (FROM JAN 18)	0 70 0 70	X						0	0	0
HOWARD PETERS III BOARD MEMBER MMC (THRU DEC 17)	0 70 0 00	X						0	0	0
JARROD WALL MD PHD BOARD MEMBER MMC	0 70 0 00	X						0	0	0
LISA HARTZLER BOARD MEMBER MMC	0 70 0 00	X						0	0	0
JOHN BLACKBURN BOARD MEMBER MMC	0 70 0 70	X						0	0	0
TODD WISE 2NDVICECHR MMC (FROM JAN 18)	0 70 0 70	X		X				0	0	0
DEAN ROBERT JR 2VCHRMHC(THRUDEC17)/1VCHR(FROMJAN18)	0 70 0 70	X		X				0	0	0
DALE BECKER TREASURER MMC	0 70 0 70	X		X				0	0	0
DIANE RUTLEDGE PHD 1VCHRMHC(THRUDEC17)/CHAIR(FROMJAN18)	0 70 0 70	X		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			
GEOFFREY ISRINGHAUSEN SECRETARY MMC	0 70	X		X				0	0	0
RANDALL GERMERAAD CHRMCM(THRUDEC17))/BRDMEMMMC	0 70	X		X				0	0	0
JAMES REED JR BRDMEMMMC/BRDMEMMMCF	1 10	X						0	0	0
JENNIFER ISRINGHAUSEN BOARD MEMBER MMCF	0 20	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
SUSAN GLEASON BOARD MEMBER MMCF (FROM JAN 18)	0 30	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

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			
MARK HANSEN MD BRDMMMPs(THRUDEC17)/CHAIR	50 00 0 00	X		X				497,238	0	114,751
MARSHALL HALE MD CHAIR MPS(THRU DEC 17)	50 00 0 00	X		X				532,219	0	153,285
J TRAVIS DOWELL PRESIDENT MPS & VP MPS	50 00 0 00	X		X				0	333,532	72,631
CARL NIEMANN BOARD MEMBER TMH (THRU DEC 17)	0 70 0 00	X						0	0	0
PAVI GILL MD JD BOARD MEMBER TMH	0 70 0 00	X						0	0	0
RONALD MIZER DDS BOARD MEMBER TMH (THRU DEC 17)	0 70 0 00	X						0	0	0
M ADAM MATHIAS BOARD MEMBER TMH (FROM JAN 18)	0 70 0 00	X						0	0	0
JOHN FERRY DDS BOARD MEMBER TMH	0 70 0 00	X						0	0	0
JOHN CORSO BOARD MEMBER TMH (THRU MAY 18)	0 70 0 00	X						0	0	0
BETH BROTHERTON JD BOARD MEMBER TMH	0 70 0 00	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			
ERIC KAHLE BOARD MEMBER TMH (FROM JAN 18)	0 70 0 00	X						0	0	0
ADAM VOCKS BRDMEMTMH(THRUDEC17)/TREASTMH	0 70 0 00	X		X				0	0	0
LINDA SMITH SECRETARY TMH	0 70 0 00	X		X				0	0	0
JUDGE RONALD SPEARS TREASTMH(THRUDEC17)/VCHRTMH	0 70 0 00	X		X				0	0	0
JAMES ADCOCK CHAIR TMH	0 70 0 00	X		X				0	0	0
JOHN DANIEL LITTEKEN VCHRTMH(THRUDEC17)/BRDMEMTMH	0 70 0 00	X		X				0	0	0
GARY SPURLING BOARD MEMBER TMH (FROM JAN 18)	0 70 0 00	X						0	0	0
WILLIAM COPE BOARD MEMBER TMHF	0 70 0 00	X						0	0	0
JUDITH SWIGERT BOARD MEMBER TMHF	0 70 0 00	X						0	0	0
SR ANGELA LAQUET ASC BRDMEMTMHF(THRUDEC17),HHOCCUPTHERAP	50 00 0 00	X						95,218	0	14,529

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			
MELISSA LIVINGSTON BOARD MEMBER TMHF	0 70 0 00	X						0	0	0
DAVID BRUMMER BOARD MEMBER TMHF	0 70 0 00	X						0	0	0
DUANNE STOCK BOARD MEMBER TMHF	0 70 0 00	X						0	0	0
LACY GLENN BOARD MEMBER TMHF (FROM JAN 18)	0 70 0 00	X						0	0	0
DENNIS KENNEDY BOARD MEMBER TMHF (FROM JAN 18)	0 70 0 00	X						0	0	0
GLORIA BRUMMER BOARD MEMBER TMHF (THRU DEC 17)	0 70 0 00	X						0	0	0
LINDSAY BARRY BRDMEMTMHF(THRUDEC17)/SECTMHF	0 70 0 00	X		X				0	0	0
BILLY WILLIAMS SECTMHF(THRUDEC17)/VPTMHF	0 70 0 00	X		X				0	0	0
MICHELLE CAPELLIN PRESTMHF(THRUDEC17)/BRDMEMTMHF	0 70 0 00	X		X				0	0	0
MICHAEL BLAKEMAN TREASTMHF	0 70 0 00	X		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			
CHARLES CALLAHAN PHD EVPCOOMMC/CHRMHV/MPSBRDMEM/PRESMH SVC	25 00 25 00	X		X				706,687	0	193,426
DOUGLAS AWE BRDMEM PAH/PAHF(FROM JAN 18)	0 70 0 00	X						0	0	0
KEITH BRADBURY BOARD MEMBER PAH	0 70 0 00	X						0	0	0
BARBARA FARLEY PHD BOARD MEMBER PAH	0 70 0 00	X						0	0	0
DANIEL HALLAM PHD MD BRDMEM PAH (FROM JAN 18)	0 70 0 00	X						0	0	0
DONALD HEADEN BOARD MEMBER PAH	0 70 0 00	X						0	0	0
GILBERT JOEHL BRDMEMLPAHF, BRDMEMLPAH	1 40 0 00	X						0	0	0
PHYLLIS LAPE PHD BOARD MEMBER PAH	0 70 0 00	X						0	0	0
STEVEN LILLOPOP MD BRDMEM PAH (THRU DEC 17)	50 00 0 00	X						708,677	0	161,537
PETER RUSSOTTO DPM BRDMEM PAH (FROM JAN 18)	50 00 0 00	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			
KEITH LAPE PHD BOARD MEMBER PAHF	0 70 0 00	X						0	0	0
LISA MUSCH BOARD MEMBER PAHF	0 70 0 00	X						0	0	0
CARRIE COLE BOARD MEMBER PAHF	0 70 0 00	X						0	0	0
DIANA OLINGER BRDMEM PAHF (THRU DEC 17)	0 70 0 00	X						0	0	0
ANN PRATHER BOARD MEMBER PAHF	0 70 0 00	X						0	0	0
MARY FERGURSON PAHF PRESIDENT	0 70 0 00	X		X				0	0	0
LINDA DONOVAN VP OF STEWARDSHIP AND GIFTS PAHF	0 70 0 00	X		X				0	0	0
CHESTER WYNN SECRETARY PAHF	0 70 0 00	X		X				0	0	0
STEVE TURNER TREASURER PAHF	0 70 0 00	X		X				0	0	0
JANICE GAMBACH PRESIDENT SRS, ADMIN MBH	2 50 47 50			X				0	208,017	24,750

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			
ELENA KEZELIS	50 00				X			200,105	0	40,968
EXEC DIR MMCf	0 00				X					
MARSHA PRATER PHD	50 00				X			382,469	0	229,469
SVP & CNO MMC	0 00				X					
LINDA JONES DNS	50 00				X			383,129	0	62,126
VP OPERATIONS MMC	0 00				X					
DREW EARLY	50 00				X			282,869	0	66,249
VPOPERATIONS (FROMDEC16)	0 00				X					
ANNA EVANS JD	25 00				X			0	440,199	137,801
GEN COUNSEL/VP INT AUDIT & COMPL MHS	25 00				X			0	604,745	86,664
RAJESH GOVINDAIAH MD	25 00				X			0	578,304	169,485
SVP & CMO MHS	25 00				X			0	511,017	123,219
DAVID GRAHAM MD	25 00				X			0	371,234	69,426
SVP & CIO MHS	25 00				X			0	218,791	27,347
MITCHELL JOHNSON	25 00				X			0		
SVP & CHIEF STRATEGY OFFICER MHS	25 00				X					
ROBERT SCOTT	25 00				X					
VP & CHRO MHS	25 00				X					
JENNIFER HARRIS	50 00				X					
ADMIN PERIOPERATIVE SERVICES	0 00				X					

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			
MITCHELL ROGERS ADMIN CARDIOVASCULAR SERVICES	50 00 0 00				X			279,957	0	41,027
CHARLES SHEAFF MD CMO PAH (THRU AUG 17)	49 30 0 70				X			257,443	49,724	33,447
FERDINAND SALVACION MD PHYSICIAN MMC	50 00 0 00					X		768,013	0	129,534
JAMES BOHAN MD PHYSICIAN MPS	50 00 0 00					X		674,093	0	101,387
CHRISTINA SCHEIBLER-VENTRESS MD PHYSICIAN MPS	50 00 0 00					X		571,533	0	105,010
DAVID SANDERCOCK MD PHYSICIAN MPS	50 00 0 00					X		601,463	0	149,858
ROBERT BUSSING MD PHYSICIAN MPS	50 00 0 00					X		632,423	0	40,000
DAN RAAB FMRPRESTMH&TMHF	0 00 0 00						X	0	289,870	0

TY 2017 Affiliate Listing

Name: MEMORIAL HEALTH SYSTEM GROUP

EIN: 90-0756744

TY 2017 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

SCHEDULE A (Form 990 or 990EZ)	Public Charity Status and Public Support 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 www.irs.gov/form990 .	OMB No 1545-0047 2017 Open to Public Inspection
Department of the Treasury Internal Revenue Service Name of the organization MEMORIAL HEALTH SYSTEM GROUP		Employer identification number 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		
Total						

Schedule A (Form 990 or 990-EZ) 2017

Page 2

Part II

Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv), 170(b)(1)(A)(vi), and 170(b)(1)(A)(ix)

(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) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grant.")	1,822,258	10,672,422	2,108,711	1,969,241	1,627,489	18,200,121
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 Total. Add lines 1 through 3	1,822,258	10,672,422	2,108,711	1,969,241	1,627,489	18,200,121
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)						5,723,125
6 Public support. Subtract line 5 from line 4						12,476,996

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a)2013	(b)2014	(c)2015	(d)2016	(e)2017	(f)Total
7 Amounts from line 4	1,822,258	10,672,422	2,108,711	1,969,241	1,627,489	18,200,121
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources	658,502	643,908	635,765	667,454	617,110	3,222,739
9 Net income from unrelated business activities, whether or not the business is regularly carried on	11,927	10,334	10,053	10,269	6,619	49,202
10 Other income. Do not include gain or loss from the sale of capital assets. (Explain in Part VI.)	403,871	441,129	445,285	442,508	463,291	2,196,084
11 Total support. Add lines 7 through 10						23,668,146
12 Gross receipts from related activities, etc. (see instructions)					12	68,816,465

13

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

14 Public support percentage for 2017 (line 6, column (f) divided by line 11, column (f))	14	52.720 %
15 Public support percentage for 2016 Schedule A, Part II, line 14	15	54.120 %

16a

33 1/3% support test—2017. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here**. The organization qualifies as a publicly supported organization ▶ ☒

b

33 1/3% support test—2016. 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 **stop here**. The organization qualifies as a publicly supported organization ▶ ☐

17a

10%-facts-and-circumstances test—2017. 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 **stop here**. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐

b

10%-facts-and-circumstances test—2016. 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 **stop here**. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐

18

Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ ☐

Schedule A (Form 990 or 990-EZ) 2017

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) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
2 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						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
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						
c Add lines 7a and 7b						
8 Public support. (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 Total support. (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

15 Public support percentage for 2017 (line 8, column (f) divided by line 13, column (f))	15	
16 Public support percentage from 2016 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2017 (line 10c, column (f) divided by line 13, column (f))	17	
18 Investment income percentage from 2016 Schedule A, Part III, line 17	18	

19a 33 1/3% support tests—2017. 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—2016. 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
1 Are all of the organization's supported organizations listed by name in the organization's governing documents? <i>If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.</i>	1	
2 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 Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).</i>	2	
3a 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>	3a	
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 Part VI when and how the organization made the determination.</i>	3b	
c 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 Part VI what controls the organization put in place to ensure such use.</i>	3c	
4a 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>	4a	
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 Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.</i>	4b	
c 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 Part VI 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>	4c	
5a 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 Part VI, 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>	5a	
b Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document?	5b	
c Substitutions only. Was the substitution the result of an event beyond the organization's control?	5c	
6 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 Part VI.</i>	6	
7 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>	7	
8 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>	8	
9a 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 Part VI.</i>	9a	
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 Part VI.</i>	9b	
c 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 Part VI.</i>	9c	
10a 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>	10a	
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>	10b	

Part IV Supporting Organizations (continued)

	Yes	No
11 Has the organization accepted a gift or contribution from any of the following persons?		
a 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 A family member of a person described in (a) above?		
c 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>		
	11a	
	11b	
	11c	

Section B. Type I Supporting Organizations

	Yes	No
1 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>		
	1	
2 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>		
	2	

Section C. Type II Supporting Organizations

	Yes	No
1 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>		
	1	

Section D. All Type III Supporting Organizations

	Yes	No
1 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?		
	1	
2 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>		
	2	
3 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>		
	3	

Section E. Type III Functionally-Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions)		
a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).		
2 Activities Test Answer (a) and (b) below.		
a 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>		
	2a	
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>		
	2b	
3 Parent of Supported Organizations Answer (a) and (b) below.		
a 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>		
	3a	
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>		
	3b	

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 (explain in Part VI) **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)
1 Net short-term capital gain	1		
2 Recoveries of prior-year distributions	2		
3 Other gross income (see instructions)	3		
4 Add lines 1 through 3	4		
5 Depreciation and depletion	5		
6 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)	6		
7 Other expenses (see instructions)	7		
8 Adjusted Net Income (subtract lines 5, 6 and 7 from line 4)	8		
Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1 Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year)	1		
a Average monthly value of securities	1a		
b Average monthly cash balances	1b		
c Fair market value of other non-exempt-use assets	1c		
d Total (add lines 1a, 1b, and 1c)	1d		
e Discount claimed for blockage or other factors (explain in detail in Part VI)			
2 Acquisition indebtedness applicable to non-exempt use assets	2		
3 Subtract line 2 from line 1d	3		
4 Cash deemed held for exempt use Enter 1-1/2% of line 3 (for greater amount, see instructions)	4		
5 Net value of non-exempt-use assets (subtract line 4 from line 3)	5		
6 Multiply line 5 by .035	6		
7 Recoveries of prior-year distributions	7		
8 Minimum Asset Amount (add line 7 to line 6)	8		
Section C - Distributable Amount			Current Year
1 Adjusted net income for prior year (from Section A, line 8, Column A)	1		
2 Enter 85% of line 1	2		
3 Minimum asset amount for prior year (from Section B, line 8, Column A)	3		
4 Enter greater of line 2 or line 3	4		
5 Income tax imposed in prior year	5		
6 Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6		
7 <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 2017 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-2017	(iii) Distributable Amount for 2017
1 Distributable amount for 2017 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2017 (reasonable cause required-- explain in Part VI) See instructions			
3 Excess distributions carryover, if any, to 2017			
a			
b From 2013.			
c From 2014.			
d From 2015.			
e From 2016.			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2017 distributable amount			
i Carryover from 2012 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2017 from Section D, line 7 \$			
a Applied to underdistributions of prior years			
b Applied to 2017 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2017, if any Subtract lines 3g and 4a from line 2 If the amount is greater than zero, explain in Part VI See instructions			
6 Remaining underdistributions for 2017 Subtract lines 3h and 4b from line 1 If the amount is greater than zero, explain in Part VI See instructions			
7 Excess distributions carryover to 2018. Add lines 3j and 4c			
8 Breakdown of line 7			
a Excess from 2013.			
b Excess from 2014.			
c Excess from 2015.			
d Excess from 2016.			
e Excess from 2017.			

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)

Facts And Circumstances Test

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>

990 Schedule A, Supplemental Information

Return Reference	Explanation
PART III, SECTION C, LINE 15 & 16	THE SOFTWARE USED TO PREPARE THE MHS GROUP RETURN DOES NOT ALLOW FOR MULTIPLE PUBLIC CHARITY STATUS. ACCORDINGLY, THE ORGANIZATION HAS SEPARATELY DOCUMENTED THEIR PUBLIC SUPPORT PERCENTAGES AGGREGATED AS FOLLOWS: LINE 15-PUBLIC SUPPORT PERCENTAGE FOR 2017: 99 3%; LINE 16-PUBLIC SUPPORT PERCENTAGE FOR 2016: 99 5%.

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.

OMB No 1545-0047

2017

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.

- 1 Provide a description of the organization's direct and indirect political campaign activities in Part IV (see instructions for definition of "political campaign activities")
- 2 Political campaign activity expenditures (see instructions) ▶ \$
- 3 Volunteer hours for political campaign activities (see instructions) ▶

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

- 1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ \$
- 2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ \$
- 3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? ☐ Yes ☐ No
- 4a Was a correction made? ☐ Yes ☐ No
- 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).

- 1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ \$
- 2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ \$
- 3 Total exempt function expenditures Add lines 1 and 2 Enter here and on Form 1120-POL, line 17b ▶ \$
- 4 Did the filing organization file **Form 1120-POL** for this year? ☐ Yes ☐ No
- 5 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-
1				
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) 2014	(b) 2015	(c) 2016	(d) 2017	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f 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
1	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			
a	Volunteers?		No	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?		No	
e	Publications, or published or broadcast statements?		No	
f	Grants to other organizations for lobbying purposes?	Yes		161,767
g	Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?		No	
j	Total. Add lines 1c through 1i			161,767
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	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
1 Were substantially all (90% or more) dues received nondeductible by members?	1	
2 Did the organization make only in-house lobbying expenditures of \$2,000 or less?	2	
3 Did the organization agree to carry over lobbying and political expenditures from the prior year?	3	

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."

1 Dues, assessments and similar amounts from members	1	
2 Section 162(e) nondeductible lobbying and political expenditures (do not include amounts of political expenses for which the section 527(f) tax was paid).	2a	
a Current year	2b	
b Carryover from last year	2c	
c Total	3	
3 Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	4	
4 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?	5	
5 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 - \$85,680 PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION - \$25,350 ABRAHAM LINCOLN MEMORIAL HOSPITAL - \$25,531 MEMORIAL PHYSICIAN SERVICES - \$273 MEMORIAL HOME SERVICES - \$4,611 TAYLORVILLE MEMORIAL HOSPITAL - \$20,322

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SCHEDULE D

(Form 990)

Supplemental Financial Statements

► 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.

Information about Schedule D (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2017

Open to Public Inspection

Department of the Treasury

Internal Revenue Service

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.

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

(a) Donor advised funds

(b) Funds and other accounts

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?

Yes

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?

Yes

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)

☐ Preservation of land for public use (e g , recreation or education)

☐ Preservation of an historically important land area

☐ Protection of natural habitat

☐ Preservation of a certified historic structure

☐ 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

Held at the End of the Year

2a

2b

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?

Yes

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)?

Yes

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

1b

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) 2017

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	13,038,025	12,076,607	12,661,077	12,566,252	11,521,169
b Contributions	9,674	17,776	14,970	1,107,070	501,283
c Net investment earnings, gains, and losses	978,889	1,356,991	677,746	-470,568	1,052,498
d Grants or scholarships	150,431	22,103	904,938	189,207	123,660
e Other expenditures for facilities and programs	284,028	298,395	280,079	263,145	304,976
f Administrative expenses	89,747	92,851	92,169	89,325	80,062
g End of year balance	13,502,382	13,038,025	12,076,607	12,661,077	12,566,252

2

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

a

Board designated or quasi-endowment

9 800 %

b

Permanent endowment

63 800 %

c

Temporarily restricted endowment

26 400 %

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
	No

(ii) related organizations

3a(ii)

Yes	No
Yes	

b

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

3b

Yes	No
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	11,261,610	10,644,103		21,905,713
b Buildings	3,226,195	445,628,563	229,653,488	219,201,270
c Leasehold improvements		11,814,959	7,159,346	4,655,613
d Equipment	5,623	281,051,430	206,139,994	74,917,059
e Other		84,315,427	23,613,702	60,701,725
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c))				381,381,380

Schedule D (Form 990) 2017

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) ▶	94,431,045

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) ▶	382,406,031	

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.

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

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.

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

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
UNAMORTIZED BOND DISCOUNTS AND ISSUE COSTS	472,669
DUE FROM AFFILIATES	1,682,996
BENEFICIAL INTEREST IN TRUSTS	46,110,880
INSURANCE RECOVERIES	2,750,591
NET EDUCATIONAL GRANTS/TUITION REIMBURSEMENT RECEIVABLE	77,489
AR CLEARING	1,450
CASH SURRENDER VALUE OF LIFE INSURANCE	155,705
SCULPTURES	635,000
LONG TERM PLEDGE RECEIVABLE	860,143
PHYSICIAN LOANS	94,677
FARM LAND	16,752,767
INTEREST IN NET ASSETS OF PAHF	4,781,485
MALPRACTICE RECEIVABLE	1,125,930
WORKERS COMP RECEIVABLE	279,097
MINIMUM PENSION ASSET	18,650,166

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

1	(a) Description of Liability	(b) Book Value
	DEFERRED COMPENSATION	3,858,619
	ESTIMATED THIRD PARTY PAYOR SETTLEMENTS	43,817,302
	RESERVE FOR POST EMPLOYMENT BENEFITS	13,715,570
	SWAP LIABILITY	1,970,021
	WORKERS' COMPENSATION AND PROFESSIONAL LIABILITY	27,369,622
	ENVIRONMENTAL HAZARDS LIABILITY	1,760,588
	DUE TO AFFILIATES	2,214,605
	CHARITABLE GIFT ANNUITY PAYABLE	189,000
	OTHER PAYABLES	113,818
	SELF INSURANCE ACCRUAL	681,107

Form 990, Schedule D, Part X, - Other Liabilities	
1 (a) Description of Liability	(b) Book Value
SERP/RESTORATION PENSION PLAN	3,060,625
INTERCOMPANY DEBT TO MEMORIAL HEALTH SYSTEM (37-1110690)	283,625,923
SCHOLARSHIP PAYABLE	29,231

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, 2018 OR 2017 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)

Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding
Fundraising or Gaming Activities

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
▶ Attach to Form 990 or Form 990-EZ.
▶ Information about Schedule G (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
MEMORIAL HEALTH SYSTEM GROUP

Employer identification number
90-0756744

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 ☐ Mail solicitations

e ☐ Solicitation of non-government grants

b ☐ Internet and email solicitations

f ☐ Solicitation of government grants

c ☐ Phone solicitations

g ☐ Special fundraising events

d ☐ 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.

		(a) Event #1 FESTIVAL OF TREES (MMCF) (event type)	(b) Event #2 BE AWARE WOMEN'S FAIR (event type)	(c) Other events 5 (total number)	(d) Total events (add col (a) through col (c))
Revenue	1 Gross receipts	620,152	30,628	77,792	728,572
	2 Less Contributions	231,135	9,000	42,794	282,929
	3 Gross income (line 1 minus line 2)	389,017	21,628	34,998	445,643
Direct Expenses	4 Cash prizes				
	5 Noncash prizes	62,321	9,034	10,687	82,042
	6 Rent/facility costs	16,010	2,363	1,100	19,473
	7 Food and beverages	75,030		5,762	80,792
	8 Entertainment	650		1,250	1,900
	9 Other direct expenses	81,637	8,351	15,459	105,447
	10 Direct expense summary Add lines 4 through 9 in column (d) ▶				289,654
	11 Net income summary Subtract line 10 from line 3, column (d) ▶				155,989

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.

		(a) Bingo	(b) Pull tabs/Instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col (a) through col (c))
Revenue	1 Gross revenue			17,648	17,648
	2 Cash prizes			1,981	1,981
Direct Expenses	3 Noncash prizes				
	4 Rent/facility costs				
	5 Other direct expenses			8,459	8,459
	6 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	
	7 Direct expense summary Add lines 2 through 5 in column (d) ▶				10,440
	8 Net gaming income summary Subtract line 7 from line 1, column (d) ▶				7,208

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?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
13 Indicate the percentage of gaming activity conducted in			
a The organization's facility	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 100px; text-align: center;">13a</td><td style="width: 100px; text-align: right;">%</td></tr></table>	13a	%
13a	%		
b An outside facility	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 100px; text-align: center;">13b</td><td style="width: 100px; text-align: right;">100 000 %</td></tr></table>	13b	100 000 %
13b	100 000 %		

14 Enter the name and address of the person who prepares the organization's gaming/special events books and recordsName ► JAN FELLHAUERAddress ► 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 informationName ► JAN FELLHAUERGaming manager compensation ► \$ 7,695Description 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 provide any additional information (see instructions).

Return Reference

Explanation

SCHEDULE H
(Form 990)

Hospitals

OMB No 1545-0047

2017

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.

Department of the Treasury

Internal Revenue Service

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	Yes	
1b	If "Yes," was it a written policy?	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	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	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"?	Yes	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	Yes	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		No
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?		
6a	Did the organization prepare a community benefit report during the tax year?	Yes	
b	If "Yes," did the organization make it available to the public?	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)	104	5,091	10,994,224		10,994,224	1 150 %
b Medicaid (from Worksheet 3, column a)	1	94,340	172,514,637	118,977,787	53,536,850	5 620 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs	105	99,431	183,508,861	118,977,787	64,531,074	6 770 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)	2,343	41,579	1,867,491	310	1,867,181	0 200 %
f Health professions education (from Worksheet 5)	91	1,978	12,351,795	3,893,236	8,458,559	0 890 %
g Subsidized health services (from Worksheet 6)	3	1,824	22,750,679		22,750,679	2 390 %
h Research (from Worksheet 7)	3	178	247,029	8,105	238,924	0 030 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)	137	66,244	38,109,722		38,109,722	4 000 %
j Total. Other Benefits	2,577	111,803	75,326,716	3,901,651	71,425,065	7 510 %
k Total. Add lines 7d and 7j	2,682	211,234	258,835,577	122,879,438	135,956,139	14 280 %

Part II Community Building Activities Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing		30	768		768	0 %
2 Economic development	3	550	17,581		17,581	0 %
3 Community support	7	25	27,208		27,208	0 %
4 Environmental improvements			13,925		13,925	0 %
5 Leadership development and training for community members	4	930	6,340		6,340	0 %
6 Coalition building	1	50	3,887		3,887	0 %
7 Community health improvement advocacy	7	15	15,409		15,409	0 %
8 Workforce development	2	20	98,987		98,987	0 010 %
9 Other						
10 Total	24	1,620	184,105		184,105	0 010 %

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	Yes	No
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	2	12,723,549	
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3		
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME).	5	231,991,648
6 Enter Medicare allowable costs of care relating to payments on line 5.	6	241,815,889
7 Subtract line 6 from line 5. This is the surplus (or shortfall).	7	-9,824,241
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input checked="" type="checkbox"/> Other		

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures

(a) Name of entity (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

Part V Facility Information**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)

		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
	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
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3 Yes	
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA 20 <u>17</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5 Yes	
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a Yes	
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	6b Yes	
7 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)	7 Yes	
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>HTTPS //WWW.CHOOSEMEMORIAL.ORG/HEALTHYCOMMUNITIES</u>		
b <input type="checkbox"/> Other website (list url) _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8 Yes	
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 <u>17</u>		
10 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>	10 Yes	
a		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c 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			
13 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	13	Yes	
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>300 000000000000</u> % and FPG family income limit for eligibility for discounted care of <u>301 000000000000</u> %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input checked="" type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input checked="" type="checkbox"/> Underinsurance discount			
g <input type="checkbox"/> Residency			
h <input type="checkbox"/> Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?	14	Yes	
15 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)	15	Yes	
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
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			
c <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			
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input type="checkbox"/> Other (describe in Section C)			
16 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)	16	Yes	
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>WWW.MEMORIALMEDICAL.COM/FINANCIAL/FINANCIAL-HELP</u>			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>WWW.MEMORIALMEDICAL.COM/FINANCIAL/FINANCIAL-HELP</u>			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>WWW.MEMORIALMEDICAL.COM/FINANCIAL/FINANCIAL-HELP</u>			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <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)			
f <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)			
g <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			
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i <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			
j <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
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17 Yes	
18 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		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <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 d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C) f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19 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?	19	No
If "Yes," check all actions in which the hospital facility or a third party engaged		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <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 d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C)		
20 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)		
a <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 <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications d <input checked="" type="checkbox"/> Made presumptive eligibility determinations e <input type="checkbox"/> Other (describe in Section C) f <input type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

21 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?	21 Yes	
If "No," indicate why		
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions b <input type="checkbox"/> The hospital facility's policy was not in writing c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) d <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
22		
23		No
24		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
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3 Yes	
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA <u>20 17</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5 Yes	
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	No
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	6b Yes	
7 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)	7 Yes	
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>WWW.CHOOSEMEMORIAL.ORG/HEALTHYCOMMUNITIES</u>		
b <input type="checkbox"/> Other website (list url) _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8 Yes	
9 Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 17</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) <u>WWW.CHOOSEMEMORIAL.ORG/HEALTHYCOMMUNITIES</u>	10 Yes	
a		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c 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			
13 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	13	Yes	
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>300 000000000000</u> % and FPG family income limit for eligibility for discounted care of <u>301 000000000000</u> %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input checked="" type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input checked="" type="checkbox"/> Underinsurance discount			
g <input type="checkbox"/> Residency			
h <input type="checkbox"/> Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?	14	Yes	
15 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)	15	Yes	
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
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			
c <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			
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input type="checkbox"/> Other (describe in Section C)			
16 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)	16	Yes	
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>WWW ALMH ORG/FINANCIAL/FINANCIAL-ASSISTANCE</u>			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>WWW ALMH ORG/FINANCIAL/FINANCIAL-ASSISTANCE</u>			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>WWW ALMH ORG/FINANCIAL/FINANCIAL-ASSISTANCE</u>			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <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)			
f <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)			
g <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			
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i <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			
j <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
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17 Yes	
18 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		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <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 d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C) f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19 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?	19	No
If "Yes," check all actions in which the hospital facility or a third party engaged		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <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 d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C)		
20 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)		
a <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 <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications d <input checked="" type="checkbox"/> Made presumptive eligibility determinations e <input type="checkbox"/> Other (describe in Section C) f <input type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

21 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?	21 Yes	
If "No," indicate why		
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions b <input type="checkbox"/> The hospital facility's policy was not in writing c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) d <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
22		
23		No
24		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
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3 Yes	
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA <u>20 17</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge 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	5 Yes	
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	No
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	6b Yes	
7 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)	7 Yes	
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>HTTPS //WWW.CHOOSEMEMORIAL.ORG/HEALTHYCOMMUNITIES</u>		
b <input type="checkbox"/> Other website (list url) _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8 Yes	
9 Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 17</u>		
10 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>	10 Yes	
a		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c 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			
13 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	13	Yes	
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>300 000000000000</u> % and FPG family income limit for eligibility for discounted care of <u>301 000000000000</u> %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input checked="" type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input checked="" type="checkbox"/> Underinsurance discount			
g <input type="checkbox"/> Residency			
h <input type="checkbox"/> Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?	14	Yes	
15 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)	15	Yes	
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
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			
c <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			
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input type="checkbox"/> Other (describe in Section C)			
16 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)	16	Yes	
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>WWW TAYLORVILLEMEMORIAL ORG/FINANCIAL/FINANCIAL-ASSISTANCE</u>			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>WWW TAYLORVILLEMEMORIAL ORG/FINANCIAL/FINANCIAL-ASSISTANCE</u>			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>WWW TAYLORVILLEMEMORIAL ORG/FINANCIAL/FINANCIAL-ASSISTANCE</u>			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <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)			
f <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)			
g <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			
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i <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			
j <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
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17 Yes	
18 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		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <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 d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C) f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19 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?	19	No
If "Yes," check all actions in which the hospital facility or a third party engaged		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <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 d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C)		
20 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)		
a <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 <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications d <input checked="" type="checkbox"/> Made presumptive eligibility determinations e <input type="checkbox"/> Other (describe in Section C) f <input type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

21 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?	21 Yes	
If "No," indicate why		
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions b <input type="checkbox"/> The hospital facility's policy was not in writing c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) d <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
22		
23		No
24		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
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	3 Yes	
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA <u>20 17</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5 Yes	
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	No
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	6b Yes	
7 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)	7 Yes	
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>WWW.CHOOSEMEMORIAL.ORG/HEALTHYCOMMUNITIES</u>		
b <input type="checkbox"/> Other website (list url) _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8 Yes	
9 Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 17</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url) <u>WWW.CHOOSEMEMORIAL.ORG/HEALTHYCOMMUNITIES</u>	10 Yes	
a		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c 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 _____

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
13 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	13	Yes	
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>300 000000000000</u> % and FPG family income limit for eligibility for discounted care of <u>301 000000000000</u> %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input checked="" type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input checked="" type="checkbox"/> Underinsurance discount			
g <input type="checkbox"/> Residency			
h <input type="checkbox"/> Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?	14	Yes	
15 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)	15	Yes	
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
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			
c <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			
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input type="checkbox"/> Other (describe in Section C)			
16 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)	16	Yes	
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>WWW PASSAVANTHOSPITAL COM/FINANCIAL/FINANCIAL-ASSISTANCE</u>			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>WWW PASSAVANTHOSPITAL COM/FINANCIAL/FINANCIAL-ASSISTANCE</u>			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>WWW PASSAVANTHOSPITAL COM/FINANCIAL/FINANCIAL-ASSISTANCE</u>			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <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)			
f <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)			
g <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			
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i <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			
j <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
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17 Yes	
18 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		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <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 d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C) f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19 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?	19	No
If "Yes," check all actions in which the hospital facility or a third party engaged		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <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 d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C)		
20 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)		
a <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 <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications d <input checked="" type="checkbox"/> Made presumptive eligibility determinations e <input type="checkbox"/> Other (describe in Section C) f <input type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

21 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?	21 Yes	
If "No," indicate why		
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions b <input type="checkbox"/> The hospital facility's policy was not in writing c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) d <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
22		
23		No
24		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)
1 See Additional Data Table	
2	
3	
4	
5	
6	
7	
8	
9	
10	

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	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 HTTPS //WWW CHOOSEMEMORIAL ORG/ABOUT/COMMUNITY-BENEFIT 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

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 \$20,887,143

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 \$ 12,723,549

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)

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 II, COMMUNITY BUILDING ACTIVITIES	<p>MMC PARTICIPATES IN NUMEROUS COMMUNITY BUILDING ACTIVITIES THAT ARE NOT ACCOUNTED FOR ELSEWHERE ON SCHEDULE H MMC SUPPORTED ECONOMIC DEVELOPMENT THROUGH VOLUNTEER LEADERSHIP IN THE GREATER SPRINGFIELD CHAMBER OF COMMERCE AND THE LAND OF LINCOLN ECONOMIC DEVELOPMENT COMMUNITY SUPPORT INCLUDED LEADERSHIP PARTICIPATION ON BOARDS AND COMMITTEES FOR SALVATION ARMY AND MERCY COMMUNITIES SHELTER AND YMCA, AS WELL AS CONTRIBUTIONS TO THE SPRINGFIELD URBAN LEAGUE, SPRINGFIELD HIGH SCHOOL, LANPHIER HIGH SCHOOL AND MERCY COMMUNITIES LEADERSHIP DEVELOPMENT/TRAINING INCLUDED SERV (SPRINGFIELD VOLUNTEER LEADERSHIP), CENTRAL ILLINOIS VOLUNTEERISM CONFERENCE, AND UNITED WAY DAY OF CARING, ILLINOIS PERFORMANCE EXCELLENCE, AND LEADERSHIP TRAINING FOR YMCA AND GOODWILL COALITION BUILDING INCLUDED PARTICIPATION ON THE BOARD OF YMCA OF SPRINGFIELD TO IMPROVE COMMUNITY ACCESS TO HEALTHY ACTIVITIES COMMUNITY HEALTH IMPROVEMENT ADVOCACY WAS SUPPORTED THROUGH LEADERSHIP INVOLVEMENT IN THE ILLINOIS HEALTH AND HOSPITAL ASSOCIATION, VIZIENT MID-AMERICA, SOUTHERN ILLINOIS UNIVERSITY SCHOOL OF MEDICINE, AMERICAN HOSPITAL ASSOCIATION, THE UNITED WAY HEALTH VISION COUNCIL, AND DONATIONS TO THE AMERICAN COLLEGE OF PHYSICIANS AND 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 MMC WORKS WITH OTHER ORGANIZATIONS TO EXPAND OPPORTUNITIES TO TRAIN AND RECRUIT HEALTHCARE PROFESSIONALS TO INCREASE ACCESS TO CARE IN RURAL AREAS ALMH PARTICIPATES IN NUMEROUS COMMUNITY BUILDING ACTIVITIES THAT ARE NOT ACCOUNTED FOR ELSEWHERE ON SCHEDULE H COALITION BUILDING INCLUDED PARTICIPATION ON THE BOARD OF LINCOLN AREA YMCA TO IMPROVE COMMUNITY ACCESS TO HEALTHY ACTIVITIES COMMUNITY HEALTH IMPROVEMENT ADVOCACY WAS SUPPORTED THROUGH LEADERSHIP INVOLVEMENT IN THE ILLINOIS HEALTH AND HOSPITAL ASSOCIATION, AMERICAN HOSPITAL ASSOCIATION AS ONE OF THE LARGEST LOCAL IN LOGAN COUNTY, ALMH IS AN IMPORTANT ECONOMIC LINK THAT PROVIDES EMPLOYMENT AND BENEFITS FOR HUNDREDS OF FAMILIES TMH PARTICIPATES IN NUMEROUS COMMUNITY BUILDING ACTIVITIES THAT ARE NOT ACCOUNTED FOR ELSEWHERE ON SCHEDULE H TMH SUPPORTED ECONOMIC DEVELOPMENT THROUGH VOLUNTEER LEADERSHIP ON THE CHRISTIAN COUNTY UNITED WAY, CHRISTIAN COUNTY YMCA, CHRISTIAN COUNTY ECONOMIC DEVELOPMENT ASSOCIATION, GREATER TAYLORVILLE CHAMBER OF COMMERCE, AND LAND OF LINCOLN WORKFORCE IMPROVEMENT BOARD COMMUNITY SUPPORT INCLUDED CONTRIBUTIONS TO THE CHRISTIAN COUNTY CEO PROGRAM, CHRISTIAN COUNTY YMCA, AND MISSIONS FOR TAYLORVILLE COMMUNITY CLEAN-UP DAYS COALITION BUILDING INCLUDED PARTICIPATION ON THE BOARD OF THE LOCAL YMCA TO IMPROVE COMMUNITY ACCESS TO HEALTHY ACTIVITIES AND TO SUPPORT THE DEVELOPMENT OF THEIR DIABETES PREVENTION PROGRAM COMMUNITY HEALTH IMPROVEMENT ADVOCACY WAS SUPPORTED THROUGH LEADERSHIP INVOLVEMENT IN THE ILLINOIS HEALTH AND HOSPITAL ASSOCIATION AND THE ILLINOIS CRITICAL ACCESS HOSPITAL NETWORK TMH SUPPORTS ECONOMIC DEVELOPMENT THROUGH FINANCIAL SUPPORT OF THE GREATER TAYLORVILLE CHAMBER OF COMMERCE AND THE CHRISTIAN COUNTY ECONOMIC DEVELOPMENT CORPORATION AND TAYLORVILLE DEVELOPMENT ASSOCIATION TMH WORKS WITH OTHER ORGANIZATIONS TO EXPAND OPPORTUNITIES TO TRAIN AND RECRUIT HEALTHCARE PROFESSIONALS TO INCREASE ACCESS TO CARE IN RURAL AREAS TMH SUPPORTED PHYSICAL IMPROVEMENTS AND HOUSING BY PROVIDING EDUCATION ON COMMON FALL RISKS IN SENIOR HOUSING DEVELOPMENTS AND WAYS TO ADDRESS THOSE RISKS PAH PARTICIPATES IN A NUMBER OF COMMUNITY BUILDING ACTIVITIES IN MORGAN COUNTY THAT ARE NOT ACCOUNTED FOR ELSEWHERE ON SCHEDULE H PAH SUPPORTS THE BUSINESS COMMUNITY BY SERVING LEADERSHIP AND COMMITTEE ROLES ON THE JACKSONVILLE AREA CHAMBER OF COMMERCE PAH ALSO SERVES ON THE BOARD OF THE REGIONAL ECONOMIC DEVELOPMENT CORPORATION AND PRAIRIELAND UNITED WAY LEADERSHIP DEVELOPMENT/TRAINING IS SUPPORTED THROUGH EDUCATIONAL SESSIONS WITH THE MORGAN SCOTT CREATING ENTREPRENEURIAL OPPORTUNITIES PROGRAM, THROUGH PARTNERSHIP IN DEVELOPING THE RN-BSN ONLINE EDUCATION PROGRAM AT ILLINOIS COLLEGE, AND BY OFFERING CAREER EXPLORATION PROGRAMS THROUGH HANDS ON HEALTHCARE AND TEENS EXPERIENCING NURSING CAMP COALITION BUILDING INCLUDED PARTICIPATION ON THE BOARD OF SHERWOOD EDDY YMCA TO IMPROVE COMMUNITY ACCESS TO HEALTHY ACTIVITIES COMMUNITY HEALTH IMPROVEMENT ADVOCACY WAS SUPPORTED THROUGH LEADERSHIP INVOLVEMENT IN THE ILLINOIS HEALTH AND HOSPITAL ASSOCIATION, REGIONAL CANCER PARTNERSHIP AND THE MORGAN COUNTY INTERAGENCY COUNCIL</p>

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 15 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 15 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 FY2018 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 \$241,815,899 THE TOTAL SHORTFALL REPORTED ON SCHEDULE H, PART III, LINE 7 WAS \$9,824,251 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 NEEDS 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 INVESTMENTS 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 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 AS APPROPRIATE.</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. 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) SERVES A WIDE REGION OF CENTRAL AND SOUTHERN ILLINOIS, WHICH IS LARGELY RURAL AND AGRICULTURAL. PATIENTS COME FROM MORE THAN 40 OTHER COUNTIES AND ALSO FROM OUT OF STATE, MAKING MMC A SIGNIFICANT RESOURCE FOR HEALTHCARE SERVICES. HOWEVER, 54 PERCENT OF MMC'S PATIENTS RESIDE IN SANGAMON COUNTY. ALSO, THE MAJORITY OF MMC'S COMMUNITY OUTREACH EFFORTS ARE FOCUSED ON SANGAMON COUNTY, WHERE MMC IS LOCATED. SANGAMON COUNTY (POPULATION 197,499) COMPRISES 868 SQUARE MILES IN CENTRAL ILLINOIS. IT IS PRIMARILY A RURAL AREA THAT INCLUDES THE CITY OF SPRINGFIELD (POPULATION 117,000), WHICH IS THE COUNTY'S LARGEST CITY AS WELL AS THE STATE CAPITOL OF ILLINOIS AND THE COUNTY SEAT. SANGAMON COUNTY HAS EIGHT FEDERALLY DESIGNATED MEDICALLY UNDERSERVED AREAS (MUAS). HEALTHCARE AND STATE AND LOCAL GOVERNMENT ARE THE MAJOR EMPLOYERS IN THE COUNTY. SMALL BUSINESS, INDUSTRY AND AGRICULTURE ARE ALSO SIGNIFICANT CONTRIBUTORS TO THE LOCAL ECONOMY. THE OTHER HOSPITAL SERVING SANGAMON COUNTY IS ST JOHN'S HOSPITAL, A 430-BED NONPROFIT HOSPITAL AFFILIATED WITH HO SPITAL SISTERS HEALTH SYSTEM. THE POPULATION OF SANGAMON COUNTY IS 80% WHITE, 12.8% BLACK AND 2% ASIAN, 2.2% HISPANIC, AND 3% OTHER. PERSONS AGE 65 AND OLDER MAKE UP 17.2% OF SANGAMON COUNTY'S POPULATION, WHICH IS HIGHER THAN THE STATE AVERAGE OF 15.2%. THE MEDIAN HOUSEHOLD INCOME IS \$56,742. A TOTAL OF 15.2% OF ALL COUNTY RESIDENTS LIVE BELOW THE FEDERAL POVERTY LEVEL, INCLUDING 28.6% OF CHILDREN UNDER THE AGE OF 6. IN TY2017/FY2018, 7% OF THE PATIENTS SERVED AT MMC RECEIVED PATIENT FINANCIAL ASSISTANCE (UNINSURED), 19.0% OF PATIENTS WERE ON MEDICAID, AND 31.6% RECEIVED MEDICARE. ABRAHAM LINCOLN MEMORIAL HOSPITAL (ALMH) IS A NON-PROFIT 25-BED RURAL CRITICAL ACCESS HOSPITAL LOCATED IN LINCOLN, IL, APPROXIMATELY 30 MILES NORTHEAST 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). THE CITY OF LINCOLN (POPULATION 13,969), WHERE ALMH IS LOCATED, IS THE COUNTY SEAT. LINCOLN CONTAINS ALMOST HALF OF THE COUNTY'S POPULATION. RACE/ETHNIC MAKEUP IS 86% WHITE, 8% BLACK AND 6% OTHER BACKGROUNDS. THE MEDIAN HOUSEHOLD INCOME IS \$52,676. PERSONS AGE 65 AND OLDER MAKE UP 17.7% OF LOGAN COUNTY'S POPULATION. 12.5% OF ALL RESIDENTS LIVE BELOW THE FEDERAL POVERTY LEVEL. HIGH SCHOOL GRADUATES MAKE UP 87.4% OF RESIDENTS. ONLY 18.4% OF RESIDENTS HAVE EARNED A BACHELOR'S DEGREE OR HIGHER, IN COMPARISON TO THE STATE AVERAGE OF 32.9%. IN TY2017/ FY2018, 27% OF PATIENTS SERVED AT ALMH RECEIVED PATIENT FINANCIAL ASSISTANCE (UNINSURED), 23% WERE ON MEDICAID, AND 46% RECEIVED 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. 33,102). 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 96.5% WHITE, 1.6% BLACK, AND 1.9% OTHER. THE MEDIAN HOUSEHOLD INCOME IS \$47,417. THE COUNTY HAS AN AGING POPULATION. PERSONS AGE 65 AND OLDER MAKE UP 19.5% OF CHRISTIAN COUNTY'S POPULATION, VS. 15.2% FOR THE STATE OF ILLINOIS. 13.6% OF ALL PEOPLE LIVE BELOW THE FEDERAL POVERTY LEVEL, INCLUDING 19.1% OF CHILDREN AND 8.9% OF SENIORS. CHRISTIAN COUNTY HAS NINE MEDICALLY UNDERSERVED AREAS. IN TY2017/FY2018, 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 AREA HOSPITAL IS LOCATED IN JACKSONVILLE, A COMMUNITY OF 18,729 LOCATED 30 MILES WEST OF SPRINGFIELD, ILLINOIS. JACKSONVILLE IS THE COUNTY SEAT OF MORGAN COUNTY AND IS A LARGELY AGRICULTURAL COMMUNITY. CORN AND SOYBEANS ARE THE MAJOR AGRICULTURAL PRODUCTS. JACKSONVILLE IS ALSO HOME TO THE ILLINOIS SCHOOL FOR THE DEAF AND THE ILLINOIS SCHOOL FOR THE VISUALLY IMPAIRED, AS WELL AS TWO PRIVATE LIBERAL ARTS COLLEGES, A COMMUNITY COLLEGE AND SEVERAL INDUSTRIAL FACTORIES. IN 2016, THE ESTIMATED POPULATION OF MORGAN COUNTY WAS 34,277. RACE AND ETHNIC BREAKOUTS ARE 91% WHITE, 6.2% BLACK, 2.4% LATINO OR HISPANIC, 1% OTHER BACKGROUNDS AND 1.8% ARE TWO OR MORE RACES. IN MORGAN COUNTY, 2.9% OF THE POPULATION SPEAKS A LANGUAGE OTHER THAN ENGLISH AT HOME. AGE GROUPS WITHIN THE POPULATION INCLUDE 19.5% UNDER THE AGE OF 18 AND 19.3% OVER AGE 65, WHILE 49.5% OF THE POPULATION IS FEMALE, AND 50.5% IS MALE. HIGH SCHOOL GRADUATES MAKE UP 90.6% OF THE POPULATION (2.7% HIGHER THAN THE ILLINOIS AVERAGE), AND 22.3% HOLD BACHELOR'S DEGREES. THERE ARE 2,997 UNITED STATES V</p>

Form and Line Reference	Explanation
PART VI, LINE 4	ETERANS LIVING IN MORGAN COUNTY THE MEDIAN HOUSEHOLD INCOME IN MORGAN COUNTY IS \$47,760 DATA SHOWS THAT 14 8% OF PEOPLE LIVE BELOW THE POVERTY LINE (1% HIGHER THAN THE ILLINOIS A VERAGE OF 14%) RURAL RESIDENTS ACCOUNT FOR 36% OF THE COUNTY'S POPULATION IN TY2017/FY20 18, 1 9% OF PATIENTS RECEIVED UNINSURED/UNDERINSURED CHARITY CARE, 19 3% OF PATIENTS ARE O N MEDICAID, AND 45 8% OF PATIENTS ARE ON MEDICARE

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 A 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. 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. THIS WORK WAS RECOGNIZED IN 2018 BY THE NOVA AWARD FROM THE AMERICAN HOSPITAL ASSOCIATION. 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 FY2018, MMC CONTINUED SUPPORT OF A NEW NURSE FAMILY PARTNERSHIP 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 THAT 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 BSN AND MA NURSING PROGRAM. MMC ALSO OFFERS CLINICAL TRAINING SITES FOR OTHER NURSING SCHOOLS AND NUMEROUS ALLIED HEALTH PROGRAMS (RADIOLOGY, PHARMACY, CERTIFIED REGISTERED NURSE ANESTHESISTS, AND OTHERS). MMC SUPPORTS CLINICAL RESEARCH, OFFERING CANCER TRIALS THROUGH THE NATIONAL CLINICAL ONCOLOGY RESEARCH PROGRAM. IN ADDITION, MMC FUNDS THE LOCAL INSTITUTIONAL REVIEW BOARD FOR CLINICAL RESEARCH TRIALS, ABOUT 450 RESEARCH PROJECTS AND PROTOCOLS ARE OPEN AT ANY GIVEN TIME. SURPLUS FUNDS ALSO IMPROVE PATIENT CARE. IN FY2017/FY2018, MMC RENOVATED THE 2E ONCOLOGY INPATIENT UNIT THAT SERVES CANCER PATIENTS FROM THROUGHOUT CENTRAL AND SOUTHERN ILLINOIS. THE RENOVATION REPLACED IRREGULARLY SHAPED 1991-ERA POD ROOMS WITH LARGER PATIENT ROOMS AND NURSES' STATION TO ENHANCE PATIENT EXPERIENCE AND IMPROVE CLINICAL OPERATIONS. MMC'S 3C INTENSIVE CARE UNIT RENOVATION CREATED A NEW 15-BED INTENSIVE CARE UNIT, WHICH ALLOWS MMC TO ASSIST SMALLER OUTLYING HOSPITALS IN CENTRAL ILLINOIS BY ACCEPTING TERTIARY REFERRALS FOR PATIENTS WITH HIGHER ACUITY NEEDS FOR ADVANCED CARE. THE MMC MORGUE IS USED BY THE SANGAMON COUNTY CORONER AS WELL AS CORONERS FROM OTHER COUNTIES TO CONDUCT THEIR FORENSIC AUTOPSIES AND INVESTIGATIONS. MMC MODERNIZED THE MORGUE TO IMPROVE WORKFLOW, INFECTION CONTROL PROCESSES AND CAPACITY, IMPROVING THE CAPABILITY TO GATHER FORENSIC EVIDENCE. MMC ALSO MODERNIZED THE ELECTRICAL SYSTEM INFRASTRUCTURE ON THE MMC CAMPUS, WHICH CREATED OPTIMAL REDUNDANCY AND SAFEGUARDS PATIENT CARE AND MEDICAL SYSTEMS FROM ELECTRICAL OUTAGES. 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 LOCAL AND CONVENIENT ACCESS TO MANY DIA</p>

Form and Line Reference	Explanation
PART VI, LINE 5	<p>GNOSTIC TESTS ALMH OFFERS MEMORIAL JOINTWORKS FOR HIP OR KNEE REPLACEMENT SURGERY, ULTRASOUND GUIDED BIOPSIES AND A HEART FAILURE CLINIC ALMH PROVIDES 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 SURPLUS FUNDS WERE USED TO IMPROVE PATIENT CARE ALMH RENOVATED SPACE TO ACCOMMODATE THE NEW SENIOR LIFE SOLUTIONS PROGRAM ADDRESSING MENTAL HEALTH PRIORITY OF THE CHNA IN ADDITION, A NEW SMARTCURVE PADDLE WAS PURCHASED TO IMPROVE PATIENT COMFORT DURING MAMMOGRAMS IN ANTICIPATION OF AN INCREASE IN MAMMOGRAPHY SCREENINGS TO ADDRESS A HIGH INCIDENCE OF BREAST CANCER TMH IS A RURAL CRITICAL ACCESS HOSPITAL WITH OCCUPANCY FOR 25 STAFFED ACUTE AND SWING BEDS SERVICES OFFERED 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 FY2018, TMH INVESTED SURPLUS FUNDS IN UPGRADING EQUIPMENT USED BY PATIENTS IN THE PHYSICAL THERAPY DEPARTMENT AND RENOVATIONS IN THE EMERGENCY DEPARTMENT TO INCREASE SAFETY FOR PATIENTS WHO HAVE MENTAL ILLNESS OR AGGRESSIVE BEHAVIOR TMH ALSO RECEIVED APPROVAL FROM THE ILLINOIS HEALTH FACILITIES SERVICES AND REVIEW BOARD FOR A MODERNIZATION PROJECT WHICH STARTED IN 2018 AN INVESTMENT OF \$57.7 MILLION WILL MODERNIZE THE AGING TMH STRUCTURE, WHICH WAS BUILT IN 1954/56, WITH SEVERAL ADDITIONS IN 1956, 1993 AND 2010 THE ORIGINAL 1954/1956 PORTION OF THE BUILDING IS BEING REPLACED IS A NEW MODERNIZED SECTION THAT WILL SUPPORT MAXIMUM EFFICIENCY AND OPERATIONAL IMPROVEMENTS NEEDED TO PROVIDE THE BEST PATIENT CARE AND EXPERIENCE FOR PATIENTS AND THEIR FAMILIES PAH, A SOLE COMMUNITY HOSPITAL WITH 131 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 OPENED A CENTER FOR WOMEN'S HEALTH TO ADDRESS INCREASING NEEDS OF WOMEN AND SPECIALTY CARE NEEDS FOR OBSTETRICS IN THE REGION ADDITIONALLY THE PAH PARTIAL HOSPITALIZATION UNIT FOR BEHAVIORAL HEALTH OPENED IN OCTOBER, 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 MEMORIAL BEHAVIORAL HEALTH 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 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 ALZHEIMER'S, BEHAVIORAL HEALTH, BREASTFEEDING, CANCER SUPPORT, DIABETES, GRIEF, GRANDPARENTS RAISING CHILDREN, PARKINSON'S AND NEUROMUSCULAR DISORDERS 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 D/B/A 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 PHYSICIANS 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, 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. MPS ALSO OFFERS FOUR WALK-IN EXPRESSCARE LOCATIONS TO IMPROVE PATIENT ACCESS, AS WELL AS A WALK-IN CLINIC IN A RETAIL SETTING, COMPRISED OF MORE THAN 150 PHYSICIANS, ADVANCED PRACTICE REGISTERED NURSES, DOCTOR OF NURSING PRACTICE AND PHYSICIAN ASSISTANTS. MPS EMPLOYS MORE THAN 460 SUPPORT PERSONNEL AND PROVIDES 375,000+ PATIENTS 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. 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 PROFESSIONAL EDUCATIONAL OPPORTUNITIES FOR MEDICAL STUDENTS, ADVANCED PRACTICE REGISTERED NURSES, DOCTOR OF NURSING PRACTICE, PHYSICIAN ASSISTANTS AND CERTIFIED MEDICAL ASSISTANTS. MEMORIAL HEALTH VENTURES MANAGES JOINT VENTURES IN WHICH MHS HAS ENTERED WITH OTHER HEALTHCARE PROFESSIONALS AND ORGANIZATIONS. MENTAL HEALTH CENTERS OF CENTRAL ILLINOIS (DBA MEMORIAL BEHAVIORAL HEALTH (MBH)) 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, MASON, 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 TO ADULTS IN SPRINGFIELD. 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 COMMUNITY-BASED CRISIS INTERVENTION SERVICES, INCLUDING AT LOCAL SCHOOLS, HOMELESS SHELTERS, PERSONAL RESIDENCES, AND WITH LOCAL LAW ENFORCEMENT. 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 ALSO COORDINATES MENTAL HEALTH FIRST AID TRAININGS WITHIN THE COUNTY SERVICE AREAS, WHICH HAVE RESULTED IN MORE THAN A THOUSAND COMMUNITY MEMBERS, TEACHERS AND FIRST RESPONDERS BEING EDUCATED 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, HOME THERAPY SERVICES, DIETARY, SOCIAL SERVICE, AND TELEHEALTH HOME MONITORING. MEMORIAL HOME</p>

Form and Line Reference	Explanation
PART VI, LINE 6	<p>MEDICAL EQUIPMENT AND SUPPLIES IS A FULL-SERVICE MEDICAL EQUIPMENY & SUPPLY COMPANY SERV ICES INCLUDE OXYGEN AND RESPIRATORY EQUIPMENT/SERVICES, HOME MEDICAL EQUIPMENT, WHEELCHAIR AND REHAB TECHNOLOGY, MOBILITY EQUIPMENT AND HOME INFUSION THERAPY</p> <p>MEMORIAL HOME HOSPICE ASSISTS PATIENTS AND FAMILIES THORUGH THE END-OF-LIFE JOURNEY SERVICES INCLUDE PHYSICIAN S, SKILLED NURSING, HOME HEALTH AIDES, SOCIAL SERVICES, VOLUNTEER SERVICES, SPIRITUAL AND EMOTIONAL CARE, AS WELL AS BEREAVEMENT SERVICES AFTER THE PASSING OF A LOVED ONE THE MEMOR IAL MEDICAL CENTER FOUNDATION (MMCF) PROVIDES GRANTS FOR PATIENT CARE, EDUCATION AND CLINI CAL RESEARCH IN FY2018, MMCF AWARDED \$576,345 FOR 26 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 NINE GRANTS, INCLUDING FUNDS FOR SIMULATION TRAINING EQUIPMENT THE UNIVERSITY OF ILLINOIS AT CHICAGO COLLEGE OF NURSING SP RINGFIELD REGIONAL CAMPUS ALSO RECEIVED FUNDING FOR SIMULATION EQUIPMENT A GRANT TO PURCH ASE EMERGENCY MEDICAL SERVICES SUPPLIES WAS AWARDED TO THE SPRINGFIELD FIRE DEPARTMENT AND THE UNIVERSITY OF ILLINOIS SPRINGFIELD RECEIVED MONEY FOR VARIOUS MUSCLE MODELS TO BE UTI LIZED BY STUDENTS MMCF ALSO ADMINISTERS A CANCER PATIENT ASSISTANCE FUND THAT PROVIDES FI NANCIAL ASSISTANCE TO PATIENTS FOR UTILITIES, RENT AND OTHER BASIC EXPENSES WHILE UNDERGOI NG CANCER TREATMENT, AND A TRANSPLANT PATIENT ASSISTANCE FUND THAT HELPS KIDNEY/PANCREAS P ATIENTS WITH THE COST OF ANTI-REJECTION MEDICATIONS, TRANSPORTATION EXPENSES AND LODGING ANOTHER FUND, SHARING WISHES, HELPS GRANT WISHES OF HOSPICE PATIENTS IN FY2018, MMCF SUPP ORTED A COMMUNITY-WIDE WOMEN'S HEALTH FAIR TO PROVIDE A VARIETY OF HEALTH SCREENINGS AND T O EDUCATE WOMEN ABOUT HEALTH ISSUES TAYLORVILLE MEMORIAL HOSPITAL FOUNDATION (TMHF) FUNDS GRANTS TO SUPPORT PATIENT CARE, EDUCATION AND COMMUNITY HEALTH OUTREACH IN ADDITION TO FA CILITATING PARTNERSHIPS AND COLLABORATION TO IMPROVE THE HEALTH OF THE COMMUNITY SERVED BY TAYLORVILLE MEMORIAL HOSPITAL IN FY2018, TMHF AWARDED NEARLY \$72,694 IN GRANTS TO TMH AN D THE COMMUNITY TO IMPROVE HEALTH SPECIFICALLY \$20,934 TO SUPPORT PATIENT CARE THROUGH IT S MEDICAL TECHNOLOGIES FUND AND CUPS FUND WHICH PROVIDES MAMMOGRAPHY SERVICES TO INDIVIDUA LS IN CHRISTIAN COUNTY WHO ARE UNINSURED OR DO NOT HAVE HEALTH INSURANCE TMHF ALSO FUNDED \$19,873 IN EDUCATION GRANTS, PROFESSIONAL CERTIFICATIONS AND SCHOLARSHIPS INCLUDING ITS F IRST HEALTHCARE CAREERS EDUCATION GRANT TO SUPPORT WORKFORCE DEVELOPMENT AT TMH OVER \$26, 500 WAS INVESTED TO FUND COMMUNITY HEALTH OUTREACH INITIATIVES INCLUDING, CATCH, PEDIATRIC DENTAL, STOP THE BLEED AND MENTAL HEALTH FIRST AIDE JACKSONVILLE CRNA'S IS A GROUP OF CER TIFIED 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 ALMH COMMUNITY HEALTH COLLABORATIVE (CHC), WHICH TOTALED MORE THAN \$100,000 IN FY2018 THE CHC PROVIDES NETWORKING AND COLLABORATION AMONG A VARIETY OF COMMUNITY ORGANIZATIONS TO ADDRESS SELECTED COMMUNITY ISSUES, AND ITS WORK IS INFORMED BY THE LOGAN COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS ALHF FUNDED THE CHC IN FY2018 TO ADDRESS OBESITY THROUGH SUPPORT OF THE ALMH FARMERS MARKET (WHICH INCLUDES HEALTH SCREENINGS AND NUTRITION EDUCATION) AND SUPPORT OF CATCH, A CHILDREN'S OBESITY PROGRAM IN LOGAN AND EASTERN MASON COUNTY SCHOOLS MENTAL HEALTH WAS SUPPORTED BY FUNDING A BEHAVIORAL HEALTH CONSULTANT THROUGH CHILDREN'S MOSAIC PROGRAM IN THE LOCAL JUNIOR HIGH AND TWO ELEMENTARY SCHOOLS SUBSTANCE ABUSE WAS ADDRESSED BY SUPPORT OF THE LOGAN COUNTY OPIOID TASK FORCE WORKING TO PREVENT OPIOID MISUSE, OVERDOSE AND DEATH PASSAVANT PHYSICIAN ASSOCIATION (PPA) CONSISTS OF TWO PHYSICIAN OFFICES THAT OFFER OBSTETRICS/GYNECOLOGY AND PSYCHIATRIC SERVICES COMPRISED OF 11 PHYSICIANS AND MID-LEVEL PROVIDERS, IT EMPLOYS MORE THAN 30 PEOPLE AND PROVIDES 15,000+ PATIENT VISITS EACH YEAR PPA PROVIDES COMMUNITY BENEFITS BY PROVIDING COMMUNITY EDUCATION PROGRAMS ON VARIOUS TOPICS</p>

Schedule H (Form 990) 2017

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

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		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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
MEMORIAL MEDICAL CENTER	PART V, SECTION B, LINE 5 MEMORIAL MEDICAL CENTER (MMC) COLLABORATED WITH HSHS ST JOHN'S HOSPITAL AND THE SANGAMON COUNTY DEPARTMENT OF PUBLIC HEALTH TO COMPLETE A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) IN TY2017/FY2018 THE HOSPITAL DID NOT RECEIVE ANY DIRECT WRITT EN COMMENTS ON THE 2015 CHNA OR IMPLEMENTATION STRATEGIES, BUT THERE WAS OVERALL COMMUNITY CONSENSUS THAT THE COLLABORATION OF THE TWO HOSPITALS AND COUNTY HEALTH DEPARTMENT WAS A GOOD MODEL THAT SHOULD BE CONTINUED FOR THE 2018 CHNA, COMMUNITY HEALTH NEEDS WERE PRIORI TIZED BASED ON REVIEWS OF MULTIPLE SOURCES OF SECONDARY DATA, AS WELL AS PRIMARY DATA GATH ERED A COMMUNITY ADVISORY COMMITTEE COMPRISED OF 13 REPRESENTATIVES FROM COMMUNITY ORGANIZ ATIONS THESE INCLUDED TWO FEDERALLY QUALIFIED HEALTH CENTERS (SIU CENTER FOR FAMILY MEDIC INE AND CENTRAL COUNTIES HEALTH CENTERS), SANGAMON COUNTY DEPARTMENT OF COMMUNITY RESOURCE S (COMMUNITY ACTION), MEMORIAL BEHAVIORAL HEALTH, CATHOLIC CHARITIES, LINCOLN LAND COMMUNI TY COLLEGE'S OPEN DOOR MENTORSHIP PROGRAM, SIU SCHOOL OF MEDICINE'S DEPARTMENT OF EQUITY, DIVERSITY AND INCLUSION, SPRINGFIELD POLICE DEPARTMENT, SPRINGFIELD SCHOOL DISTRICT 186, S ANGAMON COUNTY FARM BUREAU, GREATER SPRINGFIELD CHAMBER OF COMMERCE, SPRINGFIELD URBAN LEA GUE, AND UNITED WAY OF CENTRAL ILLINOIS THE ADVISORY COMMITTEE MET ON OCT 24, 2017, TO R EVIEW OUTCOMES OF THE 2015 CHNA IMPLEMENTATION STRATEGIES, DISCUSS SOCIAL DETERMINANTS OF HEALTH, AND AN OVERVIEW OF SECONDARY DATA CONSULTED FOR THE 2018 CHNA THE COMMITTEE HAD O PPORTUNITY TO PROVIDE INPUT ON KEY COMMUNITY ISSUES THEY WERE ADDRESSING AT THE SECOND ME ETING ON NOVEMBER 17, 2017, THE COMMITTEE REVIEWED DATA ON 18 IDENTIFIED PRIORITY NEEDS, I NCLUDING SANGAMON COUNTY INCIDENCE RATES, EMERGENCY DEPARTMENT AND HOSPITALIZATION DATA, T RENDS OVER TIME AND DISPARITIES THE COMMITTEE SHARED SPECIFIC INFORMATION ON HOW THESE IS SUES IMPACTED THEIR CLIENTS AND THE COMMUNITY, AND THEN COMPLETED A FORCED RANKING TO SELE CT THE NINE ISSUES THAT WOULD BE INCLUDED ON A COMMUNITY SURVEY THE UNIVERSITY OF ILLINOI S' SURVEY RESEARCH DEPARTMENT CONDUCTED A COMMUNITY SURVEY ON THESE NINE ISSUES FROM JANUA RY 12-FEBRUARY 12, 2018, AND PROVIDED A REPORT BACK TO THE HOSPITAL, 1,079 INDIVIDUALS COM PLETED THE SURVEY THE COMMUNITY ADVISORY COMMITTEE MET A FINAL TIME ON MARCH 20, 2018 ME MBERS RECEIVED A DETAILED REVIEW OF THE COMMUNITY SURVEY OUTCOMES THE COMMITTEE ALSO COM PLETED AN ASSET AND GAPS ANALYSIS AND DISCUSSED POPULATIONS DISPROPORTIONATELY AFFECTED US ING THE PREDEFINED CRITERIA OF MAGNITUDE, SERIOUSNESS, FEASIBILITY AND TRIPLE AIM, THE COM MITTEE RECOMMENDED FOUR FINAL ISSUES AS THE TOP PRIORITIES FOR THE HOSPITALS TO ADDRESS IN SANGAMON COUNTY ACCESS TO CARE, MENTAL HEALTH, SUBSTANCE ABUSE AND MOTHER/INFANT HEALTH MEMORIAL MEDICAL CENTER ACCEPTED THIS RECOMMENDATION AND THESE ARE THE FINAL PRIORITIES I T WILL ADDRESS IN ITS 2019-2021 CHNA IMPLEMENTATION STRATEGY A COMPLETE DESCRIPTION OF TH E CHNA PROCESS IS PROVIDED IN

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
MEMORIAL MEDICAL CENTER	MMC'S CHNA REPORT AT WWW.CHOOSMEMORIAL.ORG/HEALTHYCOMMUNITIES

Section C. Supplemental Information for Part V, Section B.Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
ABRAHAM LINCOLN MEMORIAL HOSPITAL	PART V, SECTION B, LINE 5 ABRAHAM LINCOLN MEMORIAL HOSPITAL (ALMH) COLLABORATED WITH THE LOGAN COUNTY DEPARTMENT OF PUBLIC HEALTH TO COMPLETE A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA), STARTING IN SPRING 2017 THE HOSPITAL DID NOT RECEIVE ANY DIRECT WRITTEN COMMENTS O N THE 2015 CHNA OR IMPLEMENTATION STRATEGIES, BUT THERE WAS OVERALL COMMUNITY CONSENSUS TH AT THE COLLABORATION OF THE HOSPITAL AND COUNTY HEALTH DEPARTMENT WAS A GOOD MODEL THAT SH OULD BE CONTINUED COMMUNITY AND INTERNAL ADVISORY COMMITTEES WERE USED TO ANALYZE HEALTH DATA AND SELECT THE PRIORITIES THE COMMUNITY ADVISORY COMMITTEE GROUP CONSISTED OF OVER 2 0 MEMBERS FROM THE ALMH COMMUNITY HEALTH COLLABORATIVE NETWORK INCLUDING A FEDERALLY QUALI FIED HEALTH CENTER (SIU FAMILY HEALTH CENTER), COMMUNITY ACTION PARTNERSHIP OF CENTRAL ILL INOIS, GATEWAY FOUNDATION, MOMS WHO CARE, HEARTLAND COMMUNITY COLLEGE, LINCOLN COLLEGE, LI NCOLN PARK DISTRICT, MEMORIAL BEHAVIORAL HEALTH, LOGAN COUNTY DEPARTMENT OF PUBLIC HEALTH, SIU SCHOOL OF MEDICINE, LOGAN COUNTY PROBATION, CHESTNUT HEALTH SYSTEM AND THE SIU OFFICE OF POPULATION SCIENCE AND POLICY THE INTERNAL ADVISORY BOARD COMMITTEE INCLUDED A VARIET Y OF STAKEHOLDERS INCLUDING REPRESENTATIVES FROM THE ALMH FOUNDATION, COMMUNITY ACTION PAR TNERSHIP OF CENTRAL ILLINOIS, LINCOLN SCHOOL DISTRICT 27, PRIVATE BUSINESSES, LINCOLN AREA YMCA, LINCOLN POLICE DEPARTMENT, LINCOLN PARK DISTRICT, LOGAN COUNTY PARKS AND TRAILS FOU NDATION, LOGAN COUNTY REGIONAL PLANNING COMMISSION, LOGAN COUNTY DEPARTMENT OF PUBLIC HEAL TH AND MEMORIAL BEHAVIORAL HEALTH IN THE FALL AND WINTER OF 2017, THE COMMUNITY ADVISORY COMMITTEE REVIEWED OUTCOMES OF THE 2015 CHNA IMPLEMENTATION STRATEGIES, DISCUSSED SOCIAL D ETERMINANTS OF HEALTH, AND REVIEWED AN OVERVIEW OF SECONDARY DATA TO HELP DETERMINE PRIORI TIES FOR THE 2018 CHNA THE COMMITTEE HAD AN OPPORTUNITY TO PROVIDE INPUT ON KEY COMMUNITY ISSUES THE DOT METHOD/DOTMOCRACY WAS THE METHOD CHOSEN NARROW THE LIST OF 25 POTENTIAL P RIORITIES TO 10 AREAS OF NEED FOR LOGAN COUNTY WERE IDENTIFIED BASED ON THE PREDEFINED CRI TERIA OF MAGNITUDE, SERIOUSNESS, FEASIBILITY AND TRIPLE AIM, ALONG WITH IDENTIFIED INCREAS ES IN OCCURRENCE AND TIMELINE TRENDING IDENTIFIED IN THE SECONDARY DATA IN FEBRUARY/MARCH 2018, UNIVERSITY OF ILLINOIS AT SPRINGFIELD'S SURVEY RESEARCH PROGRAM CONDUCTED A COMMUNI TY SURVEY PARTICIPANTS WERE ASKED TO RANK THE 10 PRIORITIES AND WERE ENCOURAGED TO IDENTI FY ADDITIONAL CONCERNS A TOTAL OF 565 INDIVIDUALS COMPLETED THE SURVEY THE SURVEY SHOWED SIMILAR RESULTS FOR THE TOP 10 AREAS OF COMMUNITY CONCERN THESE 10 PRIORITIES WERE PRESE NTED TO THE ALMH COMMUNITY HEALTH COLLABORATIVE ADVISORY BOARD FOR REVIEW ONCE AGAIN MAGN ITUDE, SERIOUSNESS, FEASIBILITY AND TRIPLE AIM WERE TAKEN INTO CONSIDERATION THE COMMITTEE RECEIVED A DETAILED REVIEW OF THE COMMUNITY SURVEY OUTCOMES, COMPLETED AN ASSET AND GAPS ANALYSIS AND DISCUSSED POPULATIONS DISPROPORTIONATELY AFFECTED THE COMMITTEE RECOMMENDED FOUR FINAL ISSUES AS THE TOP

Section C. Supplemental Information for Part V, Section B.Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
ABRAHAM LINCOLN MEMORIAL HOSPITAL	PRIORITIES FOR THE HOSPITAL TO ADDRESS IN LOGAN COUNTY MENTAL HEALTH, SUBSTANCE ABUSE, CANCER AND OBESITY TO ADDRESS IN ITS 2019-2021 CHNA IMPLEMENTATION STRATEGY A COMPLETE DESCRIPTION OF THE CHNA PROCESS IS PROVIDED IN ALMH'S CHNA REPORT 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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
TAYLORVILLE MEMORIAL HOSPITAL	PART V, SECTION B, LINE 5 TAYLORVILLE MEMORIAL HOSPITAL (TMH) COLLABORATED WITH THE CHRISTIAN COUNTY DEPARTMENT OF PUBLIC HEALTH TO COMPLETE A COMMUNITY HEALTH NEEDS ASSESSMENT FOR THE 2018 CHNA. COMMUNITY HEALTH NEEDS WERE PRIORITIZED BASED ON REVIEWS OF SECONDARY DATA, AS WELL AS PRIMARY DATA GATHERED FROM THE COMMUNITY ADVISORY COMMITTEE COMPRISED OF TWELVE REPRESENTATIVES FROM COMMUNITY ORGANIZATIONS. THE COMMUNITY ADVISORY COMMITTEE IS MADE UP OF REPRESENTATIVES FROM ORGANIZATIONS THAT SERVE LOW-INCOME, MINORITY AND AT-RISK POPULATIONS IN CHRISTIAN COUNTY. TWELVE ORGANIZATIONS PARTICIPATED ON THE COMMUNITY ADVISORY COMMITTEE. THESE INCLUDED: CENTRAL COUNTIES HEALTH CENTER (A FEDERALLY QUALIFIED HEALTH CENTER), GREATER TAYLORVILLE CHAMBER OF COMMERCE, CHRISTIAN COUNTY MENTAL HEALTH ASSOCIATION, SPRINGFIELD CLINIC, TAYLORVILLE MINISTERIAL ALLIANCE, CHRISTIAN COUNTY YMCA, TAYLORVILLE COMMUNITY UNIT SCHOOL DISTRICT #3, CHRISTIAN COUNTY PREVENTION COALITION, TAYLORVILLE POLICE DEPARTMENT, UNITED WAY OF CHRISTIAN COUNTY, SENIOR CITIZENS OF CHRISTIAN COUNTY, AND GATEWAY FOUNDATION. THE SECONDARY DATA SOURCES INCLUDED, COUNTY HEALTH RANKINGS AND ROADMAPS, CHRISTIAN COUNTY 2016 COMMUNITY HEALTH ASSESSMENT SURVEY, CENTRAL COUNTIES FEDERALLY QUALIFIED HEALTH CLINIC (REPORT MADE TO HRSA), IDPH STATISTICS ON INCIDENCES OF STDs, IDPH "CANCER IN ILLINOIS" REPORT 2017, IDPH ILLINOIS STATE CANCER REGISTRY DATA, ILLINOIS YOUTH SURVEY 2016, AND CONDUENT HEALTHY COMMUNITIES INSTITUTE DATA ON MEMORIAL WEBSITE. HEALTH & SOCIOECONOMIC INDICATORS SPECIFIC TO CHRISTIAN. THE MOST SIGNIFICANT SOURCE OF SECONDARY DATA WAS COLLECTED AND ANALYZED THROUGH CHOOSEMEMORIAL.ORG/HEALTHYCOMMUNITIES, A WEB-BASED COMMUNITY HEALTH DATA PLATFORM DEVELOPED BY CONDUENT HEALTHY COMMUNITIES INSTITUTE (HCI). THE ADVISORY COMMITTEE MET ON DEC 12, 2017 WHERE TAYLORVILLE MEMORIAL HOSPITAL AND CHRISTIAN COUNTY DEPARTMENT OF PUBLIC HEALTH PROVIDED AN OVERVIEW OF OUTCOMES OF THE 2015 CHNA AND IMPLEMENTATION STRATEGIES FOR THE HOSPITAL AND THE HEALTH DEPARTMENT'S IPLAN. TAYLORVILLE MEMORIAL HOSPITAL CONTRACTED WITH THE UNIVERSITY OF ILLINOIS AT SPRINGFIELD SURVEY RESEARCH DEPARTMENT TO CONDUCT THE CHRISTIAN COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT SURVEY FROM JAN 12 TO FEB 12, 2018. THE SURVEY TOOK PLACE ONLINE BECAUSE EVERYONE DOES NOT HAVE COMPUTER ACCESS, PAPER COPIES OF THE SURVEY WERE ALSO AVAILABLE. A TOTAL OF 702 INDIVIDUALS COMPLETED THE SURVEY. THE CHRISTIAN COUNTY COMMUNITY ADVISORY COMMITTEE CONVENED FOR ITS FINAL MEETING ON MARCH 29, 2018. THE COMMITTEE MEMBERS IDENTIFIED THE TOP PRIORITIES TO ADDRESS IN THE 2019-2021 CHNA IMPLEMENTATION STRATEGY: MENTAL HEALTH AND SUBSTANCE ABUSE. A COMPLETE DESCRIPTION OF THE CHNA PROCESS IS PROVIDED IN TMH'S CHNA REPORT AT WWW.CHOOSEMEMORIAL.ORG/HEALTHYCOMMUNITIES.

Section C. Supplemental Information for Part V, Section B.Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION	PART V, SECTION B, LINE 5 PASSAVANT AREA HOSPITAL (PAH) COLLABORATED WITH THE MORGAN COUN TY HEALTH DEPARTMENT (MCHD) TO COMPLETE ITS COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) IN TY 2017/FY2018 THIS WAS THE FIRST YEAR THAT THE TWO ENTITIES WERE ABLE TO ALIGN THE SURVEY D ATES SO THAT A COMMON ASSESSMENT COULD BE COMPLETED AND DATA FROM THE PROCESS COULD BE UTI LIZED TO WRITE THE PAH CHNA REPORT AND THE MCHD ILLINOIS PROJECT FOR LOCAL ASSESSMENT OF N EEDS (IPLAN) THE COLLABORATIVE CHNA PROCESS RECEIVED BROAD APPROVAL FROM COMMUNITY MEMBER S, HOSPITAL BOARD MEMBERS AND THE MEDIA NO DIRECT WRITTEN FEEDBACK WAS RECEIVED, OTHER TH AN SEVERAL ARTICLES IN THE NEWSPAPER COMMENDING THE COLLABORATION THE PROGRAMS HAVE RECEI VED GOOD VERBAL FEEDBACK FROM THE COMMUNITY, AS PATIENTS HAVE SHOWN APPRECIATION FOR THEIR ACCESS TO ADDITIONAL SERVICES COMMUNITY HEALTH NEEDS WERE PRIORITIZED BASED ON REVIEWS O F SECONDARY COMMUNITY DATA, AS WELL AS PRIMARY DATA GATHERED BY A COMMUNITY ADVISORY COMMI TTEE COMPRISED OF 15 REPRESENTATIVES FROM THE FOLLOWING COMMUNITY ORGANIZATIONS JACKSONVI LLE SCHOOL DISTRICT117/EARLY YEARS PROGRAM, PRAIRIE COUNCIL ON AGING PRAIRIE COUNCIL ON AG ING, SIU CENTER FOR FAMILY MEDICINE, MEMORIAL BEHAVIORAL HEALTH, CENTRAL COUNTIES HEALTH C ENTER, JACKSONVILLE POLICE DEPARTMENT, MORGAN COUNTY SHERIFF, MORGAN COUNTY PROBATION, MOR GAN COUNTY EMERGENCY SERVICES, SALVATION ARMY, ILLINOIS DEPARTMENT OF HUMAN SERVICES, MIDW EST YOUTH SERVICES, ELM CITY CENTER, LOCUST STREET RESOURCE CENTER, AND HOME INSTEAD SENIO R CARE NOVEMBER 2017-TWO COMMUNITY ADVISORY MEETINGS WERE HELD THE FORMAT OF THE MEETING S INCLUDED A SHORT INTRODUCTION OF THE STUDY, A SUMMARY OF THE OUTCOMES FROM THE 2015 STUD Y AND AN EXPLANATION OF THE 2018 PROCESS THIS WAS FOLLOWED BY AN ENGAGING SESSION IN WHIC H ATTENDEES WERE ASKED TO IDENTIFY THREE OF THE COUNTY'S HIGHEST UNMET NEEDS THE EXERCISE GAVE US A COMPREHENSIVE SNAPSHOT OF THE NEEDS IN OUR COMMUNITY ACCORDING TO OUR SERVICE P ROVIDERS THESE RESULTS WERE COMBINED AND CATEGORIZED ACCORDING TO THE COUNTY HEALTH RANKI NG MODEL INTO FOUR CATEGORIES HEALTH BEHAVIORS, CLINICAL CARE, SOCIAL AND ECONOMIC FACTOR S AND PHYSICAL ENVIRONMENT THE COMMUNITY ADVISORY WAS RECONVENED TO REVIEW HEALTH FACTORS AND START TO PRIORITIZE THEM BASED ON THEIR COLLECTIVE OPINIONS OF THE GREATEST NEED THE GROUP WAS ASKED TO IDENTIFY A TOP-DOWN LIST OF THE FIVE HIGHEST-NEED PRIORITIES THEY IDE NTIFIED YOUTH SERVICES, MENTAL HEALTH, DRUG/ALCOHOL TREATMENT, STDS/EARLY SEXUAL HEALTH AN D OBESITY COMMON THEMES WERE ACCESS TO CARE, INFORMATION AND AFFORDABILITY A COMMUNITY HE ALTH SURVEY WAS CONDUCTED FOR MORGAN COUNTY BY THE UNIVERSITY OF ILLINOIS' SURVEY RESEARCH DEPARTMENT JAN 12-FEB 12, 2018 OVERALL, 797 INDIVIDUALS COMPLETED THE SURVEY THE MORG AN COUNTY COMMUNITY ADVISORY COMMITTEE CONVENED FOR ITS FINAL MEETING ON MARCH 22, 2018 T HE COMMITTEE RECEIVED A DETAILED REVIEW OF THE OUTCOMES OF THE COMMUNITY SURVEY COMMITTEE MEMBERS REVIEWED THE SURVEY R

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION	RESULTS AND ENGAGED IN AN EXERCISE TO BEGIN MAPPING AVAILABLE COMMUNITY RESOURCES IN THE AREAS OF UNMET NEED. THE APPROACH WAS TO IDENTIFY RESOURCES THAT ARE PROACTIVE/PREVENTATIVE (DESIGNED TO PREVENT OR HINDER A PARTICULAR BEHAVIOR OR OUTCOME) OR REACTIVE (SERVING TO TREAT OR ADDRESS A PARTICULAR BEHAVIOR AFTER IT HAS OCCURRED). NEXT, THE COMMITTEE REVISITED THE COUNTY HEALTH RANKING MODEL UNDERSTANDING THAT BY IMPROVING HEALTH FACTORS, WE CAN IMPROVE HEALTH OUTCOMES OF THE COMMUNITY, WE USED THIS MODEL TO APPLY OUR RESEARCH AND EXPLORE HOW HEALTH FACTORS UNIQUE TO MORGAN COUNTY COULD BE ADDRESSED IN OUR IMPLEMENTATION STRATEGY. THE PRIORITIES, ALONG WITH HEALTH FACTORS IDENTIFIED BY COMMUNITY MEMBERS WHO TOOK THE SURVEY, WERE CHARTED IN THE MODEL. AGENCY LEADERS WERE ASKED TO EVALUATE EACH FACTOR ON WHETHER THEIR ORGANIZATION HAS EXISTING PROACTIVE OR REACTIVE PROGRAMS. THIS EXERCISE CREATED A SNAPSHOT OF EXISTING RESOURCES AS THEY APPLY TO OUR HEALTH NEEDS, AND ALSO IDENTIFIED GAPS THAT EXIST IN SERVICES. UPON FINAL REVIEW OF THE RESEARCH AND FEEDBACK PROVIDED BY COMMUNITY RESOURCES, PASSAVANT IDENTIFIED THREE PRIORITIES TO BE ADDRESSED IN THE FY2019-21 IMPLEMENTATION STRATEGY: ACCESS TO CARE, SUBSTANCE ABUSE AND MENTAL HEALTH. A COMPLETE DESCRIPTION OF THE CHNA PROCESS IS PROVIDED IN PAH'S 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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
MEMORIAL MEDICAL CENTER	PART V, SECTION B, LINE 6A MEMORIAL MEDICAL CENTER CONDUCTED THE 2018 SANGAMON COUNTY COMMUNITY HEALTH NEEDS 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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

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 WAS ALSO PART OF THE COLLABORATIVE CHNA, WHICH IT USES TO FULFILL ITS REQUIREMENTS TO COMPLETE ITS ILLINOIS PROJECT FOR LOCAL ASSESSMENT OF NEEDS (IPLAN), REQUIRED BY THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH EACH HOSPITAL AND THE HEALTH DEPARTMENT IDENTIFY THEIR OWN PRIORITIES AND STRATEGIES TO ADDRESS THOSE PRIORITIES

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

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 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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

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 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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION	PART V, SECTION B, LINE 6B PAH COLLABORATED WITH THE MORGAN COUNTY HEALTH DEPARTMENT ON THE NEEDS ASSESSMENT, ASSISTING THE HEALTH DEPARTMENT IN COMPLETING ITS IPLAN FOR THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
MEMORIAL MEDICAL CENTER	PART V, SECTION B, LINE 7D IN ADDITION TO POSTING THE CHNA REPORT AND 2019 IMPLEMENTATION STRATEGY AT WWW.CHOOSEMEMORIAL.ORG/HEALTHYCOMMUNITIES, THE MHS COMMUNICATIONS TEAM ISSUED PRESS RELEASES TO COMMUNICATE CHNA OUTCOMES TO LOCAL MEDIA OUTLETS, WITH RESULTING COVERAGE BY THE LOCAL PAPER. MMC ALSO PROVIDED A PRESENTATION TO THE SPRINGFIELD CITIZENS CLUB ON DEC 20, 2019, WHICH GAVE AN OVERVIEW OF THE CHNA PROCESS, OUTCOMES OF THE COMMUNITY SURVEY, FINAL SELECTED PRIORITIES AND IMPLEMENTATION STRATEGY. ALSO, THE MHS 2018 ANNUAL REPORT AND COMMUNITY BENEFIT ANNUAL REPORT CONTAIN THE WEB ADDRESS TO DIRECT READERS TO THE CHNA REPORT. A PAPER COPY WILL BE PROVIDED TO ANYONE IN THE COMMUNITY UPON REQUEST.

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
ABRAHAM LINCOLN MEMORIAL HOSPITAL	PART V, SECTION B, LINE 7D IN ADDITION TO POSTING THE CHNA REPORT AND 2019 IMPLEMENTATION STRATEGY AT WWW.CHOOSEMEMORIAL.ORG/HEALTHYCOMMUNITIES, THE MHS COMMUNICATIONS TEAM ISSUED PRESS RELEASES TO COMMUNICATE CHNA OUTCOMES TO LOCAL MEDIA OUTLETS, WITH RESULTING COVERAGE BY THE LOCAL PAPER AND RADIO STATION. THE MHS 2018 ANNUAL REPORT AND COMMUNITY BENEFIT ANNUAL REPORT CONTAIN THE WEB ADDRESS TO DIRECT READERS TO THE CHNA REPORT. A PAPER COPY WILL BE PROVIDED TO ANYONE IN THE COMMUNITY UPON REQUEST.

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
TAYLORVILLE MEMORIAL HOSPITAL	PART V, SECTION B, LINE 7D IN ADDITION TO POSTING THE CHNA REPORT AND 2019 IMPLEMENTATION STRATEGY AT CHOOSEMEMORIAL.ORG/ HEALTHYCOMMUNITIES TMH ISSUED A PRESS RELEASE TO LOCAL MEDIA OUTLETS, WITH RESULTING COVERAGE BY THE LOCAL PAPER, THE BREEZE-COURIER, AND RADIO STATION WTIM-AM, TO ANNOUNCE THE COMPLETION OF THE COMMUNITY NEEDS ASSESSMENT IN DECEMBER 2018 TMH ALSO DISTRIBUTED NEWS RELEASES TO MORE THAN A DOZEN MEDIA CONTACTS IN THE TAYLORVILLE AREA TMH ALSO WROTE A PRESS RELEASE REQUESTING INPUT FROM THE PUBLIC TO ASSESS THE HEALTH NEEDS OF RESIDENTS IN CHRISTIAN COUNTY THIS SURVEY WAS CONDUCTED BY THE RESEARCH DEPARTMENT AT THE UNIVERSITY OF ILLINOIS SPRINGFIELD ALSO, THE MHS ANNUAL REPORT AND TMH COMMUNITY BENEFIT ANNUAL REPORT CONTAIN THE WEB ADDRESS TO DIRECT READERS TO THE CHNA REPORT A PAPER COPY WILL BE PROVIDED TO ANYONE IN THE COMMUNITY UPON REQUEST

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION	PART V, SECTION B, LINE 7D IN ADDITION TO POSTING THE CHNA REPORT AND 2019 IMPLEMENTATION STRATEGY AT WWW.CHOOSEMEMORIAL.ORG/HEALTHYCOMMUNITIES, THE MHS COMMUNICATIONS TEAM ISSUED PRESS RELEASES TO COMMUNICATE CHNA OUTCOMES TO LOCAL MEDIA OUTLETS, WITH RESULTING COVERAGE BY THE JACKSONVILLE JOURNAL COURIER. PAH ALSO PROVIDED A PRESENTATION TO THE COMMUNITY OUTREACH COMMITTEE ON OCT 28, 2018, WHICH GAVE AN OVERVIEW OF THE CHNA PROCESS, OUTCOMES OF THE COMMUNITY SURVEY, FINAL SELECTED PRIORITIES AND IMPLEMENTATION STRATEGY. ALSO, THE MHS 2018 ANNUAL REPORT AND COMMUNITY BENEFIT ANNUAL REPORT CONTAIN THE WEB ADDRESS TO DIRECT READERS TO THE CHNA REPORT. A PAPER COPY WILL BE PROVIDED TO ANYONE IN THE COMMUNITY UPON REQUEST.

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
MEMORIAL MEDICAL CENTER	<p>PART V, SECTION B, LINE 11 MEMORIAL MEDICAL CENTER'S SANGAMON COUNTY CHNA IDENTIFIED NINE FINAL PRIORITIES THAT WERE RECOMMENDED BY ITS COMMUNITY ADVISORY COMMITTEE TO BE INCLUDED ON THE COMMUNITY SURVEY FOLLOWING THE SURVEY, THE COMMITTEE RECOMMENDED FOUR TOP PRIORITIES, WHICH MMC SELECTED AS ITS FINAL PRIORITIES TO ADDRESS IN 2019-2021 IMPLEMENTATION STRATEGY FIRST, ACCESS TO CARE WILL BE ADDRESSED THROUGH A COMMUNITY HEALTH WORKER PROGRAM IN TWO AT-RISK NEIGHBORHOODS, BY PROVIDING SUPPORT TO SIU SCHOOL OF MEDICINE TO CONTINUE EDUCATING THE NEXT GENERATION OF PHYSICIANS, AND SUPPORT FOR BUILDING A NEW YMCA IN DOWNTOWN SPRINGFIELD SECOND, MENTAL HEALTH WILL BE ADDRESSED BY CONTINUING TO OFFER MENTAL HEALTH FIRST AID TRAINING TO THE COMMUNITY, SUPPORT FOR THE CHILDREN'S MOSAIC MENTAL HEALTH PROGRAMS IN SCHOOLS, SUPPORT FOR GIRLS ON THE RUN, AND PROVIDING FUNDING FOR MEMORIAL BEHAVIORAL HEALTH TO COLLABORATE IN A NEW COMMUNITY OUTREACH AND ENGAGEMENT TEAM TO RESPOND TO CRISIS CALLS WITH THE SPRINGFIELD POLICE DEPARTMENT THAT DEAL WITH MENTAL ILLNESS, HOMELESSNESS AND SUBSTANCE ABUSE THIRD, MMC WILL ADDRESS SUBSTANCE ABUSE THROUGH SYSTEM-WIDE WORK WITH MHS AFFILIATES TO COMBAT OPIOID ABUSE, AND WILL COORDINATE THE WORK WITH OTHER HOSPITALS AND MEDICAL GROUPS ALSO, MHS IS DEVELOPING A SYSTEM-WIDE INITIATIVE TO EXPAND ACCESS TO SUBSTANCE ABUSE THE FINAL PRIORITY, MOTHER/INFANT HEALTH, WILL BE ADDRESSED THROUGH SUPPORT OF THE NURSE FAMILY PARTNERSHIP IN COLLABORATION WITH OTHER COMMUNITY PROVIDERS AND, WITH HSHS ST JOHN'S HOSPITAL AND THE SANGAMON COUNTY DEPARTMENT OF PUBLIC HEALTH, ADDRESS INFANT MORTALITY, PARTICULARLY ACCIDENTAL ASPHYXIATION THERE WERE FIVE NON-PRIORITIZED SIGNIFICANT HEALTH NEEDS THAT MMC DID NOT INCLUDE IN ITS IMPLEMENTATION STRATEGY (1) HOUSING IS NOT A CORE COMPETENCY OF THE HOSPITAL, AND THERE ARE A NUMBER OF OTHER ORGANIZATIONS ALREADY ADDRESSING THIS ISSUE IN THE COMMUNITY THE COMMUNITY ADVISORY COMMITTEE DID NOT RECOMMEND THAT THE HOSPITALS SELECT THIS A FINAL PRIORITY (2) VIOLENT CRIME - THE HOSPITAL DOES NOT HAVE THE EXPERTISE TO ADDRESS THIS ISSUE DIRECTLY OR THE RESOURCES TO LEAD AN INITIATIVE, ALTHOUGH IT DOES WORK WITH BOTH INDIVIDUALS AND ORGANIZATIONS ON ISSUES OF INDIVIDUAL AND PUBLIC SAFETY (3) EDUCATION - THE COMMUNITY ADVISORY COMMITTEE RECOMMENDED THAT THE HOSPITALS FOCUS ON OTHER INITIATIVES WHICH ARE A HIGHER PRIORITY (4) FOOD ACCESS - THE ASSETS/GAPS PROCESS SHOWED THAT THIS ISSUE IS BEING ADDRESSED THROUGH NUMEROUS OTHER AGENCIES AND COMMUNITY RESOURCES (5) CHILD ABUSE - ISSUES OF CHILD ABUSE ARE DEALT WITH ON AN INDIVIDUAL BASIS IN THE HOSPITAL EMERGENCY DEPARTMENT, MEMORIAL PHYSICIAN SERVICES AND MEMORIAL BEHAVIORAL HEALTH HOWEVER, THE HOSPITAL DOES NOT HAVE THE EXPERTISE TO ADDRESS THIS ISSUE ON A COMMUNITY-WIDE BASIS (6) ASTHMA - THIS ISSUE WAS NOT A HIGH PRIORITY IN THE COMMUNITY SURVEY OR FOR THE COMMUNITY ADVISORY COMMITTEE MEMORIAL CHOSE TO ADDRESS OTHER, HIGHER-PRIORITY ISSUES</p>

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
ABRAHAM LINCOLN MEMORIAL HOSPITAL	<p>PART V, SECTION B, LINE 11 ABRAHAM LINCOLN MEMORIAL HOSPITAL'S LOGAN COUNTY CHNA IDENTIFIED FOUR FINAL PRIORITIES TO ADDRESS IN THE 2019-2021 IMPLEMENTATION STRATEGY FIRST, ALMH IS ADDRESSING OBESITY BY EXPANDING THE MEMORIAL WEIGHT LOSS AND WELLNESS CENTER PROGRAM INTO LOGAN COUNTY AND EASTERN MASON COUNTY, AND BY SUPPORTING BREASTFEEDING WITH A FREE SUPPORT GROUP THAT MEETS WEEKLY SECOND, MENTAL HEALTH WILL BE ADDRESSED BY CONTINUING TO OFFER MENTAL HEALTH FIRST AID TRAINING TO THE COMMUNITY, SUPPORT FOR GIRLS ON THE RUN, AND OFFERING SENIOR LIFE SOLUTIONS PROGRAMMING TO LOGAN COUNTY SENIOR LIFE SOLUTIONS ADDRESSES DEPRESSION AND ANXIETY IN THE SENIOR POPULATION THROUGH MENTAL HEALTH COUNSELING AND SUPPORT THIRD, ALMH WILL ADDRESS SUBSTANCE ABUSE THROUGH SYSTEM-WIDE WORK WITH MHS AFFILIATES TO COMBAT OPIOID ABUSE, AND WILL COORDINATE THE WORK WITH OTHER HOSPITALS AND MEDICAL GROUPS ALSO, MHS IS DEVELOPING A SYSTEM-WIDE INITIATIVE TO EXPAND ACCESS TO SUBSTANCE ABUSE THE FINAL PRIORITY, CANCER, WILL BE ADDRESSED BY PROVIDING FREE MAMMOGRAPHY SCREENINGS, INCREASING SMOKING CESSATION SERVICES AND AWARENESS, DECREASING LUNG CANCER DEATH THROUGH INCREASED LUNG CANCER SCREENING THE FOLLOWING AREAS WERE NOT IDENTIFIED AS PRIORITIES FOR THE 2018 COMMUNITY HEALTH NEEDS ASSESSMENT BY ABRAHAM LINCOLN MEMORIAL HOSPITAL CHILD ABUSE/DOMESTIC VIOLENCE, CHRONIC DISEASE MANAGEMENT, POVERTY, MOTHER/INFANT HEALTH, EDUCATION, AND DISCONNECTED YOUTH ORGANIZATIONAL CAPACITY PROHIBITS ALMH FROM IMPLEMENTING PROGRAMS TO ADDRESS ALL SIGNIFICANT HEALTH NEEDS ALMH CHOSE TO FOCUS EFFORTS AND RESOURCES ON A FEW KEY ISSUES IN ORDER TO DEVELOP A MEANINGFUL EVALUATION PLAN AND DEMONSTRATED IMPACT THAT COULD BE REPLICATED WITH OTHER PRIORITIES IN THE FUTURE CHILD ABUSE/DOMESTIC VIOLENCE IS OFTEN A RESULT OF POVERTY AND MENTAL HEALTH ISSUES ALMH DOES NOT HAVE THE EXPERTISE/COMPETENCIES TO ADDRESS THE ISSUE EFFECTIVELY ALMH HAS CHOSEN TO ADDRESS MENTAL HEALTH THE ALMH COMMUNITY HEALTH COLLABORATIVE WILL BE ADDRESSING BOTH MENTAL HEALTH AND POVERTY CHRONIC DISEASE MANAGEMENT WAS NOT CHOSEN AS A PRIORITY THIS YEAR BECAUSE OTHER NEEDS WERE DEEMED A HIGHER PRIORITY AND THE ISSUE WAS CHOSEN AS A FOCUS FOR THE LOGAN COUNTY DEPARTMENT OF PUBLIC HEALTH MOTHER/INFANT HEALTH WAS NOT CHOSEN AS A PRIORITY THIS YEAR BECAUSE OTHER NEEDS WERE DEEMED A HIGHER PRIORITY AND IT WAS NOT A PRIORITY ISSUE FOR COMMUNITY MEMBERS EDUCATION AND DISCONNECTED YOUTH WERE NOT CHOSEN BECAUSE ALMH DOES NOT HAVE THE EXPERTISE/COMPETENCIES TO ADDRESS THE ISSUE EFFECTIVELY HOWEVER, INTERVENTIONS TO ADDRESS POVERTY AND MENTAL HEALTH MAY OVERLAP INTO THESE AREAS</p>

Section C. Supplemental Information for Part V, Section B.Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
TAYLORVILLE MEMORIAL HOSPITAL	<p>PART V, SECTION B, LINE 11 TAYLORVILLE MEMORIAL HOSPITAL REVIEWED DATA, OFFERED ADDITIONA L INSIGHTS ON ISSUES AFFECTING THE COMMUNITY AND RANKED THE PRIORITIES USING THE DEFINED C RITERIA THE COMMUNITY ADVISORY GROUP IDENTIFIED SIX PRIORITY HEALTH NEEDS CANCER, DIABET ES, OBESITY, MENTAL HEALTH, SUBSTANCE ABUSE, AND SEXUALLY TRANSMITTED DISEASES THAT WERE R ECOMMENDED TO BE INCLUDED ON THE COMMUNITY SURVEY FOLLOWING THE SURVEY, THE EXTERNAL ADVI SORY GROUP, INCLUDING REPRESENTATIVES FROM PUBLIC HEALTH, SOCIAL SERVICES ORGANIZATIONS AND THOSE OFFERING CARE UNDERSERVED POPULATIONS, AS WELL AS RECOMMENDATIONS FROM THE MEMORIA L HEALTH SYSTEM INTERNAL ADVISORY TEAM, REVIEWED THE SURVEY RESULTS AND DATA AND RECOMMEND ED TWO TOP PRIORITIES TO ADDRESS IN 2019-2021 IMPLEMENTATION STRATEGY THE TWO FINAL PRIOR ITIES WERE SELECTED MENTAL HEALTH AND SUBSTANCE ABUSE (DRUGS, ALCOHOL AND TOBACCO) THESE WERE APPROVED BY THE TAYLORVILLE MEMORIAL HOSPITAL BOARD ON JULY 10, 2018 MENTAL HEALTH WILL BE ADDRESSED BY CONTINUING TO OFFER MENTAL HEALTH FIRST AID TRAINING TO THE COMMUNITY , EXPANDING YOUTH-FOCUSED MENTAL HEALTH FIRST AID, SUPPORT FOR GIRLS ON THE RUN, CONTINUIN G TO OFFER SENIOR LIFE SOLUTIONS, AND DEVELOPING A "STEP-DOWN" PROGRAM FOR ON-GOING SUPPOR T OF SENIOR LIFE SOLUTIONS GRADUATES TMH WILL ADDRESS SUBSTANCE ABUSE THROUGH SYSTEM-WIDE WORK WITH MHS AFFILIATES TO COMBAT OPIOID ABUSE, AND WILL COORDINATE WORK WITH OTHER HOSP ITALS AND MEDICAL GROUPS ALSO, MHS IS DEVELOPING A SYSTEM-WIDE INITIATIVE TO EXPAND ACCES S TO SUBSTANCE ABUSE TREATMENT TMH WILL ALSO CONTINUE DONATION OF NARCAN TO LOCAL LAW ENF ORCEMENT IN CHRISTIAN COUNTY, FUND AN DRUG ABUSE PREVENTION PROGRAM FOR YOUTH IN TAYLORVIL LE SCHOOLS BY THE GROUP OVERDOSE LIFELINE, DEVELOP RESOURCES FOR TOBACCO CESSATION FOR THE COMMUNITY IN COLLABORATION WITH THE AMERICAN LUNG ASSOCIATION, AND CONTINUE TO PROVIDE LE ADERSHIP AND SUPPORT FOR THE INITIATIVES OF THE CHRISTIAN COUNTY PREVENTION COALITION AND FAMILIES ANONYMOUS PROGRAM THERE WERE FOUR NON-PRIORITIZED SIGNIFICANT HEALTH NEEDS THAT TMH DID NOT INCLUDE IN ITS IMPLEMENTATION STRATEGY (1) CANCER WAS NOT SELECTED BECAUSE IT WAS NOT RANKED BY THE COMMUNITY ADVISORY COMMITTEE AS HAVING A HIGH PRIORITY AND THERE WA S OPPORTUNITY TO ADDRESS LUNG CANCER INCIDENCE WITH EFFORTS TO ADDRESS TOBACCO ABUSE EXIS TING ASSETS IN THE COMMUNITY WITH CANCER DIAGNOSIS AND TREATMENT WERE CONSIDERED TO BE WEL L UTILIZED AND APPROPRIATE THE COMMUNITY ADVISORY COMMITTEE DID NOT RECOMMEND THAT THE HO SPITAL SELECT THIS AS A FINAL PRIORITY (2 AND 3) OBESITY AND DIABETES WERE ELIMINATED FRO M FURTHER CONSIDERATION BECAUSE THE ADVISORY GROUP MEMBERS BELIEVED THAT EFFORTS TO IMPROV E TREATMENT AND PREVENTION OF OBESITY WOULD ALSO POSITIVELY IMPACT INCIDENCE OF DIABETES TMH ALREADY DEVOTES SIGNIFICANT RESOURCES TO ADDRESSING DIABETES EDUCATION AND SUPPORT TM H IS PARTNERING WITH THE LOCAL YMCA'S DIABETES PREVENTION PROGRAM THE DECISION WAS MADE T O APPLY ADDITIONAL RESOURCES T</p>

Section C. Supplemental Information for Part V, Section B.Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
TAYLORVILLE MEMORIAL HOSPITAL	O OTHER SELECTED PRIORITIES (4) SEXUALLY TRANSMITTED DISEASES WAS NOT SELECTED BECAUSE IT WAS CONSISTENTLY RANKED LOW ON THE LIST OF PRIORITIES WITH BOTH THE COMMUNITY AND THE COM MUNITY ADVISORY COMMITTEE THE DECISION WAS MADE TO APPLY ADDITIONAL RESOURCES TO THE OTHE R SELECTED PRIORITIES

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION	PART V, SECTION B, LINE 11 PASSAVANT AREA HOSPITAL MORGAN COUNTY CHNA IDENTIFIED EIGHT FINAL PRIORITIES THAT WERE RECOMMENDED BY ITS COMMUNITY ADVISORY COMMITTEE TO BE INCLUDED ON THE COMMUNITY SURVEY FOLLOWING THE SURVEY, THE COMMITTEE RECOMMENDED THREE TOP PRIORITIES, WHICH PAH SELECTED AS ITS FINAL PRIORITIES TO ADDRESS IN 2019-2021 IMPLEMENTATION STRATEGY FIRST, ACCESS TO CARE WILL BE ADDRESSED THROUGH A COMMUNITY HEALTH WORKER PROGRAM IN ONE AT-RISK NEIGHBORHOOD, BY IMPROVING ACCESS THROUGH TRANSPORTATION TO AND FROM THE HOSPITAL, AND BY PROVIDING SUPPORT TO THE MCHD STD CLINIC FOR PREVENTION, DETECTION AND TREATMENT OF STDs SECOND, MENTAL HEALTH WILL BE ADDRESSED BY OPENING A PARTIAL HOSPITALIZATION PROGRAM, CONTINUING TO OFFER MENTAL HEALTH FIRST AID TRAINING TO THE COMMUNITY, SUPPORT FOR THE CHILDREN'S MOSAIC MENTAL HEALTH PROGRAMS IN SCHOOLS, AND SUPPORT FOR GIRLS ON THE RUN THIRD, PAH WILL ADDRESS SUBSTANCE ABUSE THROUGH SYSTEM-WIDE WORK WITH MHS AFFILIATES TO COMBAT OPIOID ABUSE, AND WILL COORDINATE THE WORK WITH OTHER HOSPITALS AND MEDICAL GROUPS ALSO, MHS IS DEVELOPING A SYSTEM-WIDE INITIATIVE TO EXPAND ACCESS TO SUBSTANCE ABUSE AND PAH IS REDUCING THE USE OF PRESCRIPTION OPIOIDS FOR TREATMENT OF PAIN FOR BOTH INPATIENT AND OUTPATIENT CASES THERE WERE FIVE NON-PRIORITIZED SIGNIFICANT HEALTH NEEDS THAT PAH DID NOT INCLUDE IN ITS IMPLEMENTATION STRATEGY 1) OBESITY-PASSAVANT WILL CONTINUE OFFERING THE WEIGHT LOSS & WELLNESS PROGRAM ALONG WITH THE WALKING FOR WELLNESS PARTNERSHIP WITH JACKSONVILLE HIGH SCHOOL AND FIRST CHRISTIAN CHURCH HOWEVER, THE HOSPITAL DOES NOT HAVE COMPETENCIES TO ADDRESS THIS ISSUE AS A WHOLE 2) ILLITERACY/EDUCATION-PAH WILL WORK WITH COMMUNITY PARTNERS TO PROVIDE EDUCATION RELATED TO IMPROVING HEALTH THE HOSPITAL DOES NOT HAVE EXPERTISE/ COMPETENCIES TO ADDRESS THE ISSUE AS A WHOLE 3) LICE AND BED BUGS-THE MORGAN COUNTY HEALTH DEPARTMENT AND MORGAN COUNTY HOUSING ASSOCIATION HAVE A PLAN TO ADDRESS THE ISSUE EFFECTIVELY 4) HOMELESSNESS-NEW DIRECTIONS WARMING & COOLING CENTER IS WORKING WITH ORGANIZATIONS ACROSS THE COMMUNITY TO ADDRESS THE ISSUE 5) GANG/DRUG AFFILIATION/ TRAFFICKING/GUNS-THE MORGAN COUNTY SHERIFF'S DEPARTMENT, JACKSONVILLE POLICE DEPARTMENT AND MORGAN COUNTY PROBATION HAVE A SOLID PLAN TO ADDRESS THESE ISSUES IN THE COMMUNITY

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 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.

Form and Line Reference	Explanation
LINE 13A	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

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 1 - MEMORIAL PHYSICIAN SERVICES-KOKE MILL 3132 OLD JACKSONVILLE RD SPRINGFIELD, IL 62704	MPS PHYSICIAN
1 2 - MEMORIAL PHYS SVCS-JACKSONVILLE 15 FOUNDERS LANE SUITE 100 JACKSONVILLE, IL 62650	MPS PHYSICIAN
2 3 - MEMORIAL PHYSICIAN SERVICES-LINCOLN 515 NORTH COLLEGE STREET LINCOLN, IL 62526	MPS PHYSICIAN
3 4 - MEMORIAL EXPRESSCARE AT SOUTH SIXTH 2950 SOUTH SIXTH STREET SPRINGFIELD, IL 62703	ANCILLARY SERVICES
4 5 - MEMORIAL EXPRESSCARE AT NORTH DIRKSEN 3220 ATLANTA STREET SPRINGFIELD, IL 62702	ANCILLARY SERVICES
5 6 - MEMORIAL EXPRESSCARE AT KOKE MILL 3132 OLD JACKSONVILLE RD SPRINGFIELD, IL 62704	ANCILLARY SERVICES
6 7 - MEMORIAL PHYSICIAN SERVICES-VINE STREET 3225 HEDLEY RD SPRINGFIELD, IL 62711	MPS PHYSICIAN
7 8 - MEMORIAL PHYSICIAN SERVICES-CHATHAM 101 EAST PLUMMER CHATHAM, IL 62629	MPS PHYSICIAN
8 9 - SPORTSCARE AT YMCA 4550 WEST ILES SPRINGFIELD, IL 62711	OUTPATIENT SERVICES
9 10 - MEMORIAL EXPRESSCARE AT CHATHAM 101 EAST PLUMMER CHATHAM, IL 62629	ANCILLARY SERVICES
10 11 - MEMORIAL PHYS SVCS-WOMEN'S HEALTHCARE 747 NORTH RUTLEDGE SPRINGFIELD, IL 62701	MPS PHYSICIAN
11 12 - MEMORIAL PHYSICIAN SERVICES-PETERSBURG 1 CENTRE DRIVE PETERSBURG, IL 62675	MPS PHYSICIAN
12 13 - MEMORIAL PHYS SVCS-CAPITAL HEALTHCARE 2603 SOUTH SIXTH SPRINGFIELD, IL 62703	MPS PHYSICIAN
13 14 - MEMORIAL INDUSTRIAL REHAB 775 ENGINEERING DRIVE SPRINGFIELD, IL 62703	OUTPATIENT SERVICES
14 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 16 - SPINEWORKS PAIN CENTER 501 NORTH FIRST STREET SPRINGFIELD, IL 62702	OUTPATIENT SERVICES
1 17 - MEMORIAL PHYSICIAN SERVICES-SOUTH SIXTH 2950 SOUTH SIXTH STREET SPRINGFIELD, IL 62703	MPS PHYSICIAN
2 18 - MEMORIAL PHYSICIAN SVCS-MACARTHUR 2115 SOUTH MACARTHUR BLVD SPRINGFIELD, IL 62704	MPS PHYSICIAN
3 19 - WOUND HEALING CENTER 901 NORTH FIRST STREET SPRINGFIELD, IL 62702	OUTPATIENT SERVICES
4 20 - MEMORIAL NOW 701 NORTH FIRST STREET SPRINGFIELD, IL 62781	VIRTUAL CARE

Schedule I
(Form 990)

Department of the
Treasury
Internal Revenue Service

Name of the organization
MEMORIAL HEALTH SYSTEM GROUP

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.

OMB No 1545-0047

2017

Open to Public
Inspection

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 noncash assistance	(h) Purpose of grant or assistance
(1) See Additional Data							
(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 15

3 Enter total number of other organizations listed in the line 1 table 2

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 noncash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of noncash 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
ILLINOIS HOSPITAL RESEARCH AND EDUCATION FOUNDATION 1151 EAST WARRENVILLE ROAD NAPERVILLE, IL 60566	23-7421930	501(C)(3)	142,380				TO ADDRESS THE DISPARATE AND NEGATIVE EFFECTS OF THE ILLINOIS MEDICAID PROGRAM EXPERIENCED BY HOSPITALS AND HEALTHCARE SYSTEMS IN ILLINOIS
KUMLER OUTREACH MINISTRIES 303 NORTH GRAND AVE EAST SPRINGFIELD, IL 62702	37-0695489	501(C)(3)	12,000				PHARMACEUTICAL ASSISTANCE

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		17,928				HEALTHCARE SAFETY SYMPOSIUM
MEMORIAL HOME SERVICES 701 NORTH FIRST STREET SPRINGFIELD, IL 62781	37-0714225	501(C)(3)	11,668				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
MEMORIAL MEDICAL CENTER 701 NORTH FIRST STREET SPRINGFIELD, IL 62781	37-0661220	501(C)(3)	423,277				PROVIDE DIABETES EDUCATION SCHOLARSHIPS, CRITICAL CARE CERTIFICATION AND REVIEW COURSE, STOP THE BLEED, NURSING RESEARCH CONFERENCE, ACUTE CARE NURSING CONFERENCE, EMPLOYEE CERTIFICATION PROGRAM, SIMULATOR, 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)	8,442				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)	179,432				PROVIDE GENERAL SUPPORT, CARDIOLOGY EQUIPMENT AND SUPPLIES, COMMUNITY EMS TRAINING AND EQUIPMENT, COMMUNITY HEALTH IMPROVEMENT, AND LIFELINE SUPPORT
SIU PHYSICIANS & SURGEONS INC DBA SIU HEALTHCARE PO BOX 19639 SPRINGFIELD, IL 62794	36-4143823	501(C)(3)	2,179,101				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 MMC HAS ALSO ENTERED INTO AN AGREEMENT WITH SIU HEALTHCARE TO CONTRIBUTE FROM MMC'S FUNDING FOR THE ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES ASSESSMENT PROGRAM TO SIU'S ALZHEIMER'S DISEASE AND RELATED DISORDERS 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
SIU SCHOOL OF MEDICINE 801 NORTH RUTLEDGE SPRINGFIELD, IL 62702	37-6005961	501(C)(3)	331,458				PROVIDE GENERAL SUPPORT, EQUIPMENT FOR DEMENTIA RESEARCH, CONSTRUCTING AN ILLINOIS BLUEPRINT FOR RURAL HEALTH, LUNG CANCER PATIENT SELECTION, NEWBORN SIMULATOR, PILOT STUDY FOR ADVANCED TRAUMA LIFE SUPPORT, CULTIVATING HEALTH EQUITY INITIATIVES, AND RESECTION OF HIGH GRADE GLIOMA
TAYLORVILLE MEMORIAL HOSPITAL 201 E PLEASANT ST TAYLORVILLE, IL 62568	37-0661250	501(C)(3)	92,237				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)	7,500				ANATOMICAL MODELS FOR PRE-HEALTH OCCUPATION COURSES
YMCA 701 SOUTH FOURTH STREET SPRINGFIELD, IL 62703	37-0661263	501(C)(3)	50,000				TO CONNECT PEOPLE OF ALL AGES AND BACKGROUNDS TO BRIDGE THE GAP IN COMMUNITY NEEDS SO THAT EVERYONE HAS THE OPPORTUNITY TO LEARN, GROW AND THRIVE

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
BIG BROTHERS BIG SISTERS 928 S SPRING ST SPRINGFIELD, IL 62704	37-1348685	501(C)(3)	125,000				TO PROVIDE CHILDREN FACING ADVERSITY WITH STRONG AND ENDURING, PROFESSIONALLY SUPPORTED ONE -TO -ONE RELATIONSHIPS THAT CHANGE THEIR LIVES FOR THE BETTER
ABRAHAM LINCOLN HEALTHCARE FOUNDATION 200 STAHLHUT DRIVE LINCOLN, IL 62656	36-3492268	501(C)(3)	500,000				TO FUND THE COMMUNITY HEALTH COLLABORATIVE INITIATIVES

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 CHICAGO - COLLEGE OF NURSING 845 S DAMEN AVE CHICAGO, IL 60612	34-3488183	501(C)(3)	60,310				COLLEGE OF NURSING LEARNING LAB
SPRINGFIELD FIRE DEPARTMENT 825 E CAPITOL AVE SPRINGFIELD, IL 62701	37-6002037		9,320				RESCUE TASK FORCE

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
BOARD OF TRUSTEES SIU 801 NORTH RUTLEDGE SPRINGFIELD, IL 62702	37-6005961	501(C)(3)	100,000				COMMUNITY HEALTH IMPROVEMENT

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 ASSISTANCE PAYMENTS	313	1,318,595			
PRESCRIPTION DRUGS FOR PATIENTS	47	6,787			
SHELTER AND UTILITY ASSISTANCE FOR PATIENTS	67	37,243			
DIRECT CASH ASSISTANCE TO PATIENTS	93	34,966			
TRANSPORTATION ASSISTANCE FOR PATIENTS	104	18,594			

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
EMPLOYEE ASSISTANCE	35	30,942			
TAYLORVILLE CUPS ASSISTANCE	40	6,655			
PEDIATRIC DENTISTRY	7	4,177			
COMMUNITY HEALTH OUTREACH	19	2,000			

Schedule J
(Form 990)

Compensation Information

OMB No 1545-0047

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.

2017

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 Questions Regarding Compensation

	Yes	No								
1a 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. <table style="width:100%; margin-top: 10px;"> <tr> <td><input type="checkbox"/> First-class or charter travel</td> <td><input checked="" type="checkbox"/> Housing allowance or residence for personal use</td> </tr> <tr> <td><input type="checkbox"/> Travel for companions</td> <td><input type="checkbox"/> Payments for business use of personal residence</td> </tr> <tr> <td><input type="checkbox"/> Tax indemnification and gross-up payments</td> <td><input type="checkbox"/> Health or social club dues or initiation fees</td> </tr> <tr> <td><input type="checkbox"/> Discretionary spending account</td> <td><input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)</td> </tr> </table>	<input type="checkbox"/> First-class or charter travel	<input checked="" type="checkbox"/> Housing allowance or residence for personal use	<input type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence	<input type="checkbox"/> Tax indemnification and gross-up payments	<input type="checkbox"/> Health or social club dues or initiation fees	<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)		
<input type="checkbox"/> First-class or charter travel	<input checked="" type="checkbox"/> Housing allowance or residence for personal use									
<input type="checkbox"/> Travel for companions	<input type="checkbox"/> Payments for business use of personal residence									
<input type="checkbox"/> Tax indemnification and gross-up payments	<input type="checkbox"/> Health or social club dues or initiation fees									
<input type="checkbox"/> Discretionary spending account	<input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)									
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	1b Yes									
2 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?	2	No								
3 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. <table style="width:100%; margin-top: 10px;"> <tr> <td><input type="checkbox"/> Compensation committee</td> <td><input type="checkbox"/> Written employment contract</td> </tr> <tr> <td><input type="checkbox"/> Independent compensation consultant</td> <td><input type="checkbox"/> Compensation survey or study</td> </tr> <tr> <td><input type="checkbox"/> Form 990 of other organizations</td> <td><input type="checkbox"/> Approval by the board or compensation committee</td> </tr> </table>	<input type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract	<input type="checkbox"/> Independent compensation consultant	<input type="checkbox"/> Compensation survey or study	<input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Approval by the board or compensation committee				
<input type="checkbox"/> Compensation committee	<input type="checkbox"/> Written employment contract									
<input type="checkbox"/> Independent compensation consultant	<input type="checkbox"/> Compensation survey or study									
<input type="checkbox"/> Form 990 of other organizations	<input type="checkbox"/> Approval by the board or compensation committee									
4 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:										
a Receive a severance payment or change-of-control payment?	4a	No								
b Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b Yes									
c Participate in, or receive payment from, an equity-based compensation arrangement?	4c	No								
If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.										
Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.										
5 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:										
a The organization?	5a	No								
b Any related organization?	5b	No								
If "Yes," on line 5a or 5b, describe in Part III.										
6 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:										
a The organization?	6a	No								
b Any related organization?	6b	No								
If "Yes," on line 6a or 6b, describe in Part III.										
7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III.	7	No								
8 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.	8	No								
9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	9									

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.

See Additional Data Table

[illegible]

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
PART I, LINE 1A	HARRY SCHMIDT WAS PROVIDED HOUSING OWNED BY MEMORIAL HEALTH SYSTEM FOR PERSONAL USE WHILE IN JACKSONVILLE, IL WHERE HE SERVED AS THE PRESIDENT AND CEO OF PASSAVANT AREA HOSPITAL. THIS WAS TREATED AS TAXABLE COMPENSATION AND IS LISTED AS OTHER COMPENSATION ON SCHEDULE J, PART II, COLUMN (B)(III).
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, AROUND THE MIDDLE OF THE MARKET SALARY DATA, AS MEASURED AND PRESENTED TO THE COMMITTEE BY THE INDEPENDENT COMPENSATION CONSULTANT. INCENTIVE COMPENSATION WAS CONTINGENT ON THE ACHIEVEMENT OF DEFINED SPECIFIC PERFORMANCE METRICS OF MHS, AS REVIEWED AND APPROVED IN ADVANCE BY THE MHS BOARD. RETIREMENT COMPENSATION IN COLUMNS (B)(III) AND (C) IS THE YEAR'S NORMAL INCREASE IN TOTAL RETIREMENT BENEFITS PROVIDED TO THE EXECUTIVE FOR HIS ENTIRE TERM OF SERVICE TO THE ORGANIZATION. THE RETIREMENT BENEFITS IN COLUMN (C) ARE UNVESTED, AND WILL BE FORFEITED IF THE EXECUTIVE DOES NOT SATISFY FUTURE SERVICE REQUIREMENTS.
PART I, LINE 4B	ONE OR MORE LISTED INDIVIDUALS PARTICIPATES IN NONQUALIFIED DEFERRED COMPENSATION PLANS MAINTAINED BY MEMORIAL HEALTH SYSTEM. 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 \$205,872, ROBERT BUSSING \$326,031, DOLAN DALPOAS \$28,932, TRAVIS DOWELL \$24,293, KEVIN ENGLAND \$2,523, ANTHONY GRIFFIN \$36,646, MARK HANSEN \$56,934, MARSHALL HALE \$37,885, MITCH JOHNSON \$95,159, LINDA JONES \$20,778, SCOTT KIRIAKOS \$33,517, STEVEN LILLPOP \$53,249, TRACY MIZEUR \$14,018, MARSHA PRATER \$35,840, DAN RAAB \$289,870, CHRISTOPHER RIVERA \$14,601, FERDINAND SALVACION \$75,005, DAVID SANDERCOCK \$60,492, CHRISTINA SCHEIBLER-VENTRESS \$50,042, AND AMIR WAHAB \$59,159. 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 II	THE FOLLOWING INDIVIDUALS HAVE LISTED COMPENSATION, BUT THEY ARE NOT PAID FOR THEIR SERVICE AS BOARD MEMBERS (WHICH IS WHY THEY ARE LISTED). THEY INSTEAD ARE COMPENSATED FOR THE SUBSTANTIAL SERVICES THEY PROVIDE AS AN EMPLOYEE OF THE ORGANIZATION OR OF A RELATED ORGANIZATION. THE INDIVIDUALS FALLING INTO THIS CATEGORY ARE THE FOLLOWING: AMIR WAHAB, TRACY MIZEUR, PAUL KASA, ANTHONY GRIFFIN, CHRISTOPHER RIVERA, MARK HANSEN, MARSHALL HALE, J. TRAVIS DOWELL, JAMESON ROSZHART, HARRY SCHMIDT, R. SCOTT KIRIAKOS, DOLAN DALPOAS, KIMBERLY BOURNE, EVAN DAVIS, KATHRYN KEIM, EDGAR CURTIS, ROBERT KAY, KEVIN ENGLAND, CHARLES CALLAHAN, STEVEN LILLPOP, AND JANICE GAMBACH.

Additional Data

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

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				
1AMIR JOHN WAHAB MD BOARD MEMBER ALMH	(i)	438,167	46,785	82,256	67,463	84,512	719,183	0
	(ii)	0	0	0	0	0	0	0
1TRACY MIZEUR MD BOARD MEMBER ALMH	(i)	220,112	23,510	14,318	55,933	9,449	323,322	0
	(ii)	0	0	0	0	0	0	0
2PAUL KASA MD BOARD MEMBER MPS(THRU DEC 17)	(i)	261,890	24,964	8,398	49,747	49,714	394,713	0
	(ii)	0	0	0	0	0	0	0
3ANTHONY GRIFFIN MD BOARD MEMBER MPS(FROM JAN 18)	(i)	261,927	24,929	41,958	33,591	38,811	401,216	0
	(ii)	0	0	0	0	0	0	0
4CHRISTOPHER RIVERA MD BOARD MEMBER MPS(FROM JAN 18)	(i)	248,389	25,979	18,106	38,303	32,429	363,206	0
	(ii)	0	0	0	0	0	0	0
5MARK HANSEN MD BRDMMMPs(THRUDEC17)/CHAIR	(i)	388,422	34,406	74,410	34,600	80,151	611,989	27,507
	(ii)	0	0	0	0	0	0	0
6MARSHALL HALE MD CHAIR MPS(THRU DEC 17)	(i)	428,858	39,240	64,121	71,838	81,447	685,504	35,277
	(ii)	0	0	0	0	0	0	0
7J TRAVIS DOWELL PRESIDENT MPS & VP MPS	(i)	0	0	0	0	0	0	0
	(ii)	237,164	60,248	36,120	48,090	24,541	406,163	19,796
8JAMESON ROSZHART BMMHV/BMMHSVC(THRUDEC17)CHRMHSVC/VPA	(i)	0	0	0	0	0	0	0
	(ii)	228,714	57,150	9,528	42,965	26,030	364,387	0
9HARRY SCHMIDT BRD MEM MHSVC/PRES PAH CRNA	(i)	0	0	0	0	0	0	0
	(ii)	217,861	52,300	23,826	135,270	2,602	431,859	0
10R SCOTT KIRIAKOS SVPCLININT/BMMHV(THRUDEC17)/CHRMHSVC	(i)	334,678	119,533	47,441	111,379	18,117	631,148	0
	(ii)	0	0	0	0	0	0	0
11DOLAN DALPOAS PRESIDENT ALMH/BRDMEM MHSVC/CEOALMH	(i)	0	0	0	0	0	0	0
	(ii)	271,997	67,999	50,424	53,315	405	444,140	20,384
12KIMBERLY BOURNE PRES TMH&TMHF/BRDMMMHsVC/CEOTMH	(i)	0	0	0	0	0	0	0
	(ii)	241,281	61,208	16,769	50,856	25,132	395,246	0
13EVAN DAVIS BOARD MEMBER MHV (FROM JAN 18)	(i)	185,218	23,412	5,989	16,573	2,741	233,933	0
	(ii)	0	0	0	0	0	0	0
14KATHRYN KEIM SEC/TREASMHV/VPFINANCE	(i)	8,389	0	3	260	991	9,643	0
	(ii)	209,733	56,250	4,719	35,813	24,774	331,289	0
15EDGAR CURTIS PRES&CEOMHS/PRESMMC/BRDMMMPs	(i)	0	0	0	0	0	0	0
	(ii)	832,114	367,500	77,373	290,238	19,157	1,586,382	0
16ROBERT KAY SVP CFO/SECTREASMHsVCMPS	(i)	0	0	0	0	0	0	0
	(ii)	454,858	162,021	18,929	207,925	20,914	864,647	0
17KEVIN ENGLAND VPBD(THRUSEP17)SVPBD/VC/PRESMHV/VCMH	(i)	0	0	0	0	0	0	0
	(ii)	227,066	76,088	29,429	153,803	27,795	514,181	0
18CHARLES CALLAHAN PHD EVP COOMMC/CHRMHV/MPSBRDMEM/PRESMHsVC	(i)	452,091	161,739	92,857	164,676	28,750	900,113	0
	(ii)	0	0	0	0	0	0	0
19STEVEN LILLPOP MD BRDMEM PAH (THRU DEC 17)	(i)	554,646	57,938	96,093	94,724	66,813	870,214	50,245
	(ii)	0	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				
21JANICE GAMBACH PRESIDENT SRS, ADMIN MBH	(i)	0	0	0	0	0	0	0
	(ii)	179,802	22,922	5,293	14,765	9,985	232,767	0
1ELENA KEZELIS EXEC DIR MMCF	(i)	173,045	22,460	4,600	15,282	25,686	241,073	0
	(ii)	0	0	0	0	0	0	0
2MARSHA PRATER PHD SVP & CNO MMC	(i)	312,379	0	70,090	220,264	9,205	611,938	0
	(ii)	0	0	0	0	0	0	0
3LINDA JONES DNS VP OPERATIONS MMC	(i)	264,235	66,634	52,260	52,664	9,462	445,255	15,552
	(ii)	0	0	0	0	0	0	0
4DREW EARLY VOPERATIONS (FROMDEC16)	(i)	216,366	56,250	10,253	38,674	27,575	349,118	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)	344,893	88,532	6,774	109,703	28,098	578,000	0
6RAJESH GOVINDAIAH MD SVP & CMO MHS	(i)	0	0	0	0	0	0	0
	(ii)	424,137	151,559	29,049	76,488	10,176	691,409	0
7DAVID GRAHAM MD SVP & CIO MHS	(i)	0	0	0	0	0	0	0
	(ii)	408,145	144,817	25,342	152,989	16,496	747,789	0
8MITCHELL JOHNSON SVP & CHIEF STRATEGY OFFICER MHS	(i)	0	0	0	0	0	0	0
	(ii)	294,959	105,786	110,272	104,662	18,557	634,236	33,070
9ROBERT SCOTT VP & CHRO MHS	(i)	0	0	0	0	0	0	0
	(ii)	278,708	70,593	21,933	44,123	25,303	440,660	0
10JENNIFER HARRIS ADMIN PERIOPERATIVE SERVICES	(i)	194,105	24,527	159	13,931	13,416	246,138	0
	(ii)	0	0	0	0	0	0	0
11MITCHELL ROGERS ADMIN CARDIOVASCULAR SERVICES	(i)	218,028	55,157	6,772	37,690	3,337	320,984	0
	(ii)	0	0	0	0	0	0	0
12CHARLES SHEAFF MD CMO PAH (THRU AUG 17)	(i)	231,584	25,859	0	6,743	23,721	287,907	0
	(ii)	49,724	0	0	2,983	0	52,707	0
13FERDINAND SALVACION MD PHYSICIAN MMC	(i)	483,166	190,353	94,494	87,986	41,548	897,547	67,400
	(ii)	0	0	0	0	0	0	0
14JAMES BOHAN MD PHYSICIAN MPS	(i)	399,448	42,173	232,472	34,600	66,787	775,480	37,608
	(ii)	0	0	0	0	0	0	0
15CHRISTINA SCHEIBLER- VENTRESS MD PHYSICIAN MPS	(i)	450,397	50,467	70,669	76,681	28,329	676,543	47,219
	(ii)	0	0	0	0	0	0	0
16DAVID SANDERCOCK MD PHYSICIAN MPS	(i)	468,395	49,023	84,045	65,139	84,719	751,321	36,443
	(ii)	0	0	0	0	0	0	0
17ROBERT BUSSING MD PHYSICIAN MPS	(i)	274,012	30,109	328,302	19,887	20,113	672,423	0
	(ii)	0	0	0	0	0	0	0
18DAN RAAB FMRPRESTMH&TMHF	(i)	0	0	0	0	0	0	0
	(ii)	0	0	289,870	0	0	289,870	115,803

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.

OMB No 1545-0047

2017

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

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 \$44,848 (D) MEMORIAL MEDICAL CENTER PAID COMPENSATION AND BENEFITS OF \$44,848 TO MADELINE CALLAHAN RELATED TO EMPLOYMENT SERVICES FOR THE FISCAL YEAR ENDED 9/30/2018 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 \$1,156,982 (D) MEMORIAL MEDICAL CENTER PAID FEES TO SPRINGFIELD ELECTRIC SUPPLY FOR GOODS AND SERVICES FOR THE YEAR ENDED SEPTEMBER 30, 2018 IN THE AMOUNT OF \$1,156,982 RANDALL S GERMEAAD IS AN MMC BOARD MEMBER 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 CLINICAL RADIOLOGISTS, SC(C) AMOUNT OF TRANSACTION \$609,284 (D) MEMORIAL MEDICAL CENTER PAID FEES TO CLINICAL RADIOLOGISTS, SC FOR THE YEAR ENDED SEPTEMBER 30, 2018 IN THE AMOUNT OF \$609,284 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 \$127,974 (D) PASSAVANT MEMORIAL AREA HOSPITAL PAID COMPENSATION AND BENEFITS OF \$127,974 TO SHERYL ROBERTS RELATED TO EMPLOYMENT SERVICES FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 2018 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 \$53,128 (D) PASSAVANT MEMORIAL AREA HOSPITAL PAID COMPENSATION AND BENEFITS OF \$53,128 TO AMANDA CHUKIN RELATED TO EMPLOYMENT SERVICES FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 2018 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
(A) NAME OF PERSON HENRY HURWITZ	(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION EMPLOYEE, SON OF MMC BOARD MEMBER(C) AMOUNT OF TRANSACTION \$69,900 (D) MEMORIAL MEDICAL CENTER PAID COMPENSATION AND BENEFITS OF \$69,900 TO HENRY HURWITZ RELATED TO EMPLOYMENT SERVICES FOR THE FISCAL YEAR ENDED 9/30/2018 HENRY HURWITZ IS THE SON OF JOSEPH HURWITZ, MMC BOARD MEMBER 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 BRITTANY LIBKA	(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION EMPLOYEE, DAUGHTER OF MMC AND MHS BOARD MEMBER(C) AMOUNT OF TRANSACTION \$60,793 (D) MEMORIAL MEDICAL CENTER PAID COMPENSATION AND BENEFITS OF \$60,793 TO BRITTANY LIBKA RELATED TO EMPLOYMENT SERVICES FOR THE FISCAL YEAR ENDED 9/30/2018 BRITTANY LIBKA IS THE DAUGHTER OF GEOFFREY ISRINGHAUSEN, MMC AND MHS BOARD MEMBER 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
(1) MADELINE CALLAHAN	SEE PART V	44,848	SEE PART V		No
(1) SPRINGFIELD ELECTRIC SUPPLY	SEE PART V	1,156,982	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
(3) CLINICAL RADIOLOGISTS SC	SEE PART V	609,284	SEE PART V		No
(1) SHERYL ROBERTS	SEE PART V	127,974	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
(5) AMANDA CHUKIN	SEE PART V	53,128	SEE PART V		No
(1) HENRY HURWITZ	SEE PART V	69,900	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
(7) BRITTANY LIBKA	SEE PART V	60,793	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

OMB No 1545-0047

2017

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	15,072	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	2	2,230,868	FARMLAND APPRAISAL
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

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 nonstandard 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

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Name of the organization
MEMORIAL HEALTH SYSTEM GROUP

Supplemental Information to Form 990 or 990-EZ

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
www.irs.gov/form990.

OMB No 1545-0047

2017

**Open to Public
Inspection**

Employer identification number

90-0756744

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 2	DIANE RUTLEDGE, PH D , TODD WISE, AND LYNNE BARKMEIER, M D 'S SPOUSE HAVE A BUSINESS RELATIONSHIP NINA HARRIS AND MITCHELL JOHNSON HAVE A BUSINESS RELATIONSHIP JOHN BLACKBURN AND DEAN ROBERT, JR HAVE A BUSINESS RELATIONSHIP KEVIN COAKLEY AND DALE BECKER HAVE A BUSINESS RELATIONSHIP RICHARD LEVI AND SERGIO PECORI HAVE A BUSINESS RELATIONSHIP

990 Schedule O, Supplemental Information

Return Reference	Explanation
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. DURING FY2018, TAYLORVILLE MEMORIAL HOSPITAL BECAME THE SOLE CORPORATE MEMBER OF TAYLORVILLE MEMORIAL HOSPITAL FOUNDATION, WHICH IS INCLUDED IN THE GROUP RETURN.

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
PART VII	COMPENSATION REPORTED FOR CERTAIN INDIVIDUALS ARE BASED ON THE EMPLOYER WHO ISSUED PAYMENT HOURS ARE REPORTED TO REFLECT AVERAGE HOURS IN THEIR OPERATIONAL ROLE

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART IX, LINE 11G	PHYSICIAN SERVICES PROGRAM SERVICE EXPENSES 87,408,165 MANAGEMENT AND GENERAL EXPENSES 1,415,643 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 88,823,808 CONTRACT LABOR PROGRAM SERVICE EXPENSES 3,696,262 MANAGEMENT AND GENERAL EXPENSES 401,711 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 4,097,973 PURCHASED SERVICES PROGRAM SERVICE EXPENSES 25,605,569 MANAGEMENT AND GENERAL EXPENSES 8,524,254 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 34,129,823 PROFESSIONAL FEES PROGRAM SERVICE EXPENSES 1,088,039 MANAGEMENT AND GENERAL EXPENSES 2,398,771 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 3,486,810

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	CHANGE IN MINIMUM PENSION LIABILITY 16,605,147 TRANSFERS TO RELATED ORGANIZATIONS -8,523,771 BOOK/TAX DIFFERENCE 1,762,109 OTHER -899,493 NONOPERATING NET PERIOD BENEFIT COST -3,375,011

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.

OMB No 1545-0047

2017

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) MEMORIAL EXPRESSCARE LLC 701 NORTH FIRST STREET SPRINGFIELD, IL 62781 26-3400528	PROVIDES NON-EMERGENCY CARE SEVEN DAYS A WEEK WITHOUT APPOINTMENT	IL	0	0	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)	LINE 7	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)	LINE 7	MEMORIAL HEALTH SYSTEM	Yes	
(3) MEMORIAL HEALTH SYSTEM 701 NORTH FIRST ST SPRINGFIELD, IL 62781 37-1110690	PARENT	IL	501(C)(3)	LINE 12B, 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
(1) 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	10,485,006	12,354,515	100 000 %	Yes	
(2) PASSAVANT PHYSICIAN ASSOCIATION 1600 WEST WALNUT STREET JACKSONVILLE, IL 62650 26-1200566	PHYSICIAN SERVICES	IL	PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION	C	2,633,968	874,618	100 000 %	Yes	
(3) 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
a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity	1a Yes	
b Gift, grant, or capital contribution to related organization(s)	1b Yes	
c Gift, grant, or capital contribution from related organization(s)	1c Yes	
d Loans or loan guarantees to or for related organization(s)	1d	No
e Loans or loan guarantees by related organization(s)	1e	No
f Dividends from related organization(s)	1f	No
g Sale of assets to related organization(s)	1g Yes	
h Purchase of assets from related organization(s)	1h Yes	
i Exchange of assets with related organization(s)	1i	No
j Lease of facilities, equipment, or other assets to related organization(s)	1j Yes	
k Lease of facilities, equipment, or other assets from related organization(s)	1k Yes	
l Performance of services or membership or fundraising solicitations for related organization(s)	1l Yes	
m Performance of services or membership or fundraising solicitations by related organization(s)	1m Yes	
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	1n Yes	
o Sharing of paid employees with related organization(s)	1o Yes	
p Reimbursement paid to related organization(s) for expenses	1p Yes	
q Reimbursement paid by related organization(s) for expenses	1q Yes	
r Other transfer of cash or property to related organization(s)	1r Yes	
s Other transfer of cash or property from related organization(s)	1s 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	245,654	COST BASIS
(2) MEMORIAL HOME SERVICES OF CENTRAL ILLINOIS INC	K	124,442	COST - RENTAL EQUIPMENT
(3) MEMORIAL HOME SERVICES OF CENTRAL ILLINOIS INC	H	122,603	COST BASIS
(4) PASSAVANT PHYSICIAN ASSOCIATION	R	2,507,052	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)