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Form 990

Return of Organization Exempt From Income Tax

OMB No 1545-0047

2018

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

Go to www.irs.gov/Form990 for instructions and the latest information.

A For the 2019 calendar year, or tax year beginning 10-01-2018 , and ending 09-30-2019

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

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)

152

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

109

5 Total number of individuals employed in calendar year 2018 (Part V, line 2a)

7,470

6 Total number of volunteers (estimate if necessary)

2,359

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

8,036,495

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

0

Revenue

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

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

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

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

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

Prior Year

6,134,050

973,596,468

62,224,430

18,456,223

1,060,411,171

Current Year

6,660,344

1,010,061,527

19,222,793

18,025,005

1,053,969,669

Expenses

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

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

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

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

b Total fundraising expenses (Part IX, column (D), line 25) ▶350,908

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

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

19 Revenue less expenses Subtract line 18 from line 12

5,729,917

0

423,332,994

0

535,729,543

964,792,454

95,618,717

571,498,817

1,010,025,509

43,944,160

Net Assets or Fund Balances

20 Total assets (Part X, line 16)

21 Total liabilities (Part X, line 26)

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

Beginning of Current Year

1,433,434,091

514,905,190

918,528,901

End of Year

1,448,446,551

482,421,120

966,025,431

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

2020-08-17

Date

KATHRYN J KEIM SR VICE PRESIDENT & CFO

Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name

Preparer's signature

Date

Check ☐ if self-employed

PTIN P01622613

Firm's name ▶ ERNST & YOUNG US LLP

Firm's EIN ▶ 34-6565596

Firm's address ▶ 155 N WACKER DRIVE

CHICAGO, IL 60606

Phone no (312) 879-2000

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 (2018)

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

TO IMPROVE THE HEALTH OF THE PEOPLE AND COMMUNITIES WE SERVE

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

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

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

If "Yes," describe these changes on Schedule O

**4** Describe the organization's program service accomplishments for each of its three largest program services, as measured by expenses. Section 501(c)(3) and 501(c)(4) organizations are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported**4a** (Code ) (Expenses \$ 767,569,676 including grants of \$ 8,637,776 ) (Revenue \$ 951,727,513 )

See Additional Data

**4b** (Code ) (Expenses \$ 73,296,020 including grants of \$ 27,922 ) (Revenue \$ 49,843,372 )

See Additional Data

**4c** (Code ) (Expenses \$ 7,564,136 including grants of \$ 12,127 ) (Revenue \$ 8,728,318 )

See Additional Data

(Code ) (Expenses \$ 1,964,123 including grants of \$ 1,964,123 ) (Revenue \$ )

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 FY2019, MMCF PROVIDED \$1,277,625 IN GRANTS TO ORGANIZATIONS. THIS INCLUDED \$746,650 IN GRANTS TO MEMORIAL HEALTH SYSTEM AFFILIATES, \$321,083 IN GRANTS TO SOUTHERN ILLINOIS UNIVERSITY SCHOOL OF MEDICINE, AND \$209,892 IN GRANTS TO THE COMMUNITY NONPROFITS. IN FY2019, MMCF PROVIDED \$197,146 IN GRANTS TO INDIVIDUALS. THESE GRANTS INCLUDE PATIENT ASSISTANCE OF \$138,469, EDUCATIONAL GRANTS AND CERTIFICATION REIMBURSEMENTS OF \$40,603, AND ASSISTANCE TO MHS COLLEAGUES WITH CATASTROPHIC EVENTS OF \$18,074. IN FY2019, TMHF AWARDED \$103,383 IN GRANTS TO THE COMMUNITY AND TMH. SPECIFICALLY, \$33,276 IN GRANTS WERE PROVIDED TO SUPPORT PATIENT CARE, INCLUDING DISTRIBUTIONS FROM THE CUPS FUND. A MAMMOGRAPHY ASSISTANCE PROGRAM PROVIDED TO WOMEN IN CHRISTIAN COUNTY WHO WERE UNINSURED OR DO NOT HAVE HEALTH INSURANCE. EDUCATION AND PROFESSIONAL CERTIFICATION GRANTS TOTALING \$37,108 WERE AWARDED TO BENEFIT THOSE PURSUING ADVANCED CERTIFICATIONS AND POST-SECONDARY EDUCATION IN NURSING AND OTHER HEALTHCARE RELATED FIELDS. COMMUNITY HEALTH OUTREACH GRANTS TOTALING \$26,656 WHICH INCLUDED GRANTS FOR PEDIATRIC DENTISTRY AND GRANTS FOR THE CATCH PROGRAM. NON-EDUCATION COLLEAGUE RELATED GRANTS TOTALING \$6,343, WHICH CONSISTS MOSTLY OF THE COLLEAGUE EMERGENCY FUND WHICH HELPS TMH COLLEAGUES FINANCIALLY WHILE THEY ARE SICK, HURT, OR NATURAL DISASTER STRIKES. IN FY2019, PAHF PROVIDED \$385,969 IN GRANTS AND OTHER ASSISTANCE. A TOTAL OF \$305,759 WAS GRANTED TO PAH, \$48,560 FOR GENERAL SUPPORT, \$50,250 FOR DEFIBRILLATORS, \$169,000 TO HEALTHY JACKSONVILLE, \$18,124 PARTIAL BHU PFS ASSISTANCE, \$14,386 FOR LIFELINE PROGRAM SUPPORT AND \$5,439 FOR EMS TRAINING COURSES AND EQUIPMENT. THE PURPOSE OF THE EMS GRANTS WAS TO STRENGTHEN FIRST RESPONDER CAPACITY IN THE VOLUNTEER EMS AGENCIES. THE PURPOSE OF THE EMS GRANTS WAS TO STRENGTHEN FIRST RESPONDER CAPACITY IN THE VOLUNTEER EMS AGENCIES. THE PURPOSE OF THE HEALTHY JACKSONVILLE GRANT WAS TO ASSIST PEOPLE IN THE COMMUNITY WITH FIRST NEEDS. IN ADDITION, COMMUNITIES IN PAH'S FIVE-COUNTY SERVICE AREA ALSO BENEFITED FROM FREE CANCER AND HEALTH SCREENINGS. JACKSONVILLE SCHOOL DISTRICT WAS GRANTED \$21,000 FOR COMMUNITY REHABILITATION. VARIOUS COMMUNITY EMS WERE GRANTED A TOTAL OF \$15,541 FOR FIRST RESPONDER TRAINING AND EQUIPMENT. MACMURRY COLLEGE WAS GRANTED \$8,020 FOR EQUIPMENT. WESTERN IL YOUTH CAMP WAS GRANTED \$1,920 FOR CHILDREN ASSISTANCE. PHILIPS LIFELINE WAS GRANTED \$1,881 FOR COMMUNITY LIFELINE SERVICES. GRANTS TO INDIVIDUALS FOR EDUCATIONAL ASSISTANCE \$28,025 AND COLLEAGUE ASSISTANCE \$3,823.

**4d** Other program services (Describe in Schedule O )  
(Expenses \$ 1,964,123 including grants of \$ 1,964,123 ) (Revenue \$ )**4e** Total program service expenses **▶** 850,393,955

**Part IV Checklist of Required Schedules**

	Yes	No
<b>1</b> Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A	<b>1</b> Yes	
<b>2</b> Is the organization required to complete Schedule B, Schedule of Contributors (see instructions)?	<b>2</b> Yes	
<b>3</b> Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? If "Yes," complete Schedule C, Part I	<b>3</b>	No
<b>4 Section 501(c)(3) organizations.</b> Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? If "Yes," complete Schedule C, Part II	<b>4</b> Yes	
<b>5</b> Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? If "Yes," complete Schedule C, Part III	<b>5</b>	No
<b>6</b> Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? If "Yes," complete Schedule D, Part I	<b>6</b>	No
<b>7</b> Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? If "Yes," complete Schedule D, Part II	<b>7</b>	No
<b>8</b> Did the organization maintain collections of works of art, historical treasures, or other similar assets? If "Yes," complete Schedule D, Part III	<b>8</b>	No
<b>9</b> Did the organization report an amount in Part X, line 21 for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? If "Yes," complete Schedule D, Part IV	<b>9</b>	No
<b>10</b> Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? If "Yes," complete Schedule D, Part V	<b>10</b> Yes	
<b>11</b> If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable		
<b>a</b> Did the organization report an amount for land, buildings, and equipment in Part X, line 10? If "Yes," complete Schedule D, Part VI	<b>11a</b> Yes	
<b>b</b> Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VII	<b>11b</b>	No
<b>c</b> Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part VIII	<b>11c</b>	No
<b>d</b> Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? If "Yes," complete Schedule D, Part IX	<b>11d</b>	No
<b>e</b> Did the organization report an amount for other liabilities in Part X, line 25? If "Yes," complete Schedule D, Part X	<b>11e</b> Yes	
<b>f</b> Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? If "Yes," complete Schedule D, Part X	<b>11f</b> Yes	
<b>12a</b> Did the organization obtain separate, independent audited financial statements for the tax year? If "Yes," complete Schedule D, Parts XI and XII	<b>12a</b>	No
<b>b</b> Was the organization included in consolidated, independent audited financial statements for the tax year? If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional	<b>12b</b> Yes	
<b>13</b> Is the organization a school described in section 170(b)(1)(A)(ii)? If "Yes," complete Schedule E	<b>13</b>	No
<b>14a</b> Did the organization maintain an office, employees, or agents outside of the United States?	<b>14a</b>	No
<b>b</b> Did the organization have aggregate revenues or expenses of more than \$10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at \$100,000 or more? If "Yes," complete Schedule F, Parts I and IV	<b>14b</b>	No
<b>15</b> Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? If "Yes," complete Schedule F, Parts II and IV	<b>15</b>	No
<b>16</b> Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? If "Yes," complete Schedule F, Parts III and IV	<b>16</b>	No
<b>17</b> Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? If "Yes," complete Schedule G, Part I (see instructions)	<b>17</b>	No
<b>18</b> Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? If "Yes," complete Schedule G, Part II	<b>18</b> Yes	
<b>19</b> Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? If "Yes," complete Schedule G, Part III	<b>19</b> Yes	
<b>20a</b> Did the organization operate one or more hospital facilities? If "Yes," complete Schedule H	<b>20a</b> Yes	
<b>b</b> If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	<b>20b</b> Yes	
<b>21</b> Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? If "Yes," complete Schedule I, Parts I and II	<b>21</b> Yes	
<b>22</b> Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? If "Yes," complete Schedule I, Parts I and III	<b>22</b> Yes	

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

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

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

		Yes	No
<b>1a</b>	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable . . . . .	<b>1a</b> 421	
<b>b</b>	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable . . . . .	<b>1b</b> 1	
<b>c</b>	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners? . . . . .	<b>1c</b> Yes	

<b>2a</b> Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return . . . . .		<b>2a</b>	7,470			
<b>b</b> If at least one is reported on line 2a, did the organization file all required federal employment tax returns? <b>Note.</b> If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)				<b>2b</b>	Yes	
<b>3a</b> Did the organization have unrelated business gross income of \$1,000 or more during the year? . . . .				<b>3a</b>	Yes	
<b>b</b> If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O . . . .				<b>3b</b>	Yes	
<b>4a</b> At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . . . .				<b>4a</b>		No
<b>b</b> If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)						
<b>5a</b> Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . . . .				<b>5a</b>		No
<b>b</b> Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?				<b>5b</b>		No
<b>c</b> If "Yes," to line 5a or 5b, did the organization file Form 8886-T? . . . . .				<b>5c</b>		
<b>6a</b> Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . . .				<b>6a</b>	Yes	
<b>b</b> If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible? . . . . .				<b>6b</b>	Yes	
<b>7 Organizations that may receive deductible contributions under section 170(c).</b>						
<b>a</b> Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor? . . . . .				<b>7a</b>	Yes	
<b>b</b> If "Yes," did the organization notify the donor of the value of the goods or services provided? . . . . .				<b>7b</b>	Yes	
<b>c</b> Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282? . . . . .				<b>7c</b>		No
<b>d</b> If "Yes," indicate the number of Forms 8282 filed during the year . . . . .				<b>7d</b>		
<b>e</b> Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?				<b>7e</b>		No
<b>f</b> Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . . . .				<b>7f</b>		No
<b>g</b> If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required? . . . . .				<b>7g</b>		
<b>h</b> If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C? . . . . .				<b>7h</b>		
<b>8 Sponsoring organizations maintaining donor advised funds.</b> Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year? . . . . .						
				<b>8</b>		
<b>9a</b> Did the sponsoring organization make any taxable distributions under section 4966? . . . .				<b>9a</b>		
<b>b</b> Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . . .				<b>9b</b>		
<b>10 Section 501(c)(7) organizations.</b> Enter						
<b>a</b> Initiation fees and capital contributions included on Part VIII, line 12 . . . . .				<b>10a</b>		
<b>b</b> Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities				<b>10b</b>		
<b>11 Section 501(c)(12) organizations.</b> Enter						
<b>a</b> Gross income from members or shareholders . . . . .				<b>11a</b>		
<b>b</b> Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them ) . . . . .				<b>11b</b>		
<b>12a Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?						
<b>b</b> If "Yes," enter the amount of tax-exempt interest received or accrued during the year				<b>12b</b>		
<b>13 Section 501(c)(29) qualified nonprofit health insurance issuers.</b>						
<b>a</b> Is the organization licensed to issue qualified health plans in more than one state? <b>Note.</b> See the instructions for additional information the organization must report on Schedule O				<b>13a</b>		
<b>b</b> Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans . . . . .				<b>13b</b>		
<b>c</b> Enter the amount of reserves on hand . . . . .				<b>13c</b>		
<b>14a</b> Did the organization receive any payments for indoor tanning services during the tax year? . . . . .				<b>14a</b>		No
<b>b</b> If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O . . . .				<b>14b</b>		
<b>15</b> Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see instructions and file Form 4720, Schedule N . . . . .				<b>15</b>		No
<b>16</b> Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O . . . . .				<b>16</b>		No

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

**Section A. Governing Body and Management**

		Yes	No
<b>1a</b> Enter the number of voting members of the governing body at the end of the tax year	<b>1a</b> 152		
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>b</b> Enter the number of voting members included in line 1a, above, who are independent	<b>1b</b> 109		
<b>2</b> Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	<b>2</b>	Yes	
<b>3</b> Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	<b>3</b>		No
<b>4</b> Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	<b>4</b>		No
<b>5</b> Did the organization become aware during the year of a significant diversion of the organization's assets?	<b>5</b>		No
<b>6</b> Did the organization have members or stockholders?	<b>6</b>	Yes	
<b>7a</b> Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	<b>7a</b>	Yes	
<b>b</b> Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	<b>7b</b>	Yes	
<b>8</b> Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following			
<b>a</b> The governing body?	<b>8a</b>	Yes	
<b>b</b> Each committee with authority to act on behalf of the governing body?	<b>8b</b>	Yes	
<b>9</b> Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O	<b>9</b>		No

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

	Yes	No
<b>10a</b> Did the organization have local chapters, branches, or affiliates?	<b>10a</b>	No
<b>b</b> If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	<b>10b</b>	
<b>11a</b> Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	<b>11a</b>	Yes
<b>b</b> Describe in Schedule O the process, if any, used by the organization to review this Form 990		
<b>12a</b> Did the organization have a written conflict of interest policy? If "No," go to line 13	<b>12a</b>	Yes
<b>b</b> Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	<b>12b</b>	Yes
<b>c</b> Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done	<b>12c</b>	Yes
<b>13</b> Did the organization have a written whistleblower policy?	<b>13</b>	Yes
<b>14</b> Did the organization have a written document retention and destruction policy?	<b>14</b>	Yes
<b>15</b> Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?		
<b>a</b> The organization's CEO, Executive Director, or top management official	<b>15a</b>	Yes
<b>b</b> Other officers or key employees of the organization	<b>15b</b>	Yes
If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions)		
<b>16a</b> Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	<b>16a</b>	Yes
<b>b</b> If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	<b>16b</b>	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-A if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.  
☐ Own website ☐ Another's website ☒ Upon request ☐ Other (explain in Schedule O)

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

**20** State the name, address, and telephone number of the person who possesses the organization's books and records  
► KATHRYN J KEIM SENIOR VP & CFO 701 NORTH FIRST STREET SPRINGFIELD, IL 62781 (217) 788-3830

## Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

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]

**Part VII      Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees (continued)**

[illegible]

<b>1b Sub-Total</b>			
<b>c Total from continuation sheets to Part VII, Section A</b>			
<b>d Total (add lines 1b and 1c)</b>	12,825,374	20,874,454	2,934,117

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 ▶ 433

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

## Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
SIU SCHOOL OF MEDICINE PO BOX 19607 SPRINGFIELD, IL 627949607	PHYSICIAN SERVICES	38,042,126
HAROLD O'SHEA BUILDERS INC 3401 CONSTITUTION DR SPRINGFIELD, IL 62711	CONSTRUCTION	20,083,178
SPRINGFIELD CLINIC PO BOX 19260 SPRINGFIELD, IL 627049260	PHYSICIAN SERVICES	13,981,331
MID-AMERICA EMERGENCY PHYSICIANS INC KERBER ECK BRAECKEL LLP SPRINGFIELD, IL 62701	ER STAFFING	6,452,374
SIEMENS MEDICAL SOLUTIONS INC 40 LIBERTY BLVD MALVEM, PA 19355	MEDICAL EQUIPMENT	5,568,445

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 ► 136



## 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	3,270			
	b	Membership dues . . .	1b				
	c	Fundraising events . . .	1c	280,197			
	d	Related organizations	1d	1,422,290			
	e	Government grants (contributions)	1e	646,504			
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	4,308,083			
	g	Noncash contributions included in lines 1a - 1f \$		1,577,688			
	h	Total. Add lines 1a-1f . . . . .		6,660,344			
Program Service Revenue			Business Code				
	2a	PATIENT SERVICE REV	900099	935,717,499	935,717,499		
	b	PROGRAM RELATED REV	900099	63,687,888	63,687,888		
	c	HOSPICE SERVICES	621610	5,168,241	5,168,241		
	d	HOME HEALTH SERVICES	621610	3,526,856	3,526,856		
	e	PATHOLOGY EDUCATION &	561700	307,547	307,547		
	f	All other program service revenue		1,653,496	1,653,496		
	g	Total. Add lines 2a-2f . . . . .		1,010,061,527			
Other Revenue	3		Investment income (including dividends, interest, and other similar amounts) . . . . .	9,553,887		9,553,887	
	4		Income from investment of tax-exempt bond proceeds	14,629		14,629	
	5		Royalties . . . . .				
	6a	(i) Real	(ii) Personal				
	b	Less rental expenses					
	c	Rental income or (loss)					
	d	Net rental income or (loss) . . . . .		835,453	237,676	24,208	573,569
	7a	(i) Securities	(ii) Other				
	b	Less cost or other basis and sales expenses					
	c	Gain or (loss)					
	d	Net gain or (loss) . . . . .		9,654,277			9,654,277
	8a	Gross income from fundraising events (not including \$ 280,197 of contributions reported on line 1c) See Part IV, line 18 . . . . .		a	415,383		
b		Less direct expenses . . . . .	b	262,159			
c		Net income or (loss) from fundraising events . . . . .		153,224		153,224	
9a	Gross income from gaming activities See Part IV, line 19 . . . . .		a	145,904			
	b		Less direct expenses . . . . .	b	107,902		
	c		Net income or (loss) from gaming activities . . . . .		38,002		38,002
10a	Gross sales of inventory, less returns and allowances . . . . .		a				
	b		Less cost of goods sold . . . . .	b			
	c		Net income or (loss) from sales of inventory . . . . .				
Miscellaneous Revenue		Business Code					
11a	REFERENCE LAB REVENUE	621500	6,643,926		6,643,926		
b	CAFETERIA REVENUE	722320	5,536,857		264,401	5,272,456	
c	PROMPT PAY INTEREST	622110	1,334,207			1,334,207	
d	All other revenue . . . . .		3,483,336		1,103,960	2,379,376	
e	Total. Add lines 11a-11d . . . . .		16,998,326				
12	Total revenue. See Instructions . . . . .		1,053,969,669	1,010,299,203	8,036,495	28,973,627	

**Part IX Statement of Functional Expenses**

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

Check if Schedule O contains a response or note to any line in this Part IX ☒**Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.**

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21.	9,404,708	9,404,708		
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22.	1,237,240	1,237,240		
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, line 15 and 16.				
<b>4</b> Benefits paid to or for members.				
<b>5</b> Compensation of current officers, directors, trustees, and key employees.	8,965,865	6,908,499	1,980,032	77,334
<b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B).	111,361	60,985	50,376	
<b>7</b> Other salaries and wages.	330,072,542	289,153,765	40,738,099	180,678
<b>8</b> Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).	20,072,629	17,567,327	2,504,338	964
<b>9</b> Other employee benefits.	44,748,340	38,821,598	5,886,979	39,763
<b>10</b> Payroll taxes.	23,914,007	20,363,757	3,535,616	14,634
<b>11</b> Fees for services (non-employees):				
<b>a</b> Management.				
<b>b</b> Legal.	297,305		297,305	
<b>c</b> Accounting.	85,163		85,163	
<b>d</b> Lobbying.	123,608		123,608	
<b>e</b> Professional fundraising services. See Part IV, line 17.				
<b>f</b> Investment management fees.	1,056,380		1,056,380	
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O).	146,539,357	134,429,847	12,109,510	
<b>12</b> Advertising and promotion.	2,081,445	249,187	1,832,258	
<b>13</b> Office expenses.	15,470,002	13,352,208	2,104,001	13,793
<b>14</b> Information technology.	17,228,241	14,994,500	2,232,009	1,732
<b>15</b> Royalties.				
<b>16</b> Occupancy.	16,288,142	14,690,453	1,597,689	
<b>17</b> Travel.	706,513	546,157	160,356	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials.				
<b>19</b> Conferences, conventions, and meetings.	811,787	222,715	589,072	
<b>20</b> Interest.	11,435,405	11,435,405		
<b>21</b> Payments to affiliates.				
<b>22</b> Depreciation, depletion, and amortization.	46,800,354	36,517,998	10,282,356	
<b>23</b> Insurance.	6,500,181	622,105	5,878,076	
<b>24</b> Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O):				
<b>a</b> PATIENT SERV. SUPPLIES	100,633,670	100,633,670		
<b>b</b> MANAGEMENT FEE	59,363,948		59,363,948	
<b>c</b> PHARMACEUTICAL SUPPLIES	38,642,288	38,642,288		
<b>d</b> PURCHASED MEDICAL SERVI	33,097,609	33,097,609		
<b>e</b> All other expenses	74,337,419	67,441,934	6,873,475	22,010
<b>25</b> Total functional expenses. Add lines 1 through 24e.	1,010,025,509	850,393,955	159,280,646	350,908
<b>26</b> Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

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

				(A) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b>	Cash—non-interest-bearing . . . . .		5,491,351	<b>1</b>	7,901,820
	<b>2</b>	Savings and temporary cash investments . . . . .		119,815,046	<b>2</b>	111,881,733
	<b>3</b>	Pledges and grants receivable, net . . . . .		236,310	<b>3</b>	266,487
	<b>4</b>	Accounts receivable, net . . . . .		169,800,007	<b>4</b>	176,405,313
	<b>5</b>	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L . . . . .			<b>5</b>	
	<b>6</b>	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L . . . . .			<b>6</b>	
	<b>7</b>	Notes and loans receivable, net . . . . .		12,051,228	<b>7</b>	12,010,642
	<b>8</b>	Inventories for sale or use . . . . .		14,129,432	<b>8</b>	14,460,971
	<b>9</b>	Prepaid expenses and deferred charges . . . . .		8,463,207	<b>9</b>	6,807,041
	<b>10a</b>	Land, buildings, and equipment—cost or other basis. Complete Part VI of Schedule D . . . . .	<b>10a</b>	892,888,825		
	<b>b</b>	Less: accumulated depreciation . . . . .	<b>10b</b>	498,593,268		
				381,381,380	<b>10c</b>	394,295,557
	<b>11</b>	Investments—publicly traded securities . . . . .		589,450,250	<b>11</b>	592,160,484
	<b>12</b>	Investments—other securities. See Part IV, line 11 . . . . .		28,904,291	<b>12</b>	67,394,448
	<b>13</b>	Investments—program-related. See Part IV, line 11 . . . . .		9,280,544	<b>13</b>	8,346,368
	<b>14</b>	Intangible assets . . . . .			<b>14</b>	
<b>15</b>	Other assets. See Part IV, line 11 . . . . .		94,431,045	<b>15</b>	56,515,687	
<b>16</b>	<b>Total assets.</b> Add lines 1 through 15 (must equal line 34) . . . . .		1,433,434,091	<b>16</b>	1,448,446,551	
<b>Liabilities</b>	<b>17</b>	Accounts payable and accrued expenses . . . . .		100,842,730	<b>17</b>	114,021,380
	<b>18</b>	Grants payable . . . . .		528,509	<b>18</b>	773,248
	<b>19</b>	Deferred revenue . . . . .		1,127,920	<b>19</b>	789,782
	<b>20</b>	Tax-exempt bond liabilities . . . . .			<b>20</b>	
	<b>21</b>	Escrow or custodial account liability. Complete Part IV of Schedule D . . . . .			<b>21</b>	
	<b>22</b>	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L . . . . .			<b>22</b>	
	<b>23</b>	Secured mortgages and notes payable to unrelated third parties . . . . .		30,000,000	<b>23</b>	15,000,000
	<b>24</b>	Unsecured notes and loans payable to unrelated third parties . . . . .			<b>24</b>	
	<b>25</b>	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24). Complete Part X of Schedule D . . . . .		382,406,031	<b>25</b>	351,836,710
	<b>26</b>	<b>Total liabilities.</b> Add lines 17 through 25 . . . . .		514,905,190	<b>26</b>	482,421,120
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.</b>					
	<b>27</b>	Unrestricted net assets . . . . .		824,153,662	<b>27</b>	888,879,720
	<b>28</b>	Temporarily restricted net assets . . . . .		68,063,650	<b>28</b>	47,979,050
	<b>29</b>	Permanently restricted net assets . . . . .		26,311,589	<b>29</b>	29,166,661
	<b>Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.</b>					
	<b>30</b>	Capital stock or trust principal, or current funds . . . . .			<b>30</b>	
	<b>31</b>	Paid-in or capital surplus, or land, building or equipment fund . . . . .			<b>31</b>	
	<b>32</b>	Retained earnings, endowment, accumulated income, or other funds . . . . .			<b>32</b>	
<b>33</b>	<b>Total net assets or fund balances</b> . . . . .		918,528,901	<b>33</b>	966,025,431	
<b>34</b>	<b>Total liabilities and net assets/fund balances</b> . . . . .		1,433,434,091	<b>34</b>	1,448,446,551	

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	1,053,969,669
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	1,010,025,509
<b>3</b>	Revenue less expenses Subtract line 2 from line 1	<b>3</b>	43,944,160
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	<b>4</b>	918,528,901
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	501,438
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	32,655,042
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	-29,604,110
<b>10</b>	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	<b>10</b>	966,025,431

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

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

# Additional Data

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

Form 990 (2018)

**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 143,027 PATIENT DAYS, 28,305 DISCHARGES, AND 634,494 OUTPATIENT VISITS WERE PROVIDED BY THE HOSPITALS IN FY2019 IN FY2019, \$13 MILLION IN CHARITY CARE WAS PROVIDED BY MHS HOSPITALS JACKSONVILLE CRNA PROVIDES PROFESSIONAL CERTIFIED REGISTERED NURSE ANESTHETIST SERVICES TO THE COMMUNITIES IN THE PAH SERVICE AREA FOR FY 2019, SERVICES WERE PROVIDED FOR 5,599 CASES DURING FY2019, MMC COMPLETED SUCCESSFUL IMPLEMENTATION OF THE CERNER REVENUE CYCLE SYSTEM AS WELL AS RENOVATED EIGHT OPERATING ROOMS ADDITIONALLY, MMC RECEIVED A 3 YEAR CARF ACCREDITATION FOR ALL 5 OF MMC'S REHAB PROGRAM AREAS THIS WAS THE FIFTH TIME MMC RECEIVED THIS AWARD WHILE THERE ARE ONLY 78 OTHER REHAB PROGRAMS WORLDWIDE WHO HAVE AN ACCREDITATION FOR 4 OR MORE INPATIENT UNITS MMC ALSO RECEIVED 4 STATE JOURNAL REGISTER READER CHOICE AWARDS FOR BEST HOSPITAL, BEST EMERGENCY ROOM, BEST TRAUMA CENTER AND BEST SURGICAL WEIGHT LOSS CENTER FOR FY2019 IN FY2019, PAH BEGAN RENOVATIONS ON A 22 BED PATIENT UNIT ALL ROOMS WILL BE PRIVATE UPON COMPLETION, PROVIDING AN OVERALL IMPROVED PATIENT EXPERIENCE ADDITIONALLY, PAH BEGAN RENOVATIONS TO ITS PHARMACY TO COMPLY WITH UPDATED REGULATORY STANDARDS AND REQUIREMENTS THESE REQUIREMENTS PROVIDE STANDARDS TO ENSURE PATIENTS RECEIVE QUALITY PREPARATIONS THAT ARE FREE FROM CONTAMINANTS AND ARE CONSISTENT IN INTENDED IDENTITY, STRENGTH AND POTENCY ADDITIONALLY, IT PROVIDES STANDARDS FOR SAFE HANDLING OF HAZARDOUS DRUGS TO MINIMIZE THE RISK OF EXPOSURE TO HEALTHCARE PERSONNEL, PATIENTS, AND THE ENVIRONMENT IN FY2019, ALMH IMPLEMENTED A NEW MENTAL HEALTH PROGRAM SPECIFICALLY FOR THOSE 65 YEARS AND OLDER WITH TRADITIONAL MEDICARE PART B, SENIOR LIFE SOLUTIONS TREATMENT INCLUDES A 6-12 WEEK PROGRAM WITH 4 WEEKLY ALL DAY SESSIONS SESSIONS INCLUDE GROUP, INDIVIDUAL AND FAMILY THERAPY COMPLETION OF THE PROGRAM INCLUDES DISCHARGE PLANNING AND ONE YEAR OF AFTERCARE FOR ALL PATIENTS WHO COMPLETE THE PROGRAM IN FY2019, TMH IMPLEMENTED A SMALL AND RURAL HOSPITAL AWARD WINNING PROGRAM FOR COMMUNITY BASED FALL PREVENTION, GO STEADY THE PROGRAM FOCUS IS TO WORK WITH SENIORS WITHIN THE COMMUNITY TO ELIMINATE EMERGENCY ROOM PRESENTATIONS FOR FALLS TMH REHAB STAFF PARTNERED WITH LOCAL ASSISTED LIVING FACILITIES TO EDUCATE RESIDENTS, FAMILY AND CAREGIVERS ABOUT FALL PREVENTION POST-SCREENING INTERVENTIONS INCLUDE PHYSICAL THERAPY, VISION CHECK-UPS, FOOTWEAR MODIFICATION, MEDICATION REVIEW, AND MODIFIED EXERCISE PROGRAMS TO MEET RESIDENT NEEDS FOR BALANCE CHALLENGES

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

PHYSICIANS MEMORIAL PHYSICIAN SERVICES (MPS) IS A PROVIDER NETWORK OF 11 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. MPS PROVIDED 279,251 PRIMARY CARE PATIENTS VISITS AND 98,941 EXPRESSCARE VISITS FOR FY 2019. 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.

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

AMBULATORY & OTHER MEMORIAL HEALTH SYSTEM OPERATES THREE AMBULATORY AFFILIATES THAT ARE INCLUDED IN THE GROUP 990 RETURN: 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 INCLUDE 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. HOME HEALTH RECORDED A TOTAL OF 21,146 VISITS IN FY2019 AND 1,387 ADMISSIONS. THE HOSPICE AVERAGE DAILY CENSUS IN FY2019 WAS 91.4 DAYS WITH 682 ADMISSIONS, FOR A TOTAL OF 33,366 DAYS. 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 FY2019, 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. THE AMBULATORY SURGICAL TREATMENT CENTER COMPLETED 4,726 SURGICAL AND PAIN PROCEDURES IN FY2019. SRS PROVIDES HOUSING FACILITIES AND SERVICES TO NON-ELDERLY ADULTS DIAGNOSED WITH MENTAL ILLNESSES BY MEANS OF CONSTRUCTING A HUD HOUSING PROJECT. DURING FY2019, A TOTAL OF 17 CLIENTS RESIDED IN THE FACILITY.

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Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
AMIR JOHN WAHAB MD ..... BOARD MEMBER ALMH/MPS PHYSICIAN	50 00 ..... 0 00	X						627,424	0	76,188
GREG EIMER ..... 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/MPS PHYSICIAN	50 00 ..... 0 00	X						220,500	0	28,775
DON SIELAFF ..... BOARD MEMBER ALMH	0 70 ..... 0 00	X						0	0	0
RONALD SCHILLING ..... BOARD MEMBER ALMH(THRUJAN19)	0 70 ..... 0 00	X						0	0	0
CHRISTOPHER GRAUE ..... BOARD MEMBER ALMH	0 70 ..... 0 00	X						0	0	0
CHRISTINE SHORT ..... BOARD MEMBER ALMH(FROMFEB19)	0 70 ..... 0 70	X						0	0	0
JUNE KIDD ..... TREASALMH	1 40 ..... 0 00	X		X				0	0	0
KEITH SNYDER ..... SECALMH	1 40 ..... 0 00	X		X				0	0	0



Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
DAVID IRWIN ..... CHRELECTALMH(THRUJAN19)/CHRALMH	1 40 ..... 0 00	X		X				0	0	0
BRUCE CARMITCHEL ..... BRDMEM ALMH(THRUJAN19)/CHRELECTALMH	1 40 ..... 0 00	X		X				0	0	0
WILLIAM BATES ..... IMDPASTCHRALMH(THRUJAN19)/BRDMEMALMH	1 40 ..... 0 00	X		X				0	0	0
DAVID CAMPBELL ..... CHRALMH(THRUJAN19)/IMPASTCHRALMH	1 40 ..... 0 70	X		X				0	0	0
DERON POWELL ..... BOARD MEMBER ALMH(THRUJAN19)	0 70 ..... 0 70	X						0	0	0
MICHELLE BAUR ..... BOARD MEMBER ALMH(FROMFEB19)	0 70 ..... 0 00	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(FROMJAN19)	0 70 ..... 0 70	X						0	0	0
RICHARD LEVI ..... BOARD MEMBER MMC	0 70 ..... 0 00	X						0	0	0

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(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(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			
KEVIN COAKLEY MD ..... BOARD MEMBER MMC(THRUDEC18)	0 70 ..... 0 00	X						0	0	0
NINA HARRIS ..... BOARD MEMBER MMC	0 70 ..... 0 70	X						0	0	0
SERGIO PECORI ..... BOARD MEMBER MMC	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
RANDALL GERMERAAD ..... BOARD MEMBER MMC	0 70 ..... 0 70	X						0	0	0
JAMES REED JR ..... BRDMEEMMC/BRDMEEMMCF	1 10 ..... 0 00	X						0	0	0
TODD WISE ..... 2NDVICECHR MMC	1 40 ..... 1 40	X		X				0	0	0
DEAN ROBERT JR ..... 1STVICECHR MMC	1 40 ..... 1 40	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			
DALE BECKER ..... TREASURER MMC	1 40 ..... 1 40	X		X				0	0	0
DIANE RUTLEDGE PHD ..... CHAIR MMC	1 40 ..... 1 40	X		X				0	0	0
GEOFFREY ISRINGHAUSEN ..... SECRETARY MMC	1 40 ..... 1 40	X		X				0	0	0
JENNIFER ISRINGHAUSEN ..... BOARD MEMBER MMCF	0 20 ..... 0 00	X						0	0	0
DAVID GRIFFEN MD PHD ..... BOARD MEMBER MMCF	0 20 ..... 0 00	X						0	0	0
J WILLIAM ROBERTS ..... BOARD MEMBER MMCF	0 20 ..... 0 00	X						0	0	0
SUSAN GLEASON ..... BOARD MEMBER MMCF	0 30 ..... 0 00	X						0	0	0
J MARTIN GREEN ..... BOARD MEMBER MMCF	0 20 ..... 0 00	X						0	0	0
HENRY DALE SMITH JR ..... BOARD MEMBER MMCF	0 40 ..... 0 00	X						0	0	0
VALERA YAZELL ..... BOARD MEMBER MMCF	0 40 ..... 0 00	X						0	0	0

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(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(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			
CHERYL MARTIN ..... BOARD MEMBER MMCF	0 40 ..... 0 00	X						0	0	0
TRICIA NELSON BECKER ..... BOARD MEMBER MMCF	0 40 ..... 0 00	X						0	0	0
CHERRILYN MAYFIELD ..... TREASURER MMCF	0 40 ..... 0 00	X		X				0	0	0
G VIRGINIA CONLEE ..... SECRETARY MMCF	0 40 ..... 0 00	X		X				0	0	0
BRIDGET LAMONT ..... CHAIR MMCF	0 40 ..... 0 00	X		X				0	0	0
ROB PIETROBURGO ..... VICE CHAIR MMCF	0 40 ..... 0 00	X		X				0	0	0
ANTHONY GRIFFIN MD ..... BOARD MEMBER MPS/MPS PHYSICIAN	50 00 ..... 0 00	X						400,287	0	60,964
CHRISTOPHER RIVERA MD ..... BOARD MEMBER MPS/MPS PHYSICIAN	50 00 ..... 0 00	X						285,211	0	52,164
MARK HANSEN MD ..... CHAIR MPS/MPS PHYSICIAN	50 00 ..... 0 00	X		X				499,205	0	64,368
J TRAVIS DOWELL ..... PRESIDENT MPS & VP MPS	50 00 ..... 0 00	X		X				0	405,361	89,628

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
PAVI GILL MD JD ..... BOARD MEMBER TMH	0 70 ..... 0 00	X						0	0	0
M ADAM MATHIAS ..... BOARD MEMBER TMH	0 70 ..... 0 00	X						0	0	0
JOHN FERRY DDS ..... BOARD MEMBER TMH	0 70 ..... 0 00	X						0	0	0
BETH BROTHERTON JD ..... BOARD MEMBER TMH	0 70 ..... 0 00	X						0	0	0
ERIC KAHLE ..... BOARD MEMBER TMH	0 70 ..... 0 00	X						0	0	0
JOHN DANIEL LITTEKEN ..... BOARD MEMBER TMH	0 70 ..... 0 00	X						0	0	0
GARY SPURLING ..... BOARD MEMBER TMH	0 70 ..... 0 00	X						0	0	0
N TERESA FRANCE ..... BOARD MEMBER TMH (FROMJAN19)	0 70 ..... 0 00	X						0	0	0
ADAM VOCKS ..... TREASURER TMH	1 40 ..... 0 00	X		X				0	0	0
LINDA SMITH ..... SECRETARY TMH	1 40 ..... 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			
JUDGE RONALD SPEARS ..... VICE CHAIR TMH	1 40 ..... 0 00	X		X				0	0	0
JAMES ADCOCK ..... CHAIR TMH	1 40 ..... 0 00	X		X				0	0	0
WILLIAM COPE ..... BOARD MEMBER TMHF (THRUDEC18)	0 70 ..... 0 00	X						0	0	0
JUDITH SWIGERT ..... BOARD MEMBER TMHF	0 70 ..... 0 00	X						0	0	0
D JANE DAVIS ..... BOARD MEMBER TMHF (FROMJAN19)	0 70 ..... 0 00	X						0	0	0
KENT RICHARDSON ..... BOARD MEMBER TMHF	0 70 ..... 0 00	X						0	0	0
SHIRLEY DEFRATIES ..... BOARD MEMBER TMHF (FROMJAN19)	0 70 ..... 0 00	X						0	0	0
PENELOPE BLILER ..... BOARD MEMBER TMHF (THRUDEC18)	0 70 ..... 0 00	X						0	0	0
MATTHEW HUTCHISON ..... BOARD MEMBER TMHF (FROMJAN19)	0 70 ..... 0 00	X						0	0	0
GREGORY PATRICK ..... BOARD MEMBER TMHF	0 70 ..... 0 00	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
MARY MCNEELY ..... BOARD MEMBER TMHF (THRUDEC18)	0 70 ..... 0 00	X						0	0	0
JERRY GARDNER DDS ..... BOARD MEMBER TMHF	0 70 ..... 0 00	X						0	0	0
CHERYL HUGGINS ..... BOARD MEMBER TMHF	0 70 ..... 0 00	X						0	0	0
DAVID HIXENBAUGH ..... BOARD MEMBER TMHF (THRUDEC18)	0 70 ..... 0 00	X						0	0	0
MELISSA LIVINGSTON ..... 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	0 70 ..... 0 00	X						0	0	0
DENNIS KENNEDY ..... BOARD MEMBER TMHF	0 70 ..... 0 00	X						0	0	0
LORETTA KAHLE ..... BOARD MEMBER TMHF (FROMJAN19)	0 70 ..... 0 00	X						0	0	0
RONALD MIZER DDS ..... BOARD MEMBER TMHF (FROMJAN19)	0 70 ..... 0 00	X						0	0	0

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MICHELLE CAPELLIN ..... BOARD MEMBER TMHF	0 70 ..... 0 00	X						0	0	0
RAEDENA RYAN ..... EXECUTIVE DIRECTOR TMHF	50 00 ..... 0 00	X						74,685	0	37,507
DAVID BRUMMER ..... BRDMEMTMHF(THRU DEC18)/TREASURER	1 40 ..... 0 00	X		X				0	0	0
LINDSAY BARRY ..... SECRETARY TMHF	1 40 ..... 0 00	X		X				0	0	0
BILLY WILLIAMS ..... VICE PRES TMHF	1 40 ..... 0 00	X		X				0	0	0
MICHAEL BLAKEMAN ..... TREASTMHF(THRUDEC18)/BRDMEMTMHF	1 40 ..... 0 00	X		X				0	0	0
SCOTT MCCLURE ..... PRESIDENT TMHF	1 40 ..... 0 00	X		X				0	0	0
JOHN MILHISER ..... BOARD MEMBER SRS(THRU FEB19)	0 70 ..... 0 70	X						0	0	0
JENNIFER MORRISON ..... BOARD MEMBER SRS(THRU FEB19)	0 70 ..... 0 70	X						0	0	0
MICHAEL O'SHEA ..... BOARD MEMBER SRS(THRU FEB19)	0 70 ..... 0 70	X						0	0	0



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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
VIRGINIA DOLAN MD ..... BOARD MEMBER SRS (FROMMAR19)	0 70 .....	X						496,743	0	62,965
NICOLE FLORENCE MD ..... BOARD MEMBER SRS (FROMMAR19)	0 70 .....	X						491,286	0	60,066
ANNE MORGAN PHD ..... BOARD MEMBER SRS (FROMMAR19)	0 70 .....	X						0	0	0
SAIF MOUILISH ..... BOARD MEMBER SRS (FROMMAR19)	0 70 .....	X						0	0	0
SCOTT SABIN ..... BOARD MEMBER SRS (FROMMAR19)	0 70 .....	X						0	0	0
ERICA SMITH ..... BOARD MEMBER SRS (FROMMAR19)	0 70 .....	X						0	0	0
JANET STOVER ..... BOARD MEMBER SRS (FROMMAR19)	0 70 .....	X						0	0	0
IRIS WESLEY ..... BOARD MEMBER SRS (FROMMAR19)	0 70 .....	X						0	0	0
KENNY WINSLOW ..... BOARD MEMBER SRS (FROMMAR19)	0 70 .....	X						0	0	0
KARI WOLF MD ..... BOARD MEMBER SRS (FROMMAR19)	0 70 .....	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
DANIEL WRIGHT ..... BOARD MEMBER SRS (FROMMAR19)	0 70 .....	X						0	0	0
LEIGH STEINER PHD ..... SEC SRS(THRUFE19)/CHAIRSRS	1 40 .....	X		X				0	3,125	0
WANDA LEE ROHLFS ..... BRDMEMSR(S(THRUFE19)/TREASURERSRS	1 40 .....	X		X				0	0	0
BRENT BORAH ..... TREASSRS(THRUFE19)/VICECHAIRSRS	1 40 .....	X		X				0	0	0
TIFFANY NIELSON ..... SECRETARY SRS(FROMMAR19)	1 40 .....	X		X				0	0	0
CATHERINE GONZALEZ JD ..... VICE CHAIR SRS (THRUFE19)	1 40 .....	X		X				0	0	0
SANDY ROBINSON II ..... CHAIRSRS(THRUFE19)/BRDMEMSR(S	1 40 .....	X		X				0	0	0
TAMAR KUTZ ..... BOARD MEMBER MHSVC	50 00 .....	X						0	202,783	13,922
JAMESON ROSZHART ..... BMMHVMPSCRMHSVC/VPAMNT(TRMY19)PRSAMG	35 00 .....	X		X				0	338,363	73,998
HARRY SCHMIDT ..... BMMH(SVC(TRJN19)PRSC(EOPAHCRNA(TRJN19)	50 00 .....	X		X				0	352,581	146,226

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
W SCOTT BOSTON MD ..... BRD MEM MHSVC/PRES & CEO PAH,CRNA	50 00 ..... 0 00	X		X				0	0	0
DOLAN DALPOAS ..... PRESIDENT ALMH/BRDMEM MHSVC/CEOALMH	49 30 ..... 0 70	X		X				0	423,074	55,859
KIMBERLY BOURNE ..... PRES TMH&TMHF/BRDMMHMSVC/CEOTMH	50 00 ..... 0 00	X		X				0	346,862	80,423
EVAN DAVIS ..... BMMHV/ADMINORTHQ(TRMAY19)/VPCLINOPS	50 00 ..... 0 00	X						227,109	0	23,707
KATHRYN KEIM ..... SCTRSMHVMHSCMPS/VPFN(TRDC18)/SVPCFO	25 00 ..... 25 00	X		X				0	317,283	72,489
EDGAR CURTIS ..... PRES&CEOMHS/PRESMMC(THRUMAY19)/BMMPS	25 00 ..... 25 00	X		X				0	10,801,187	140,392
ROBERT KAY ..... SVPCFO(TRMR19)/SCTRSMHSCMPS(TRDC18)	25 00 ..... 25 00	X		X				0	4,671,741	213,793
KEVIN ENGLAND ..... VCPSMHV/VCMHSCVC/SVPBD(TRMY19)/SVPCAO	25 00 ..... 25 00	X		X				0	430,006	187,879
CHARLES CALLAHAN PHD ..... EVPCOMMC(TRMY19) PRCEOMMCPRSMHSCCRMHV/BMMPS(TRJN19)	25 00 ..... 25 00	X		X				747,382	0	204,897
DOUGLAS AWE ..... BRDMEPAH(THRUDEC18)SECPAH/BRDMPAHF	1 40 ..... 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			
NANCY SPANGENBERG ..... BRDMEMPAH/PAHF	0 70 ..... 0 00	X						0	0	0
KELLY STAAKE ..... BRDMEMPAH(THRUDEC18)TREASPAH	1 40 ..... 0 00	X		X				0	0	0
GREG LEPPER ..... IMMEDPCHPAH(THRUDEC18)/BRDMEMPAH	1 40 ..... 0 00	X		X				0	0	0
REGINALD BENTON ..... CHAIRPAH(THRUDEC18)IPCHAIRPAH	1 40 ..... 0 70	X		X				0	0	0
GARY SCOTT ..... TREASURERPAH(THRUDEC18)/CELECTPAH	1 40 ..... 0 00	X		X				0	0	0
THOMAS VEITH ..... CELECTPAH(THRUDEC18)/CHAIRPAH	1 40 ..... 0 00	X		X				0	0	0
GINNY FANNING ..... VP OF NOMINATIONS PAHF, PAH BRDMEM	1 40 ..... 0 70	X		X				0	0	0
JAMES HINCHEN MD ..... SECPAH(THRUDEC18)/BMPAH/BMPAHF	1 40 ..... 0 00	X		X				0	0	0
FRANK CUMMINGS ..... BOARD MEMBER PAHF(THRUDEC18)	0 70 ..... 0 00	X						0	0	0
ALBAN HAXHINASTO ..... BOARD MEMBER PAHF	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			
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
ANN PRATHER ..... BOARD MEMBER PAHF	0 70 ..... 0 00	X						0	0	0
MARY FERGURSON ..... PAHF PRESIDENT	1 40 ..... 0 00	X		X				0	0	0
LINDA DONOVAN ..... VP OF STEWARDSHIP AND GIFTS PAHF	1 40 ..... 0 00	X		X				0	0	0
CHESTER WYNN ..... SECRETARY PAHF	1 40 ..... 0 00	X		X				0	0	0
STEVE TURNER ..... TREASURER PAHF	1 40 ..... 0 00	X		X				0	0	0
JANICE GAMBACH ..... PRESIDENT SRS, ADMIN MBH	2 50 ..... 47 50			X				0	220,938	25,733
MELISSA HANSEN-SCHMADEKE ..... EXECDIRMMCF(FROMJAN18)	50 00 ..... 0 00				X			150,601	0	15,443

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			
MARSHA PRATER PHD .....	50 00 .....				X			3,921,726	0	101,156
SVP & CNO MMC .....	0 00 .....				X					
LINDA JONES DNS .....	50 00 .....				X			658,196	0	56,510
VP OPS MMC(THRUMAY19)/VP ANCOPS .....	0 00 .....				X					
DREW EARLY .....	50 00 .....				X			329,925	0	75,368
VP OPERATIONS (THRUMAY19)/VP,INT&SPECPROJ .....	0 00 .....				X					
ANNA EVANS JD .....	25 00 .....				X			0	528,119	150,240
GENCO/VPACOMPMHS(TRMAY19)/SVP&GENCO MHS .....	25 00 .....				X					
RAJESH GOVINDAIAH MD .....	25 00 .....				X			0	686,627	90,523
SVP & CMO MHS .....	25 00 .....				X					
DAVID GRAHAM MD .....	25 00 .....				X			0	696,324	181,661
SVP & CIO MHS(THRUMAY19)/SVP&CQ&IO MHS .....	25 00 .....				X					
ROBERT SCOTT .....	25 00 .....				X			0	450,080	73,208
VP & CHRO MHS(THRUMAY19)/SVP & CHRO MHS .....	25 00 .....				X					
JENNIFER HARRIS .....	50 00 .....				X			236,830	0	16,182
ADMIN,PERIOP(TRMAY19)/SYSADM,PERIOP .....	0 00 .....				X					
MITCHELL ROGERS .....	50 00 .....				X			302,340	0	41,409
SYSTEM ADMIN CARDIO SVCS .....	0 00 .....				X					
FERDINAND SALVACION MD .....	50 00 .....					X		680,948	0	130,436
PHYSICIAN MMC .....	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			
STEVEN LILLOPOP MD ..... PHYSICIAN MPS	50 00 ..... 0 00					X		646,890	0	76,311
CHRISTINA SCHEIBLER-VENTRESS MD ..... PHYSICIAN MPS	50 00 ..... 0 00					X		611,164	0	52,528
DAVID SANDERCOCK MD ..... PHYSICIAN MPS	50 00 ..... 0 00					X		613,697	0	70,422
GUSTAVO MOSQUERA MD ..... PHYSICIAN MPS	50 00 ..... 0 00					X		603,225	0	30,777



## TY 2018 Affiliate Listing

**Name:** MEMORIAL HEALTH SYSTEM GROUP

**EIN:** 90-0756744

### TY 2018 Affiliate Listing

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

<b>SCHEDULE A</b> (Form 990 or 990-EZ)	<b>Public Charity Status and Public Support</b> Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust. ▶ Attach to Form 990 or Form 990-EZ. ▶ Go to <a href="http://www.irs.gov/Form990">www.irs.gov/Form990</a> for the latest information.	OMB No 1545-0047
		<b>2018</b>
		<b>Open to Public Inspection</b>
Department of the Treasury Internal Revenue Service	<b>Name of the organization</b> MEMORIAL HEALTH SYSTEM GROUP	<b>Employer identification number</b> 90-0756744

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

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

- 1

☐

A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
- 2

☐

A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ) )
- 3

☐

A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4

☐

A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state
- 5

☐

An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II )
- 6

☐

A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7

☒

An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II )
- 8

☐

A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II )
- 9

☐

An agricultural research organization described in **170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture See instructions Enter the name, city, and state of the college or university
- 10

☐

An organization that normally receives (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2).** (Complete Part III )
- 11

☐

An organization organized and operated exclusively to test for public safety See **section 509(a)(4).**
- 12

☐

An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g
- a

☐

**Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization **You must complete Part IV, Sections A and B.**
- b

☐

**Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s) **You must complete Part IV, Sections A and C.**
- c

☐

**Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions) **You must complete Part IV, Sections A, D, and E.**
- d

☐

**Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions) **You must complete Part IV, Sections A and D, and Part V.**
- e

☐

Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization
- f

Enter the number of supported organizations
- g

Provide the following information about the supported organization(s)

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

Part II

Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv), 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) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
1	Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant ")	10,672,422	2,108,711	1,969,241	1,627,489	3,586,238	19,964,101
2	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3	The value of services or facilities furnished by a governmental unit to the organization without charge						
4	<b>Total.</b> Add lines 1 through 3	10,672,422	2,108,711	1,969,241	1,627,489	3,586,238	19,964,101
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)						7,446,065
6	<b>Public support.</b> Subtract line 5 from line 4						12,518,036

Section B. Total Support							
Calendar year (or fiscal year beginning in) ►		(a)2014	(b)2015	(c)2016	(d)2017	(e)2018	(f)Total
7	Amounts from line 4	10,672,422	2,108,711	1,969,241	1,627,489	3,586,238	19,964,101
8	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources	643,908	635,765	667,454	617,110	809,941	3,374,178
9	Net income from unrelated business activities, whether or not the business is regularly carried on	10,334	10,053	10,269	6,619	6,055	43,330
10	Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI )	441,129	445,285	442,508	463,291	561,287	2,353,500
11	<b>Total support.</b> Add lines 7 through 10						25,735,109
12	Gross receipts from related activities, etc. (see instructions)					12	63,091,472
13	<b>First five years.</b> If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and <b>stop here</b> . . . . . ► <input type="checkbox"/>						

Section C. Computation of Public Support Percentage		
<b>14</b>	Public support percentage for 2018 (line 6, column (f) divided by line 11, column (f))	<b>14</b> 48.640 %
<b>15</b>	Public support percentage for 2017 Schedule A, Part II, line 14	<b>15</b> 52.720 %
<b>16a</b>	<b>33 1/3% support test—2018.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization. ► <input checked="" type="checkbox"/>	
<b>b</b>	<b>33 1/3% support test—2017.</b> If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization. ► <input type="checkbox"/>	
<b>17a</b>	<b>10%-facts-and-circumstances test—2018.</b> If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization. ► <input type="checkbox"/>	
<b>b</b>	<b>10%-facts-and-circumstances test—2017.</b> If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and <b>stop here.</b> Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization. ► <input type="checkbox"/>	
<b>18</b>	<b>Private foundation.</b> If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions. ► <input type="checkbox"/>	

**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) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
<b>1</b> Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
<b>2</b> Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
<b>3</b> Gross receipts from activities that are not an unrelated trade or business under section 513						
<b>4</b> Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
<b>5</b> The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>6 Total.</b> Add lines 1 through 5						
<b>7a</b> Amounts included on lines 1, 2, and 3 received from disqualified persons						
<b>b</b> Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
<b>c</b> Add lines 7a and 7b						
<b>8 Public support.</b> (Subtract line 7c from line 6.)						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
<b>9</b> Amounts from line 6						
<b>10a</b> Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
<b>b</b> Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
<b>c</b> Add lines 10a and 10b						
<b>11</b> Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
<b>12</b> Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
<b>13 Total support.</b> (Add lines 9, 10c, 11, and 12.)						

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

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

<b>15</b> Public support percentage for 2018 (line 8, column (f) divided by line 13, column (f))	<b>15</b>	
<b>16</b> Public support percentage from 2017 Schedule A, Part III, line 15	<b>16</b>	

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

<b>17</b> Investment income percentage for <b>2018</b> (line 10c, column (f) divided by line 13, column (f))	<b>17</b>	
<b>18</b> Investment income percentage from <b>2017</b> Schedule A, Part III, line 17	<b>18</b>	

**19a 33 1/3% support tests—2018.** 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—2017.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ► ☐

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

**Part IV Supporting Organizations**

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

**Section A. All Supporting Organizations**

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

Part IV

Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

<b>Part V</b> <b>Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations</b>			
<div>1</div> <div><input type="checkbox"/></div> <div>Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970 (explain in Part VI). <b>See instructions.</b> All other Type III non-functionally integrated supporting organizations must complete Sections A through E.</div>			
<b>Section A - Adjusted Net Income</b>		(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	<b>Adjusted Net Income</b> (subtract lines 5, 6 and 7 from line 4)	8	
<b>Section B - Minimum Asset Amount</b>		(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	<b>Total</b> (add lines 1a, 1b, and 1c)	1d	
e	<b>Discount</b> 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	<b>Minimum Asset Amount</b> (add line 7 to line 6)	8	
<b>Section C - Distributable Amount</b>			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	<b>Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	
7	<div><input type="checkbox"/></div> 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 2018 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-2018	(iii) Distributable Amount for 2018
1 Distributable amount for 2018 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2018 (reasonable cause required-- explain in Part VI) See instructions			
3 Excess distributions carryover, if any, to 2018			
a From 2013. . . . .			
b From 2014. . . . .			
c From 2015. . . . .			
d From 2016. . . . .			
e From 2017. . . . .			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2018 distributable amount			
i Carryover from 2013 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2018 from Section D, line 7 \$			
a Applied to underdistributions of prior years			
b Applied to 2018 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2018, 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 2018 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 2019. Add lines 3j and 4c			
8 Breakdown of line 7			
a Excess from 2014. . . . .			
b Excess from 2015. . . . .			
c Excess from 2016. . . . .			
d Excess from 2017. . . . .			
e Excess from 2018. . . . .			



**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 2018: 99 3%; LINE 16 - PUBLIC SUPPORT PERCENTAGE FOR 2017: 99 3%.

**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.  
▶Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No 1545-0047

**2018**

**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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4a	Was a correction made?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 <b>Form 1120-POL</b> for this year?	<input type="checkbox"/> Yes <input type="checkbox"/> 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)	<b>(a)</b> 2015	<b>(b)</b> 2016	<b>(c)</b> 2017	<b>(d)</b> 2018	<b>(e)</b> Total
<b>2a</b> Lobbying nontaxable amount					
<b>b</b> Lobbying ceiling amount (150% of line 2a, column(e))					
<b>c</b> Total lobbying expenditures					
<b>d</b> Grassroots nontaxable amount					
<b>e</b> Grassroots ceiling amount (150% of line 2d, column (e))					
<b>f</b> Grassroots lobbying expenditures					

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

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

		(a)		(b)
		Yes	No	Amount
<b>1</b>	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
<b>a</b>	Volunteers?		No	
<b>b</b>	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
<b>c</b>	Media advertisements?		No	
<b>d</b>	Mailings to members, legislators, or the public?		No	
<b>e</b>	Publications, or published or broadcast statements?		No	
<b>f</b>	Grants to other organizations for lobbying purposes?	Yes		123,608
<b>g</b>	Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
<b>h</b>	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
<b>i</b>	Other activities?		No	
<b>j</b>	Total. Add lines 1c through 1i			123,608
<b>2a</b>	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
<b>b</b>	If "Yes," enter the amount of any tax incurred under section 4912			
<b>c</b>	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
<b>d</b>	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

**Part IV** Supplemental Information

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

Return Reference	Explanation
PART II-B, LINE 1	MEMORIAL HEALTH SYSTEM ENGAGES LOBBYISTS TO ASSIST IT IN SECURING FEDERAL GRANTS AND MONITORING STATE REGULATIONS IN SUPPORT OF FURTHERING MEMORIAL HEALTH SYSTEM'S MISSION, WHICH IS "TO IMPROVE THE HEALTH OF THE PEOPLE AND COMMUNITIES WE SERVE" THIS INCLUDES ASSISTING MEMORIAL HEALTH SYSTEM IN DEVELOPING PRESENTATIONS TO THE ILLINOIS CONGRESSIONAL DELEGATION REQUESTING APPROPRIATIONS FOR PRIORITY PROJECTS INVOLVING LOCAL PATIENT SAFETY, QUALITY IMPROVEMENT AND IMPROVED LOCAL ACCESS TO MEDICAL CARE THE LOBBYISTS ALSO ASSIST MEMORIAL IN COMMUNICATING THE IMPORTANCE OF ADEQUATE MEDICAID FUNDING IN SUPPORT OF THE SUBSTANTIAL SERVICES MEMORIAL'S AFFILIATES PROVIDE TO THOSE IN POVERTY AND IN MONITORING LEGISLATIVE AND REGULATORY DEVELOPMENTS THAT WOULD AFFECT MEMORIAL MEDICAL CENTER'S ABILITY TO CONTINUE DELIVERING ITS ALREADY SUBSTANTIAL COMMUNITY BENEFIT THE FOLLOWING ORGANIZATIONS PAID FUNDS TO HEALTHCARE ASSOCIATIONS TO AID AND ASSIST HOSPITALS AND HEALTHCARE ENTITIES REGARDING LEGISLATIVE CHANGES THESE COSTS INCLUDE AMOUNTS PAID DIRECTLY TO LOBBYISTS FROM THE VARIOUS ENTITIES AND ALSO INCLUDE AMOUNTS PAID INDIRECTLY TO LOBBYISTS THROUGH ASSOCIATION DUES MEMORIAL MEDICAL CENTER - \$61,487 PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION - \$22,667 ABRAHAM LINCOLN MEMORIAL HOSPITAL - \$16,193 TAYLORVILLE MEMORIAL HOSPITAL - \$19,974 MEMORIAL HOME SERVICES - \$3,287

SCHEDULE D  
(Form 990)

Department of the Treasury  
Internal Revenue Service

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.  
► Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization  
MEMORIAL HEALTH SYSTEM GROUP

Employer identification number  
90-0756744

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.  
Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

	(a) Donor advised funds	(b) Funds and other accounts
1 Total number at end of year		
2 Aggregate value of contributions to (during year)		
3 Aggregate value of grants from (during year)		
4 Aggregate value at end of year		

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?

☐ 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
a Total number of conservation easements	2a
b Total acreage restricted by conservation easements	2b
c Number of conservation easements on a certified historic structure included in (a)	2c
d Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register	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

b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items

(i) Revenue included on Form 990, Part VIII, line 1

► \$

(ii) Assets included in Form 990, Part X

► \$

2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items

a Revenue included on Form 990, Part VIII, line 1

► \$

b Assets included in Form 990, Part X

► \$

**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
<b>1c</b>	
<b>1d</b>	
<b>1e</b>	
<b>1f</b>	

**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
<b>1a</b> Beginning of year balance . . . . .	13,503,905	13,038,025	12,076,607	12,661,077	12,566,252
<b>b</b> Contributions . . . . .	761,484	9,674	17,776	14,970	1,107,070
<b>c</b> Net investment earnings, gains, and losses	425,684	980,412	1,357,336	678,147	-470,568
<b>d</b> Grants or scholarships . . . . .	40,603	150,431	22,448	905,339	189,207
<b>e</b> Other expenditures for facilities and programs . . . . .	349,039	284,028	298,395	280,079	263,145
<b>f</b> Administrative expenses . . . . .	99,068	89,747	92,851	92,169	89,325
<b>g</b> End of year balance . . . . .	14,202,363	13,503,905	13,038,025	12,076,607	12,661,077

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

**a** Board designated or quasi-endowment ▶ 14 070 %

**b** Permanent endowment ▶ 61 570 %

**c** Temporarily restricted endowment ▶ 24 360 %

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 . . . . .

**(ii)** related organizations . . . . .

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

	Yes	No
<b>3a(i)</b>		No
<b>3a(ii)</b>	Yes	
<b>3b</b>	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
<b>1a</b> Land . . . . .	11,126,960	9,612,498		20,739,458
<b>b</b> Buildings . . . . .	1,127,468	465,486,726	253,783,984	212,830,210
<b>c</b> Leasehold improvements		12,926,133	7,866,203	5,059,930
<b>d</b> Equipment . . . . .	5,623	283,143,342	211,372,686	71,776,279
<b>e</b> Other . . . . .		109,460,075	25,570,395	83,889,680
<b>Total.</b> Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c) ) . . . ▶				394,295,557

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
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 15 ) . . . . . ▶	

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 ) ▶	351,836,710

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



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

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

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

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

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

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

**Part XIII Supplemental Information**

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

Return Reference	Explanation
See Additional Data Table	

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

Return Reference	Explanation

**Additional Data**

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

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

1	(a) Description of Liability	(b) Book Value
	DEFERRED COMPENSATION	4,288,688
	ESTIMATED THIRD PARTY PAYOR SETTLEMENTS	46,820,410
	RESERVE FOR POST EMPLOYMENT BENEFITS	13,488,129
	SWAP LIABILITY	2,657,522
	WORKERS' COMPENSATION AND PROFESSIONAL LIABILITY	28,011,374
	ENVIRONMENTAL HAZARDS LIABILITY	1,319,028
	DUE TO AFFILIATES	1,267,052
	CHARITABLE GIFT ANNUITY PAYABLE	168,548
	OTHER PAYABLES	171,792
	SELF INSURANCE ACCRUAL	667,879

Form 990, Schedule D, Part X, - Other Liabilities	
1 (a) Description of Liability	(b) Book Value
SERP/RESTORATION PENSION PLAN	1,576,191
INTERCOMPANY DEBT TO MEMORIAL HEALTH SYSTEM (37-1110690)	248,942,565
MINIMUM PENSION LIABILITY	2,457,532

**Supplemental Information**

Return Reference	Explanation
PART V, LINE 4	<p>PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION'S ENDOWMENT CONSISTS OF 15 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	EACH OF MEMORIAL HEALTH SYSTEM'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 TAXES, NO TAX PROVISION WAS RECORDED FOR THE YEARS ENDED SEPTEMBER 30, 2019 OR 2018. MEMORIAL HEALTH SYSTEM IS NO LONGER SUBJECT TO INCOME TAX EXAMINATIONS FOR YEARS PRIOR TO 2016. MHS QALIC B, LLC (QALICB), MCDEKK, LLC (MCDEKK), AND MEMORIAL HEALTH PARTNERS (MHP) 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.

Supplemental Information	
Return Reference	Explanation
SCHEDULE D, PART V	THE AMOUNTS IN COLUMN (B) FOR TAX YEAR 2017 HAVE BEEN UPDATED TO REPORT ADDITIONAL INVESTMENT EARNINGS FOR THE TAYLORVILLE MEMORIAL HOSPITAL FOUNDATION ENDOWMENT





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

Revenue		(a) Event #1 <b>FESTIVAL OF TREES (MMCF)</b> (event type)	(b) Event #2 <b>TRANSPLANT WALK</b> (event type)	(c) Other events <b>5</b> (total number)	(d) Total events (add col (a) through col (c))
Revenue	<b>1</b> Gross receipts . . . . .	606,989	12,112	76,479	695,580
	<b>2</b> Less Contributions . . . . .	223,606	6,802	49,789	280,197
	<b>3</b> Gross income (line 1 minus line 2) . . . . .	383,383	5,310	26,690	415,383
Direct Expenses	<b>4</b> Cash prizes . . . . .				
	<b>5</b> Noncash prizes . . . . .	63,248	1,557	2,629	67,434
	<b>6</b> Rent/facility costs . . . . .	14,661	150	1,918	16,729
	<b>7</b> Food and beverages . . . . .	76,477		4,634	81,111
	<b>8</b> Entertainment . . . . .	350		10,042	10,392
	<b>9</b> Other direct expenses . . . . .	72,096	493	13,904	86,493
	<b>10</b> Direct expense summary Add lines 4 through 9 in column (d) . . . . . ►				262,159
	<b>11</b> Net income summary Subtract line 10 from line 3, column (d) . . . . . ►				153,224

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

Revenue		(a) Bingo	(b) Pull tabs/Instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col (a) through col (c))
Revenue	<b>1</b> Gross revenue . . . . .			145,904	145,904
	<b>2</b> Cash prizes . . . . .			94,500	94,500
	<b>3</b> Noncash prizes . . . . .			1,456	1,456
	<b>4</b> Rent/facility costs . . . . .				
	<b>5</b> Other direct expenses . . . . .			11,946	11,946
Direct Expenses	<b>6</b> Volunteer labor . . . . .	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input checked="" type="checkbox"/> No	
	<b>7</b> Direct expense summary Add lines 2 through 5 in column (d) . . . . . ►				107,902
	<b>8</b> Net gaming income summary Subtract line 7 from line 1, column (d) . . . . . ►				38,002

**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 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<b>11</b>	Does the organization conduct gaming activities with nonmembers?	<input checked="" type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
<b>12</b>	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"/> <b>Yes</b> <input checked="" type="checkbox"/> <b>No</b>
<b>13</b>	Indicate the percentage of gaming activity conducted in	
<b>a</b>	The organization's facility	<b>13a</b> 98 000 %
<b>b</b>	An outside facility	<b>13b</b> 2 000 %

**14** Enter the name and address of the person who prepares the organization's gaming/special events books and records

Name ► KATHRYN J KEIM

Address ► 701 NORTH FIRST STREET  
SPRINGFIELD, IL 62781

**15a** Does the organization have a contract with a third party from whom the organization receives gaming revenue? ☐ **Yes**   ☒ **No**

**b** If "Yes," enter the amount of gaming revenue received by the organization ► \$ \_\_\_\_\_ and the amount of gaming revenue retained by the third party ► \$ \_\_\_\_\_

**c** If "Yes," enter name and address of the third party

Name ► \_\_\_\_\_

Address ► \_\_\_\_\_

**16** Gaming manager information

Name ► MELISSA HANSEN-SCHMADEKE

Gaming manager compensation ► \$ 2,000

Description of services provided ► OVERSAW THE RAFFLE PROCESS

☒ 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

<b>SCHEDULE H</b> <b>(Form 990)</b>  Department of the Treasury Internal Revenue Service	<h2 style="margin:0;">Hospitals</h2> <p>► <b>Complete if the organization answered "Yes" on Form 990, Part IV, question 20.</b>                  ► <b>Attach to Form 990.</b>                  ► <b>Go to <a href="http://www.irs.gov/Form990EZ">www.irs.gov/Form990EZ</a> for instructions and the latest information.</b></p>	OMB No 1545-0047  <div style="font-size: 2em; font-weight: bold; text-align: center;">2018</div> Open to Public Inspection
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
<b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	<b>1a</b>	Yes	
<b>b</b> If "Yes," was it a written policy? . . . . .	<b>1b</b>	Yes	
<b>2</b> If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year			
<input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities			
<b>3</b> Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year			
<b>a</b> Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>30000 0000000000 %</u>	<b>3a</b>	Yes	
<b>b</b> Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care <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 <u>30100 0000000000 %</u>	<b>3b</b>	Yes	
<b>c</b> 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			
<b>4</b> Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	<b>4</b>	Yes	
<b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	<b>5a</b>	Yes	
<b>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	<b>5b</b>	Yes	
<b>c</b> If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	<b>5c</b>		No
<b>6a</b> Did the organization prepare a community benefit report during the tax year?	<b>6a</b>	Yes	
<b>b</b> If "Yes," did the organization make it available to the public?	<b>6b</b>	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
<b>a</b> Financial Assistance at cost (from Worksheet 1)	104	5,607	12,801,458		12,801,458	1 300 %
<b>b</b> Medicaid (from Worksheet 3, column a)	1	84,576	187,923,239	138,709,566	49,213,673	4 990 %
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b)	3	161	46,522	285,111	0	0 %
<b>d Total</b> Financial Assistance and Means-Tested Government Programs	108	90,344	200,771,219	138,994,677	62,015,131	6 290 %
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4)	2,430	31,911	2,253,474	492	2,252,982	0 230 %
<b>f</b> Health professions education (from Worksheet 5)	69	1,454	13,215,699	3,870,939	9,344,760	0 950 %
<b>g</b> Subsidized health services (from Worksheet 6)	3	91	22,753,206		22,753,206	2 310 %
<b>h</b> Research (from Worksheet 7)	1	0	276,996		276,996	0 030 %
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8)	134	71,052	52,430,971		52,430,971	5 310 %
<b>j Total.</b> Other Benefits	2,637	104,508	90,930,346	3,871,431	87,058,915	8 830 %
<b>k Total.</b> Add lines 7d and 7j	2,745	194,852	291,701,565	142,866,108	149,074,046	15 120 %

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
<b>1</b> Physical improvements and housing	1		1,000		1,000	0 %
<b>2</b> Economic development	3		3,767		3,767	0 %
<b>3</b> Community support	11	2	36,473		36,473	0 %
<b>4</b> Environmental improvements						
<b>5</b> Leadership development and training for community members	2	190	6,580		6,580	0 %
<b>6</b> Coalition building	1		12,461		12,461	0 %
<b>7</b> Community health improvement advocacy	6		12,992		12,992	0 %
<b>8</b> Workforce development						
<b>9</b> Other						
<b>10 Total</b>	24	192	73,273		73,273	0 %

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

**Section A. Bad Debt Expense**

		Yes	No
<b>1</b> Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	<b>1</b>	Yes	
<b>2</b> Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	<b>2</b>	23,090,683	
<b>3</b> Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	<b>3</b>		
<b>4</b> Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

**Section B. Medicare**

<b>5</b> Enter total revenue received from Medicare (including DSH and IME).	<b>5</b>	229,119,003
<b>6</b> Enter Medicare allowable costs of care relating to payments on line 5.	<b>6</b>	249,337,887
<b>7</b> Subtract line 6 from line 5. This is the surplus (or shortfall).	<b>7</b>	-20,218,884
<b>8</b> Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used.		
<input type="checkbox"/> Cost accounting system	<input type="checkbox"/> Cost to charge ratio	<input checked="" type="checkbox"/> Other

**Section C. Collection Practices**

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

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

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
<b>1</b>				
<b>2</b>				
<b>3</b>				
<b>4</b>				
<b>5</b>				
<b>6</b>				
<b>7</b>				
<b>8</b>				
<b>9</b>				
<b>10</b>				
<b>11</b>				
<b>12</b>				
<b>13</b>				

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

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

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

**4**

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)

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

**Part V Facility Information** (continued)**Section B. Facility Policies and Practices**(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)  
MEMORIAL MEDICAL CENTER**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** \_\_\_\_\_

1

**Community Health Needs Assessment**

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

Part VFacility 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 300 000000000000 % and FPG family income limit for eligibility for discounted care of 301 000000000000 %			
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) WWW MEMORIALMEDICAL COM/FINANCIAL/FINANCIAL-HELP			
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) WWW MEMORIALMEDICAL COM/FINANCIAL/FINANCIAL-HELP			
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) WWW MEMORIALMEDICAL COM/FINANCIAL/FINANCIAL-HELP			
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
<b>17</b> Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment? . . . . .	<b>17</b> Yes	
<b>18</b> Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C) <b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b> Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? . . . . .	<b>19</b>	No
If "Yes," check all actions in which the hospital facility or a third party engaged		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b> Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply)		
<b>a</b> <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs <b>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process <b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications <b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations <b>e</b> <input type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

<b>21</b> Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? . . . . .	<b>21</b> Yes	
If "No," indicate why		
<b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions <b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing <b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) <b>d</b> <input type="checkbox"/> Other (describe in Section C)		



**Part V Facility Information** *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

MEMORIAL MEDICAL CENTER

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

- a** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☒ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- c** ☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- d** ☐ The hospital facility used a prospective Medicare or Medicaid method

**23** During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? . . . . .

If "Yes," explain in Section C

**24** During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? . . . . .

If "Yes," explain in Section C

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

**Part V Facility Information** (continued)**Section B. Facility Policies and Practices**(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)  
ABRAHAM LINCOLN MEMORIAL HOSPITAL**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** \_\_\_\_\_**2****Community Health Needs Assessment**

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

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

ABRAHAM LINCOLN MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
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 300 000000000000 % and FPG family income limit for eligibility for discounted care of 301 000000000000 %			
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) WWW ALMH ORG/FINANCIAL/FINANCIAL-ASSISTANCE			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) WWW ALMH ORG/FINANCIAL/FINANCIAL-ASSISTANCE			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) WWW ALMH ORG/FINANCIAL/FINANCIAL-ASSISTANCE			
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
<b>17</b> Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment? . . . . .	<b>17</b> Yes	
<b>18</b> Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C) <b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b> Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? . . . . .	<b>19</b>	No
If "Yes," check all actions in which the hospital facility or a third party engaged		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b> Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply)		
<b>a</b> <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs <b>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process <b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications <b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations <b>e</b> <input type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

<b>21</b> Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? . . . . .	<b>21</b> Yes	
If "No," indicate why		
<b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions <b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing <b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) <b>d</b> <input type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information** *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

ABRAHAM LINCOLN MEMORIAL HOSPITAL

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

- a** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☒ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- c** ☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- d** ☐ The hospital facility used a prospective Medicare or Medicaid method

**23** During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? . . . . .

If "Yes," explain in Section C

**24** During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? . . . . .

If "Yes," explain in Section C

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

**Part V Facility Information** (continued)**Section B. Facility Policies and Practices**(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)  
TAYLORVILLE MEMORIAL HOSPITAL**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** \_\_\_\_\_**3****Community Health Needs Assessment**

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

**Part V Facility Information** (continued)**Financial Assistance Policy (FAP)**

TAYLORVILLE MEMORIAL HOSPITAL

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

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
<b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	<b>13</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>300 000000000000</u> % and FPG family income limit for eligibility for discounted care of <u>301 000000000000</u> %			
<b>b</b> <input type="checkbox"/> Income level other than FPG (describe in Section C)			
<b>c</b> <input checked="" type="checkbox"/> Asset level			
<b>d</b> <input checked="" type="checkbox"/> Medical indigency			
<b>e</b> <input checked="" type="checkbox"/> Insurance status			
<b>f</b> <input checked="" type="checkbox"/> Underinsurance discount			
<b>g</b> <input type="checkbox"/> Residency			
<b>h</b> <input type="checkbox"/> Other (describe in Section C)			
<b>14</b> Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b>	Yes	
<b>15</b> Explained the method for applying for financial assistance? . . . . . If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	<b>15</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
<b>b</b> <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
<b>c</b> <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
<b>d</b> <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
<b>e</b> <input type="checkbox"/> Other (describe in Section C)			
<b>16</b> Was widely publicized within the community served by the hospital facility? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	<b>16</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>WWW TAYLORVILLEMEMORIAL ORG/FINANCIAL/FINANCIAL-ASSISTANCE</u>			
<b>b</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>			
<b>c</b> <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>			
<b>d</b> <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>e</b> <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>f</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>g</b> <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
<b>h</b> <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
<b>i</b> <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
<b>j</b> <input type="checkbox"/> Other (describe in Section C)			

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

TAYLORVILLE MEMORIAL HOSPITAL

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

	Yes	No
<b>17</b> Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment? . . . . .	<b>17</b> Yes	
<b>18</b> Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C) <b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b> Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? . . . . .	<b>19</b>	No
If "Yes," check all actions in which the hospital facility or a third party engaged		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b> Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply)		
<b>a</b> <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs <b>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process <b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications <b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations <b>e</b> <input type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

<b>21</b> Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? . . . . .	<b>21</b> Yes	
If "No," indicate why		
<b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions <b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing <b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) <b>d</b> <input type="checkbox"/> Other (describe in Section C)		



**Part V Facility Information** *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

TAYLORVILLE MEMORIAL HOSPITAL

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

- a** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☒ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- c** ☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- d** ☐ The hospital facility used a prospective Medicare or Medicaid method

**23** During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? . . . . .

If "Yes," explain in Section C

**24** During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? . . . . .

If "Yes," explain in Section C

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

**Part V Facility Information** (continued)**Section B. Facility Policies and Practices**(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)  
PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIA**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** \_\_\_\_\_

4

**Community Health Needs Assessment**

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

**Part V Facility Information** (continued)**Financial Assistance Policy (FAP)**

PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIA

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

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that			
<b>13</b> Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	<b>13</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>300 000000000000</u> % and FPG family income limit for eligibility for discounted care of <u>301 000000000000</u> %			
<b>b</b> <input type="checkbox"/> Income level other than FPG (describe in Section C)			
<b>c</b> <input checked="" type="checkbox"/> Asset level			
<b>d</b> <input checked="" type="checkbox"/> Medical indigency			
<b>e</b> <input checked="" type="checkbox"/> Insurance status			
<b>f</b> <input checked="" type="checkbox"/> Underinsurance discount			
<b>g</b> <input type="checkbox"/> Residency			
<b>h</b> <input type="checkbox"/> Other (describe in Section C)			
<b>14</b> Explained the basis for calculating amounts charged to patients? . . . . .	<b>14</b>	Yes	
<b>15</b> Explained the method for applying for financial assistance? . . . . . If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	<b>15</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
<b>b</b> <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
<b>c</b> <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
<b>d</b> <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
<b>e</b> <input type="checkbox"/> Other (describe in Section C)			
<b>16</b> Was widely publicized within the community served by the hospital facility? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	<b>16</b>	Yes	
<b>a</b> <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>WWW PASSAVANTHOSPITAL COM/FINANCIAL/FINANCIAL-ASSISTANCE</u>			
<b>b</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>			
<b>c</b> <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>			
<b>d</b> <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>e</b> <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>f</b> <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
<b>g</b> <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
<b>h</b> <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
<b>i</b> <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
<b>j</b> <input type="checkbox"/> Other (describe in Section C)			

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

PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIA

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

	Yes	No
<b>17</b> Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment? . . . . .	<b>17</b> Yes	
<b>18</b> Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C) <b>f</b> <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
<b>19</b> Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? . . . . .	<b>19</b>	No
If "Yes," check all actions in which the hospital facility or a third party engaged		
<b>a</b> <input type="checkbox"/> Reporting to credit agency(ies) <b>b</b> <input type="checkbox"/> Selling an individual's debt to another party <b>c</b> <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP <b>d</b> <input type="checkbox"/> Actions that require a legal or judicial process <b>e</b> <input type="checkbox"/> Other similar actions (describe in Section C)		
<b>20</b> Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply)		
<b>a</b> <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs <b>b</b> <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process <b>c</b> <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications <b>d</b> <input checked="" type="checkbox"/> Made presumptive eligibility determinations <b>e</b> <input type="checkbox"/> Other (describe in Section C) <b>f</b> <input type="checkbox"/> None of these efforts were made		

**Policy Relating to Emergency Medical Care**

<b>21</b> Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? . . . . .	<b>21</b> Yes	
If "No," indicate why		
<b>a</b> <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions <b>b</b> <input type="checkbox"/> The hospital facility's policy was not in writing <b>c</b> <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) <b>d</b> <input type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information** *(continued)*

**Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIA

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

**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care

- a** ☐ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b** ☒ The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- c** ☐ The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- d** ☐ The hospital facility used a prospective Medicare or Medicaid method

**23** During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? . . . . .

If "Yes," explain in Section C

**24** During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? . . . . .

If "Yes," explain in Section C

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

**Section C. Supplemental Information for Part V, Section B.** Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

[illegible]

**Part V** Facility Information *(continued)***Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility**

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

How many non-hospital health care facilities did the organization operate during the tax year? **21**

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

**Part VI Supplemental Information**

Provide the following information

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7, Part II and Part III, lines 2, 3, 4, 8 and 9b
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e g , open medical staff, community board, use of surplus funds, etc )
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
PART I, LINE 3C	OTHER THAN USING THE FPG, MHS QUALIFIES UNINSURED PATIENTS FOR 100% FINANCIAL ASSISTANCE USING THE PRESUMPTIVE ELIGIBILITY CRITERIA AS DEFINED IN THE ILLINOIS FAIR BILLING ACT AND LISTED IN THE FAP OTHER THAN THE FPG, OTHER CRITERIA FOR AN UNINSURED PATIENT WITH ANNUAL FAMILY INCOME OVER 300% OF THE FPG IS THAT THE SUM OF THE ACCOUNT BALANCES ON ACCOUNTS WITHIN A 12 MONTH PERIOD MUST EXCEED 25% OF THEIR ANNUAL FAMILY INCOME OTHER THAN THE FPG FOR INSURED PATIENTS, CRITERIA INCLUDES PROOF OF ONE OR MORE OF THE PRESUMPTIVE ELIGIBILITY CATEGORIES LISTED IN THE FAP IN THE EVENT OF AN ILLNESS WHICH IS CATASTROPHIC AND WHERE PROPER DOCUMENTATION HAS BEEN SUBMITTED, BUT THE PATIENT STILL OWES MONIES THAT CAUSES AN UNDUE HARDSHIP UPON THE HOUSEHOLD, THE PATIENT FINANCIAL SERVICES DIRECTOR ALONG WITH SENIOR LEADERSHIP MAY REVIEW AND DETERMINE IF AN ADDITIONAL FINANCIAL ASSISTANCE DISCOUNT IS MERITED THE DEFINITION OF "CATASTROPHIC AND THE AMOUNT OF FINANCIAL ASSISTANCE WILL BE DETERMINED ON A CASE BY CASE BASIS, CONSIDERING ALL FINANCIAL, FAMILY, AND HEALTH CIRCUMSTANCES OF THE PATIENT
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 <a href="https://www.choosememorial.org/about/community-benefit">HTTPS //WWW.CHOOSMEMORIAL.ORG/ABOUT/COMMUNITY-BENEFIT</a> A PDF VERSION IS AVAILABLE TO ANYONE UPON REQUEST THE COMMUNITY BENEFIT ANNUAL REPORT IS ALSO INCLUDED WITHIN MEMORIAL HEALTH SYSTEM'S COMPLETE ANNUAL REPORT, WHICH IS DISTRIBUTED IN PRINT TO MEMBERS OF THE COMMUNITY AT LARGE



**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 FY2018 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
PART I, LINE 7G	MEMORIAL HEALTH SYSTEM HOSPITALS (MMC, ALMH, TMH, AND PAH) INCLUDED SUBSIDIZED HEALTH SERVICES FOR MEMORIAL PHYSICIAN SERVICES WHICH HAS PHYSICIAN CLINICS FOR \$21,637,041

**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 \$ 23,090,683
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
PART II, COMMUNITY BUILDING ACTIVITIES	MHS PARTICIPATES IN NUMEROUS COMMUNITY BUILDING ACTIVITIES THAT ARE NOT ACCOUNTED FOR ELSEWHERE ON SCHEDULE H OUR ORGANIZATION SUPPORTED ECONOMIC DEVELOPMENT THROUGH SERVICE WITH OUR LOCAL CHAMBERS OF COMMERCE AND COMMUNITY COLLEGES WE PROMOTED HEALTH BY EXPANDING ACCESS TO CARE THROUGH FINANCIAL AND IN-KIND SUPPORT FOR OUR COMMUNITY UNITED WAY ORGANIZATIONS, LOCAL DAYS-OF-SERVICE, AND YMCAS TWO OF OUR AFFILIATES, PAH AND ALMH, HAVE CROSS-SECTIONAL COMMUNITY HEALTH COLLABORATIVES TO ADDRESS THE HIGHEST NEEDS OF THEIR COMMUNITIES COMMUNITY HEALTH IMPROVEMENT ADVOCACY IS PROMOTED THROUGH LEADERSHIP INVOLVEMENT WITH THE ILLINOIS HEALTH AND HOSPITAL ASSOCIATION, THE AMERICAN HOSPITAL ASSOCIATION, AND SIU SCHOOL OF MEDICINE, AS WELL AS FUNDING TO THE FAITH COALITION FOR THE COMMON GOOD AS ONE OF THE LARGEST LOCAL EMPLOYERS OUTSIDE OF STATE GOVERNMENT, OUR ORGANIZATION IS AN IMPORTANT ECONOMIC LINK THAT PROVIDES EMPLOYMENT AND BENEFITS FOR THOUSANDS OF FAMILIES OUR ORGANIZATION ALSO COLLABORATES WITH OTHER ORGANIZATIONS TO EXPAND OPPORTUNITIES TO TRAIN AND RECRUIT HEALTHCARE PROFESSIONALS TO INCREASE ACCESS TO CARE IN RURAL AREAS

**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 17 OF THE NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS IN THE MEMORIAL HEALTH SYSTEM'S CONSOLIDATED FINANCIAL STATEMENTS
PART III, LINE 3	MEMORIAL HEALTH SYSTEM DOES NOT BELIEVE ANY AMOUNT OF BAD DEBT EXPENSES WOULD BE ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY ANY EXPENSES RELATED TO A PATIENT WHO IS ELIGIBLE UNDER THE FAP WOULD BE RECORDED AS CHARITY CARE RATHER THAN BAD DEBT

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 17 OF THE NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS IN THE MEMORIAL HEALTH SYSTEM'S CONSOLIDATED FINANCIAL STATEMENTS
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 FY2019 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 FY2018 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 1 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 \$249,337,887 THE TOTAL SHORTFALL REPORTED ON SCHEDULE H, PART III, LINE 7 WAS \$20,218,884 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 APPLICABLE MHS HOSPITAL, MHS 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 APPLICABLE MHS HOSPITAL, MHS WILL NOT PURSUE COLLECTION ACTION PER THE FINANCIAL ASSISTANCE POLICY, IF MHS 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 MHS 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>
PART VI, LINE 2	<p>MHS REVIEWS 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 ORGANIZATION'S FOUNDATIONS INFORMATION FROM THESE SOURCES HELPS PRIORITIZE MHS'S COMMUNITY BENEFIT INVESTMENTS AND HELPS ENSURE THOSE INITIATIVES ARE ALIGNED WITH OUR MISSION, VALUES, STRATEGIC PLAN AND BUDGET PRIORITIES ARE ESTABLISHED BASED ON OVERALL NEED, LEADING CAUSES OF DEATH, IMPACT ON HEALTH STATUS, ORGANIZATIONAL CORE COMPETENCIES, AND RESOURCES TO MEANINGFULLY ADDRESS THE NEEDS EACH MHS AFFILIATED ORGANIZATION HAS THE FLEXIBILITY TO DEVELOP SPECIFIC COMMUNITY BENEFIT INITIATIVES THAT ARE DESIGNED TO RESPOND TO THE NEEDS OF ITS PARTICULAR COMMUNITY MHS UNDERSTANDS COLLABORATION WITH OTHER COMMUNITY ORGANIZATIONS IS AN IMPORTANT COMPONENT OF COMMUNITY HEALTH IMPROVEMENT EFFORTS AND RESPONDS TO DIRECT COMMUNITY REQUESTS 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 MHS 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. MHS COLLEAGUES 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 MHS 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. MHS 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 MHS HOSPITAL VERIFIES THE FOLLOWING: REASONABLE BASIS FOR BELIEVING PATIENT OWES THE DEBT, THE MHS 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 MHS HOSPITAL WILL ATTEMPT TO VALIDATE THE INABILITY TO PAY AND THE MHS 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>
PART VI, LINE 4	<p>MEMORIAL HEALTH SYSTEM INCLUDES FOUR HOSPITALS IN SANGAMON, LOGAN, CHRISTIAN, AND MORGAN COUNTIES, SERVING A WIDE REGION OF CENTRAL AND SOUTHERN ILLINOIS, WHICH IS LARGELY RURAL AND AGRICULTURAL. IN SANGAMON COUNTY, PATIENTS COME FROM MORE THAN 40 OTHER COUNTIES AND ALSO FROM OUT OF STATE, MAKING MMC A SIGNIFICANT RESOURCE FOR HEALTHCARE SERVICES. SANGAMON COUNTY (POPULATION 195,348) 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). THE OTHER HOSPITAL SERVING SANGAMON COUNTY IS ST. JOHN'S HOSPITAL, A 430-BED NONPROFIT HOSPITAL AFFILIATED WITH HOSPITAL SISTERS HEALTH SYSTEM. THE POPULATION OF SANGAMON COUNTY IS 82.2% WHITE, 13% BLACK, 2.1% ASIAN, AND 2.4% HISPANIC. PERSONS AGE 65 AND OLDER MAKE UP 17.9% OF SANGAMON COUNTY'S POPULATION, WHICH IS HIGHER THAN THE STATE AVERAGE OF 15.6%. THE MEDIAN HOUSEHOLD INCOME IS \$60,446. A TOTAL OF 15.2% OF ALL COUNTY RESIDENTS LIVE BELOW THE FEDERAL POVERTY LEVEL, INCLUDING 24.4% OF CHILDREN UNDER THE AGE OF 6. IN TY2018/FY2019, 0.8% OF THE PATIENTS SERVED AT MMC RECEIVED PATIENT FINANCIAL ASSISTANCE (UNINSURED), 17.2% OF PATIENTS WERE ON MEDICAID, AND 32.8% RECEIVED MEDICARE. IN LOGAN COUNTY, ALMH IS THE ONLY HOSPITAL IN THE PRIMARY SERVICE AREA OF LOGAN COUNTY (POP. 28,925). THE CITY OF LINCOLN (POPULATION 13,685), WHERE ALMH IS LOCATED, IS THE COUNTY SEAT. LINCOLN CONTAINS ALMOST HALF OF THE COUNTY'S POPULATION. RACE/ETHNIC MAKEUP IS 89% WHITE, 8.3% BLACK AND 3.5% HISPANIC. THE MEDIAN HOUSEHOLD INCOME IS \$57,899. PERSONS AGE 65 AND OLDER MAKE UP 18.3% OF LOGAN COUNTY'S POPULATION. 8.5% OF ALL RESIDENTS LIVE BELOW THE FEDERAL POVERTY LEVEL. HIGH SCHOOL GRADUATES MAKE UP 88.9% OF RESIDENTS. ONLY 20.4 PERCENT OF RESIDENTS HAVE EARNED A BACHELOR'S DEGREE OR HIGHER, IN COMPARISON TO THE STATE AVERAGE OF 34.1%. IN TY2018/FY2019, 2% OF PATIENTS SERVED AT ALMH RECEIVED PATIENT FINANCIAL ASSISTANCE (UNINSURED), 22% WERE ON MEDICAID, AND 48% RECEIVED MEDICARE. TMH IS ONE OF TWO HOSPITALS IN THE PRIMARY SERVICE AREA OF CHRISTIAN COUNTY (POP. 32,661). TMH IS LOCATED IN TAYLORVILLE, WHILE 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. CHRISTIAN COUNTY'S RACE/ETHNICITY INCLUDES 96.3% WHITE, 1.6% BLACK, AND 1.7% HISPANIC. THE MEDIAN HOUSEHOLD INCOME IS \$52,415. THE COUNTY HAS AN AGING POPULATION. PERSONS AGE 65 AND OLDER MAKE UP 19.9% OF THE POPULATION, VS. 15.6% FOR THE STATE OF ILLINOIS. 13% OF ALL PEOPLE LIVE BELOW THE FEDERAL POVERTY LEVEL, INCLUDING 16.5% OF CHILDREN. CHRISTIAN COUNTY HAS NINE MEDICALLY UNDERSERVED AREAS. IN TY2018/FY2019, 2.5% OF THE PATIENTS SERVED AT TMH RECEIVED UNINSURED/UNDERINSURED CHARITY CARE ASSISTANCE, 18.8% OF THE PATIENTS WERE ON MEDICAID AND 53.5% WERE COVERED BY MEDICARE. PAH IS LOCATED IN JACKSONVILLE, THE COUNTY SEAT OF MORGAN COUNTY. JACKSONVILLE IS 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 33,976. RACE AND ETHNIC BREAKOUTS ARE 89.9% WHITE, 7% BLACK, 2.5% LATINO OR HISPANIC. IN MORGAN COUNTY, 2.9 PERCENT OF THE POPULATION SPEAKS A LANGUAGE OTHER THAN ENGLISH AT HOME. PEOPLE OVER THE AGE OF 65 MAKE UP 20 PERCENT OF THE POPULATION. HIGH SCHOOL GRADUATES MAKE UP 91.7% OF THE POPULATION (2.8 PERCENT HIGHER THAN THE ILLINOIS AVERAGE). THE MEDIAN HOUSEHOLD INCOME IN MORGAN COUNTY IS \$48,508. 14.6% OF PEOPLE LIVE BELOW THE POVERTY LINE (1.5% HIGHER THAN THE ILLINOIS AVERAGE OF 14%), INCLUDING 22.7%. IN TY2018/FY2019, 1.6% OF PATIENTS SERVED AT PAH RECEIVED CHARITY CARE, 18.9% OF PATIENTS ARE ON MEDICAID, AND 47.2% OF PATIENTS ARE ON MEDICARE.</p>

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Form and Line Reference	Explanation
PART VI, LINE 5	<p>EACH MHS HOSPITAL 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 THEREOF THEY DONATE NUMEROUS HOURS OF SERVICE IN THEIR OVERSIGHT ROLE, INCLUDING DURING THE CHNA PROCESS ALL MHS HOSPITALS HAVE OPEN MEDICAL STAFF THAT ALLOW MEMBERSHIP TO ANYONE WHO MEETS THE CREDENTIALING REQUIREMENTS ALL MHS HOSPITALS PROVIDE 24/7 EMERGENCY DEPARTMENTS THAT SERVE AS SAFETY NET PROVIDERS FOR THE UNINSURED AND UNDERINSURED WHO DO NOT HAVE PRIMARY CARE PHYSICIANS MHS PROVIDES CARE TO ALL PEOPLE REGARDLESS OF THEIR ABILITY TO PAY IN ADDITION TO MHS STANDARD COMMUNITY BENEFIT PLANS, MHS UTILIZES SURPLUS FUNDS TO IMPROVE PATIENT CARE, MEDICAL EDUCATION, RESEARCH, AND ACCESS TO HEALTH CARE, AS WELL AS UPGRADING HOSPITAL INFRASTRUCTURE MMC SERVES AS THE REGIONAL BURN CENTER FOR CENTRAL AND SOUTHERN ILLINOIS AND IS THE REGIONAL REHABILITATION PROVIDER FOR COMPREHENSIVE INPATIENT AND OUTPATIENT REHAB MMC'S REGIONAL CANCER CENTER APPLIES ITS RESOURCES AND RESEARCH TO OFFER THE LATEST IN CANCER EDUCATION AND TREATMENT MMC'S TRANSPLANT SERVICES HAS COMPLETED HUNDREDS OF KIDNEY OR PANCREAS TRANSPLANTS AND OUR EMERGENCY DEPARTMENT IS A LEVEL 1 TRAUMA CENTER MMC SUPPORTS PATIENTS FROM TWO FQHCs IN SANGAMON COUNTY AND COLLABORATES WITH ST JOHN'S HOSPITAL AND SIU TO PLACE COMMUNITY HEALTH WORKERS IN AT-RISK NEIGHBORHOODS TO ADDRESS SOCIAL DETERMINANTS OF HEALTH MMC PROVIDES SIGNIFICANT FINANCIAL SUPPORT FOR THE SIU SCHOOL OF MEDICINE, WHO DOES NOT RECEIVE SUFFICIENT OPERATING SUPPORT FROM THE STATE OF ILLINOIS MMC SERVES AS A MAJOR TEACHING HOSPITAL FOR SIU SOM AND COLLABORATES WITH LOCAL COLLEGES TO OFFER NURSING PROGRAMS TO HELP FILL THE GAP OF NURSING SHORTAGES ALMH AND PAH PROVIDE REGULAR HEALTH SCREENINGS, SUPPORT GROUPS, AND COMMUNITY PROGRAMS, IN ADDITION TO THEIR GENERAL SERVICE LINES (INCLUDING GENERAL ACUTE INPATIENT CARE, ORTHOPEDICS, SURGERY, OUTPATIENT REHABILITATION, AND MORE) PAH ALSO FUNDS A COMMUNITY HEALTH WORKER PROGRAM FOCUSED ON THE SOCIAL DETERMINANTS OF HEALTH TMH IS WELL INTO A MULTI-YEAR FACILITY RENOVATION PROJECT TO REPLACE OUTDATED INPATIENT AND OUTPATIENT FACILITIES 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</p>
PART VI, LINE 6	<p>MEMORIAL HEALTH SYSTEM (MHS), A 501C3 CORPORATION, IS THE SOLE CORPORATE MEMBER OF ABRAHAM LINCOLN MEMORIAL HOSPITAL (ALMH), TAYLORVILLE MEMORIAL HOSPITAL (TMH), PASSAVANT MEMORIAL AREA HOSPITAL (PAH), AND MEMORIAL MEDICAL CENTER (MMC) OTHER AFFILIATES INCLUDE MEMORIAL PHYSICIAN SERVICES, A PRIMARY CARE PHYSICIAN NETWORK THAT INCLUDES SEVERAL CLINICS LOCATED IN MEDICALLY UNDERSERVED OR HEALTH MANPOWER SHORTAGE AREAS, MEMORIAL BEHAVIORAL HEALTH, A MULTI-COUNTY OUTPATIENT MENTAL HEALTH NETWORK THAT PROVIDES SERVICE BASED ON A SLIDING-SCALE FEE SCHEDULE AND FREE CARE TO A WIDE RANGE OF PATIENTS WITH PSYCHIATRIC DISORDERS, MEMORIAL HOME SERVICES, A MULTI-COUNTY HOME CARE AND HOSPICE PROGRAM, A CHILD CARE CENTER, PASSAVANT PHYSICIAN ASSOCIATION, AND FOUR MHS HOSPITAL FOUNDATIONS, ALL OF WHICH ARE 501C3 ENTITIES MHS AFFILIATES ENGAGE IN A WIDE RANGE OF PROGRAMS THAT PROMOTE COMMUNITY HEALTH, INCLUDING INTEGRATING SERVICES TO PROVIDE IMPROVED ACCESS AND STREAMLINING TRANSACTIONS BETWEEN DOCTOR'S OFFICES, HOSPITALS, HOME HEALTH AGENCIES, AND MENTAL HEALTH CLINICS IN ADDITION TO HOSPITAL COMMUNITY BENEFIT ACTIVITIES, OTHER MHS AFFILIATES' COMMUNITY BENEFIT CONTRIBUTIONS TOTAL MORE THAN \$6.5 MILLION MEMORIAL PHYSICIAN SERVICES (MPS) OFFERS FOUR WALK-IN EXPRESSCARE LOCATIONS, TWO WALK-IN CLINICS IN A RETAIL AND NURSING HOME SETTING, AND TELEHEALTH, IN ORDER TO IMPROVE PATIENT ACCESS COMPRISED OF MORE THAN 150 PHYSICIANS, ADVANCED PRACTICE REGISTERED NURSES, DOCTOR OF NURSING PRACTICE AND PHYSICIAN ASSISTANTS, MPS PROVIDES 375,000+ PATIENTS VISITS EACH YEAR PHYSICIAN OFFICES AND CLINICS ARE LOCATED IN SPRINGFIELD, JACKSONVILLE, LINCOLN, PETERSBURG AND CHATHAM MPS PROVIDES COMMUNITY BENEFITS BY MENTORING AND PROVIDING HEALTH PROFESSION EDUCATIONAL OPPORTUNITIES FOR MEDICAL STUDENTS, ADVANCED PRACTICE REGISTERED NURSES, DOCTOR OF NURSING PRACTICE, PHYSICIAN ASSISTANTS AND CERTIFIED MEDICAL ASSISTANTS MEMORIAL BEHAVIORAL HEALTH (MBH) CARES FOR CHILDREN AND ADULTS AT ITS MULTIPLE SITES OF CARE IN SPRINGFIELD, LINCOLN, AND JACKSONVILLE SERVICES INCLUDE CRISIS INTERVENTION, PSYCHIATRIC SERVICES, SCREENING AND ASSESSMENT, OUTPATIENT THERAPY, CASE MANAGEMENT, SUPPORT GROUPS, EMPLOYMENT SERVICES, AND RESIDENTIAL CARE, AS WELL AS LEVEL 1 SUBSTANCE USE SERVICES TO ADULTS IN SPRINGFIELD THE PSYCHIATRIC RESPONSE TEAM WORKS WITH FOUR AREA HOSPITAL EMERGENCY DEPARTMENTS MBH ALSO PROVIDES COMMUNITY-BASED CRISIS INTERVENTION SERVICES AT LOCAL SCHOOLS, HOMELESS SHELTERS, 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 CONFERENCE ATTENDED BY PROVIDERS THROUGHOUT THE STATE MHS FOUNDATIONS PROVIDE GRANTS FOR PATIENT CARE, EDUCATION, AND CLINICAL RESEARCH THESE ADDITIONAL FOUNDATION COMMUNITY BENEFITS TOTALED MORE THAN \$1.6 MILLION SUPPORT WAS GRANTED TO SIU SCHOOL OF MEDICINE, THE UNIVERSITY OF ILLINOIS AT CHICAGO, EMERGENCY MEDICAL SERVICES, PATIENT ASSISTANCE FUNDS, THE ALMH COMMUNITY HEALTH COLLABORATIVE, CATCH (CHILDHOOD OBESITY PROGRAMS), SCHOLARSHIPS, STOP THE BLEED PROGRAMS, AND MANY OTHER GROUPS AND PROGRAMS THROUGHOUT CENTRAL ILLINOIS</p>



990 Schedule H, Supplemental Information

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

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

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

**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 5 MEMORIAL MEDICAL CENTER (MMC) COLLABORATED WITH HSHS ST JOHN'S HOSPITAL AND THE SANGAMON COUNTY DEPARTMENT OF PUBLIC HEALTH TO COMPLETE A CHNA IN TY2017/FY2018 MMC DID NOT RECEIVE ANY DIRECT WRITTEN COMMENTS ON THE 2015 CHNA OR IMPLEMENTATION STRATEGIES FOR THE 2018 CHNA, COMMUNITY HEALTH NEEDS WERE PRIORITIZED BASED ON REVIEWS OF MULTIPLE SOURCES OF SECONDARY DATA, AS WELL AS PRIMARY DATA GATHERED BY A COMMUNITY ADVISORY COMMITTEE (CAC) COMPRISED OF 13 REPRESENTATIVES FROM COMMUNITY ORGANIZATIONS THESE INCLUDED TWO FEDERALLY QUALIFIED HEALTH CENTERS (SIU CENTER FOR FAMILY MEDICINE AND CENTRAL COUNTIES HEALTH CENTERS), SANGAMON COUNTY DEPARTMENT OF COMMUNITY RESOURCES (COMMUNITY ACTION), MEMORIAL BEHAVIORAL HEALTH, CATHOLIC CHARITIES, LINCOLN LAND COMMUNITY COLLEGE'S OPEN DOOR MENTORSHIP PROGRAM, SIU SCHOOL OF MEDICINE'S DEPARTMENT OF EQUITY, DIVERSITY AND INCLUSION, SPRINGFIELD POLICE DEPARTMENT, SPRINGFIELD SCHOOL DISTRICT #186, SANGAMON COUNTY FARM BUREAU, GREATER SPRINGFIELD CHAMBER OF COMMERCE, SPRINGFIELD URBAN LEAGUE, AND UNITED WAY OF CENTRAL ILLINOIS THE CAC MET ON OCTOBER 24, 2017, TO REVIEW OUTCOMES OF THE 2015 CHNA IMPLEMENTATION STRATEGIES AND TO DISCUSS SOCIAL DETERMINANTS OF HEALTH AND AN OVERVIEW OF SECONDARY DATA CONSULTED FOR THE 2018 CHNA THE CAC HAD AN OPPORTUNITY TO PROVIDE INPUT ON KEY COMMUNITY ISSUES IT WAS ADDRESSING AT THE SECOND MEETING ON NOVEMBER 17, 2017, THE CAC REVIEWED DATA ON 18 IDENTIFIED PRIORITY NEEDS, INCLUDING SANGAMON COUNTY INCIDENCE RATES, EMERGENCY DEPARTMENT AND HOSPITALIZATION DATA, TRENDS OVER TIME AND DISPARITIES THE CAC SHARED SPECIFIC INFORMATION ON HOW THESE ISSUES IMPACTED THEIR CLIENTS AND THE COMMUNITY, AND THEN COMPLETED A FORCED RANKING TO SELECT THE NINE ISSUES THAT WOULD BE INCLUDED ON A COMMUNITY SURVEY THE UNIVERSITY OF ILLINOIS' SURVEY RESEARCH DEPARTMENT CONDUCTED A COMMUNITY SURVEY ON THESE NINE ISSUES FROM JANUARY 12-FEBRUARY 12, 2018, AND PROVIDED A REPORT BACK TO MMC, 1,079 INDIVIDUALS COMPLETED THE SURVEY THE CAC MET A FINAL TIME ON MARCH 20, 2018 MEMBERS RECEIVED A DETAILED REVIEW OF THE COMMUNITY SURVEY OUTCOMES THE CAC ALSO COMPLETED AN ASSET AND GAPS ANALYSIS AND DISCUSSED POPULATIONS DISPROPORTIONATELY AFFECTED USING THE PREDEFINED CRITERIA OF MAGNITUDE, SERIOUSNESS, FEASIBILITY AND TRIPLE AIM, THE CAC 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 MMC ACCEPTED THIS RECOMMENDATION A COMPLETE DESCRIPTION OF THE CHNA PROCESS IS PROVIDED IN MMC'S CHNA REPORT AT <a href="https://www.choosememorial.org/community-health-needs-assessment">HTTPS //WWW CHOOSEMEMORIAL ORG/COMMUNITY-HEALTH-NEEDS-ASSESSMENT</a></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
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 THE SPRING OF 2017 ALMH DID NOT RECEIVE ANY DIRECT WRITTEN COMMENTS ON THE 2015 CHNA OR IMPLEMENTATION STRATEGIES COMMUNITY AND INTERNAL ADVISORY COMMITTEES WE RE USED TO ANALYZE HEALTH DATA AND SELECT THE PRIORITIES THE COMMUNITY ADVISORY COMMITTEE (CAC) CONSISTED OF OVER 20 MEMBERS FROM THE ALMH COMMUNITY HEALTH COLLABORATIVE NETWORK I NCLUDING A FEDERALLY QUALIFIED HEALTH CENTER (SIU FAMILY HEALTH CENTER), COMMUNITY ACTION PARTNERSHIP OF CENTRAL ILLINOIS, GATEWAY FOUNDATION, MOMS WHO CARE, HEARTLAND COMMUNITY CO LLEGE, LINCOLN COLLEGE, LINCOLN PARK DISTRICT, MEMORIAL BEHAVIORAL HEALTH, LOGAN COUNTY DE PARTMENT 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 C OMMITTEE INCLUDED A VARIETY OF STAKEHOLDERS INCLUDING REPRESENTATIVES FROM THE ALMH FOUNDA TION, COMMUNITY ACTION PARTNERSHIP OF CENTRAL ILLINOIS, LINCOLN SCHOOL DISTRICT #27, PRIVA TE BUSINESSES, LINCOLN AREA YMCA, LINCOLN POLICE DEPARTMENT, LINCOLN PARK DISTRICT, LOGAN COUNTY PARKS AND TRAILS FOUNDATION, LOGAN COUNTY REGIONAL PLANNING COMMISSION, LOGAN COUNT Y DEPARTMENT OF PUBLIC HEALTH AND MEMORIAL BEHAVIORAL HEALTH IN THE FALL AND WINTER OF 20 17, THE CAC REVIEWED OUTCOMES OF THE 2015 CHNA IMPLEMENTATION STRATEGIES, DISCUSSED SOCIAL DETERMINANTS OF HEALTH, AND REVIEWED AN OVERVIEW OF SECONDARY DATA TO HELP DETERMINE PRIO RITIES FOR THE 2018 CHNA THE CAC HAD AN OPPORTUNITY TO PROVIDE INPUT ON KEY COMMUNITY ISS UES THE DOT METHOD/DOTMOCRACY WAS THE METHOD CHOSEN TO NARROW THE LIST OF 25 POTENTIAL PR IORITIES 10 AREAS OF NEED FOR LOGAN COUNTY WERE IDENTIFIED BASED ON THE PREDEFINED CRITER IA OF MAGNITUDE, SERIOUSNESS, FEASIBILITY AND TRIPLE AIM, ALONG WITH IDENTIFIED INCREASES IN OCCURRENCE AND TIMELINE TRENDING IDENTIFIED IN THE SECONDARY DATA IN FEBRUARY/MARCH 20 18, UNIVERSITY OF ILLINOIS AT SPRINGFIELD'S SURVEY RESEARCH PROGRAM CONDUCTED A COMMUNITY SURVEY PARTICIPANTS WERE ASKED TO RANK THE 10 PRIORITIES AND WERE ENCOURAGED TO IDENTIFY ADDITIONAL CONCERNS A TOTAL OF 565 INDIVIDUALS COMPLETED THE SURVEY THE SURVEY SHOWED SI MILAR RESULTS FOR THE TOP 10 AREAS OF COMMUNITY CONCERN THESE 10 PRIORITIES WERE PRESENTE D TO THE ALMH COMMUNITY HEALTH COLLABORATIVE ADVISORY BOARD FOR REVIEW ONCE AGAIN MAGNITU DE, SERIOUSNESS, FEASIBILITY AND TRIPLE AIM WERE TAKEN INTO CONSIDERATION THE CAC RECEIVE D A DETAILED REVIEW OF THE COMMUNITY SURVEY OUTCOMES, COMPLETED AN ASSET AND GAPS ANALYSIS AND DISCUSSED POPULATIONS DISPROPORTIONATELY AFFECTED THE CAC RECOMMENDED FOUR FINAL ISS UES AS THE TOP PRIORITIES FOR THE HOSPITAL TO ADDRESS IN LOGAN COUNTY MENTAL HEALTH, SUBS TANCE ABUSE, CANCER AND OBESITY A COMPLETE DESCRIPTION OF THE CHNA PROCESS IS PROVIDED IN ALMH'S CHNA REPORT AT HTTPS /

**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	/WWW CHOOSEMEMORIAL ORG/COMMUNITY-HEALTH-NEEDS-ASSESSMENT

**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	<p>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 (CHNA) 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 (CAC) COMPRISED OF TWELVE REPRESENTATIVES FROM COMMUNITY ORGANIZATIONS THE CAC IS MADE UP OF REPRESENTATIVES FROM ORGANIZATIONS THAT SERVE LOW-INCOME, MINORITY AND AT-RISK POPULATIONS IN CHRISTIAN COUNTY TWELVE ORGANIZATIONS PARTICIPATED ON THE CAC 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, AND THE ILLINOIS YOUTH SURVEY 2016 THE MOST SIGNIFICANT SOURCE OF SECONDARY DATA WAS COLLECTED AND ANALYZED THROUGH CONDUENT'S HEALTHY COMMUNITIES INSTITUTE DATA PLATFORM THE CAC MET ON DECEMBER 12, 2017 WHERE TMH 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 TMH CONTRACTED WITH THE UNIVERSITY OF ILLINOIS AT SPRINGFIELD SURVEY RESEARCH DEPARTMENT TO CONDUCT THE CHRISTIAN COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT SURVEY FROM JANUARY 12 TO FEBRUARY 12, 2018 THE SURVEY TOOK PLACE ONLINE, BUT PAPER COPIES OF THE SURVEY WERE ALSO AVAILABLE A TOTAL OF 702 INDIVIDUALS COMPLETED THE SURVEY THE CAC CONVENED FOR ITS FINAL MEETING ON MARCH 29, 2018 THE CAC MEMBERS IDENTIFIED THE TOP PRIORITIES AS MENTAL HEALTH AND SUBSTANCE ABUSE A COMPLETE DESCRIPTION OF THE CHNA PROCESS IS PROVIDED IN TMH'S CHNA REPORT AT <a href="https://www.choosememorial.org/community-health-needs-assessment">HTTPS //WWW CHOOSEMEMORIAL ORG/COMMUNITY-HEALTH-NEEDS-ASSESSMENT</a></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
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 NO DIRECT WRITTEN FEEDBACK WAS RECEIVED, OTHER THAN SEVERAL ARTICLES IN THE N EWSPAPER COMMENDING THE COLLABORATION COMMUNITY HEALTH NEEDS WERE PRIORITIZED BASED ON RE VIEWS OF SECONDARY COMMUNITY DATA, AS WELL AS PRIMARY DATA GATHERED BY A COMMUNITY ADVISOR Y COMMITTEE (CAC) COMPRISED OF 15 REPRESENTATIVES FROM THE FOLLOWING COMMUNITY ORGANIZATION NS JACKSONVILLE SCHOOL DISTRICT #117/EARLY YEARS PROGRAM, SERVES CHILDREN AGES 3-18, PRAI RIE COUNCIL ON AGING, SIU CENTER FOR FAMILY MEDICINE (FQHC), MEMORIAL BEHAVIORAL HEALTH, C ENTRAL COUNTIES HEALTH CENTER (FQHC), JACKSONVILLE POLICE DEPARTMENT, MORGAN COUNTY SHERIF F, MORGAN COUNTY PROBATION, MORGAN COUNTY EMERGENCY SERVICES, SALVATION ARMY, ILLINOIS DEP ARTMENT OF HUMAN SERVICES, MIDWEST YOUTH SERVICES, ELM CITY CENTER, LOCUST STREET RESOURCE CENTER, AND HOME INSTEAD SENIOR CARE NOVEMBER 2017-TWO CAC MEETINGS WERE HELD THE FORMA T OF THE MEETINGS INCLUDED A SHORT INTRODUCTION OF THE CHNA, A SUMMARY OF THE OUTCOMES FRO M THE 2015 CHNA AND AN EXPLANATION OF THE 2018 PROCESS THIS WAS FOLLOWED BY AN ENGAGING S ESSION IN WHICH ATTENDEES WERE ASKED TO IDENTIFY THREE OF THE COUNTY'S HIGHEST UNMET NEEDS THE EXERCISE GAVE US A COMPREHENSIVE SNAPSHOT OF THE NEEDS IN THE COMMUNITY ACCORDING TO ITS SERVICE PROVIDERS THESE RESULTS WERE COMBINED AND CATEGORIZED ACCORDING TO THE COUNT Y HEALTH RANKING MODEL INTO FOUR CATEGORIES HEALTH BEHAVIORS, CLINICAL CARE, SOCIAL AND E CONOMIC FACTORS AND PHYSICAL ENVIRONMENT THE CAC WAS RECONVENED TO REVIEW HEALTH FACTORS AND START TO PRIORITIZE THOSE FACTORS BASED ON ITS COLLECTIVE OPINION OF THE GREATEST NEED THE CAC WAS ASKED TO IDENTIFY A TOP-DOWN LIST OF THE FIVE HIGHEST-NEED PRIORITIES THE C AC IDENTIFIED YOUTH SERVICES, MENTAL HEALTH, DRUG/ALCOHOL TREATMENT, STDs/EARLY SEXUAL HEA LTH AND OBESITY COMMON THEMES WERE ACCESS TO CARE, INFORMATION AND AFFORDABILITY A SURVEY WAS CONDUCTED FOR MORGAN COUNTY BY THE UNIVERSITY OF ILLINOIS' SURVEY RESEARCH DEPARTMEN T FROM JANUARY 12-FEBRUARY 12, 2018 797 INDIVIDUALS COMPLETED THE SURVEY THE CAC CONVENE D FOR ITS FINAL MEETING ON MARCH 22, 2018 THE CAC RECEIVED A DETAILED REVIEW OF THE OUTCO MES OF THE COMMUNITY SURVEY CAC MEMBERS REVIEWED THE SURVEY RESULTS AND ENGAGED IN AN EXE RCISE TO BEGIN MAPPING AVAILABLE COMMUNITY RESOURCES IN THE AREAS OF UNMET NEED NEXT, THE CAC REVISITED THE COUNTY HEALTH RANKING MODEL THE CAC USED THIS MODEL TO APPLY ITS RESEA RCH AND EXPLORE HOW HEALTH FACTORS UNIQUE TO MORGAN COUNTY COULD BE ADDRESSED IN ITS IMPLE MENTATION STRATEGY THE PRIORITIES, ALONG WITH HEALTH FACTORS IDENTIFIED BY COMMUNITY MEMB ERS 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 THI S EXERCISE CREATED A SNAPSHOT

**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	OF EXISTING RESOURCES WHICH APPLY TO THE HEALTH NEEDS, AND ALSO IDENTIFIED GAPS THAT EXIST IN SERVICES UPON FINAL REVIEW OF THE RESEARCH AND FEEDBACK PROVIDED BY COMMUNITY RESOURCES, PAH IDENTIFIED THREE PRIORITIES TO BE ADDRESSED ACCESS TO CARE, SUBSTANCE ABUSE AND MENTAL HEALTH A COMPLETE DESCRIPTION OF THE CHNA PROCESS IS PROVIDED IN PAH'S CHNA REPORT AT <a href="https://www.choosememorial.org/community-health-needs-assessment">HTTPS //WWW CHOOSEMEMORIAL ORG/COMMUNITY-HEALTH-NEEDS-ASSESSMENT</a>



<b>Form 990 Part V Section C Supplemental Information for Part V, Section B.</b>	
<b>Section C. Supplemental Information for Part V, Section B.</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 (MMC) CONDUCTED THE 2018 SANGAMON COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT IN COLLABORATION WITH HSHS ST JOHN'S HOSPITAL

**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 MMC ALSO COLLABORATED WITH THE SANGAMON COUNTY DEPARTMENT OF PUBLIC HEALTH ON THE CHNA, ASSISTING THE HEALTH DEPARTMENT IN COMPLETING ITS IPLAN FOR THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH MMC 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
ABRAHAM LINCOLN MEMORIAL HOSPITAL	PART V, SECTION B, LINE 6B ALMH COLLABORATED WITH THE LOGAN COUNTY DEPARTMENT OF PUBLIC HEALTH ON THE CHNA, ASSISTING THE HEALTH DEPARTMENT IN COMPLETING ITS IPLAN FOR THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH ALMH 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 TMH COLLABORATED WITH THE CHRISTIAN COUNTY HEALTH DEPARTMENT ON THE CHNA, ASSISTING THE HEALTH DEPARTMENT IN COMPLETING ITS IPLAN FOR THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH TMH 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 PAH 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
MEMORIAL MEDICAL CENTER	PART V, SECTION B, LINE 7D THE MEMORIAL HEALTH SYSTEM (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 DECEMBER 20, 2019 ALSO, THE MHS 2019 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 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 2019 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 THE MHS COMMUNICATIONS TEAM ISSUED PRESS RELEASES 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 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 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 OCTOBER 28, 2018 ALSO, THE MHS 2019 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 (MMC) SANGAMON COUNTY CHNA IDENTIFIED NINE FINAL PRIORITIES THAT WERE RECOMMENDED BY ITS COMMUNITY ADVISORY COMMITTEE (CAC) TO BE INCLUDED ON THE COMMUNITY SURVEY FOLLOWING THE SURVEY, THE CAC 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 THROUGH MARCH 2020 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 CAC DID NOT RECOMMEND THAT THE HOSPITALS SELECT THIS A FINAL PRIORITY (2) VIOLENT CRIME - MMC 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 CAC 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 MMC EMERGENCY DEPARTMENT, MEMORIAL PHYSICIAN SERVICES AND MEMORIAL BEHAVIORAL HEALTH HOWEVER, MMC 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 CAC MMC 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 (ALMH) 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, SUPPORTING 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 ALMH 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 (TMH) REVIEWED DATA, OFFERED ADD ITIONAL INSIGHTS ON ISSUES AFFECTING THE COMMUNITY AND RANKED THE PRIORITIES USING THE DEF INED CRITERIA THE COMMUNITY ADVISORY GROUP (CAC) IDENTIFIED SIX PRIORITY HEALTH NEEDS CA NCER, DIABETES, OBESITY, MENTAL HEALTH, SUBSTANCE ABUSE, AND SEXUALLY TRANSMITTED DISEASES THAT WERE RECOMMENDED TO BE INCLUDED ON THE COMMUNITY SURVEY FOLLOWING THE SURVEY, THE E XTERNAL ADVISORY GROUP, INCLUDING REPRESENTATIVES FROM PUBLIC HEALTH, SOCIAL SERVICES ORGA NIZATIONS AND THOSE OFFERING CARE UNDERSERVED POPULATIONS, AS WELL AS RECOMMENDATIONS FROM THE MEMORIAL HEALTH SYSTEM INTERNAL ADVISORY TEAM, REVIEWED THE SURVEY RESULTS AND DATA A ND RECOMMENDED TWO TOP PRIORITIES TO ADDRESS IN 2019-2021 IMPLEMENTATION STRATEGY THE TWO FINAL PRIORITIES WERE SELECTED MENTAL HEALTH AND SUBSTANCE ABUSE (DRUGS, ALCOHOL AND TOB ACCO) THESE WERE APPROVED BY THE TMH BOARD ON JULY 10, 2018 MENTAL HEALTH WILL BE ADDRES SED BY CONTINUING TO OFFER MENTAL HEALTH FIRST AID TRAINING TO THE COMMUNITY, EXPANDING YO UTH-FOCUSED MENTAL HEALTH FIRST AID, SUPPORT FOR GIRLS ON THE RUN, CONTINUING TO OFFER SEN IOR LIFE SOLUTIONS, AND DEVELOPING A "STEP-DOWN" PROGRAM FOR ON-GOING SUPPORT OF SENIOR LI FE SOLUTIONS GRADUATES TMH WILL ADDRESS SUBSTANCE ABUSE THROUGH SYSTEM-WIDE WORK WITH MHS AFFILIATES TO COMBAT OPIOID ABUSE, AND WILL COORDINATE WORK WITH OTHER HOSPITALS AND MEDI CAL GROUPS ALSO, MHS IS DEVELOPING A SYSTEM-WIDE INITIATIVE TO EXPAND ACCESS TO SUBSTANCE ABUSE TREATMENT TMH WILL ALSO CONTINUE DONATION OF NARCAN TO LOCAL LAW ENFORCEMENT IN CH RISTIAN COUNTY, FUND AN DRUG ABUSE PREVENTION PROGRAM FOR YOUTH IN TAYLORVILLE 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 LEADERSHIP AND S UPPORT FOR THE INITIATIVES OF THE CHRISTIAN COUNTY PREVENTION COALITION AND FAMILIES ANONY MOUS PROGRAM THERE WERE FOUR NON-PRIORITIZED SIGNIFICANT HEALTH NEEDS THAT TMH DID NOT IN CLUDE IN ITS IMPLEMENTATION STRATEGY (1) CANCER WAS NOT SELECTED BECAUSE IT WAS NOT RANKE D BY THE CAC AS HAVING A HIGH PRIORITY AND THERE WAS OPPORTUNITY TO ADDRESS LUNG CANCER IN CIDENCE WITH EFFORTS TO ADDRESS TOBACCO ABUSE EXISTING ASSETS IN THE COMMUNITY WITH CANCER DIAGNOSIS AND TREATMENT WERE CONSIDERED TO BE WELL UTILIZED AND APPROPRIATE THE CAC DID NOT RECOMMEND THAT TMH SELECT THIS AS A FINAL PRIORITY (2 AND 3) OBESITY AND DIABETES WE RE ELIMINATED FROM FURTHER CONSIDERATION BECAUSE THE CAC MEMBERS BELIEVED THAT EFFORTS TO IMPROVE TREATMENT AND PREVENTION OF OBESITY WOULD ALSO POSITIVELY IMPACT INCIDENCE OF DIAB ETES TMH ALREADY DEVOTES SIGNIFICANT RESOURCES TO ADDRESSING DIABETES EDUCATION AND SUPPO RT TMH IS PARTNERING WITH THE LOCAL YMCA'S DIABETES PREVENTION PROGRAM THE DECISION WAS MADE TO APPLY ADDITIONAL RESOURCES TO OTHER SELECTED PRIORITIES (4) SEXUALLY TRANSMITTED DISEASES WAS NOT SELECTED BECA</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	USE IT WAS CONSISTENTLY RANKED LOW ON THE LIST OF PRIORITIES WITH BOTH THE COMMUNITY AND T HE CAC THE DECISION WAS MADE TO APPLY ADDITIONAL RESOURCES TO THE OTHER SELECTED PRIORITI ES

**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	<p>PART V, SECTION B, LINE 11 PASSAVANT AREA HOSPITAL (PAH) AND MORGAN COUNTY CHNA IDENTIFIED EIGHT FINAL PRIORITIES THAT WERE RECOMMENDED BY ITS COMMUNITY ADVISORY COMMITTEE (CAC) 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 IS BEING ADDRESSED THROUGH A COMMUNITY HEALTH WORKER PROGRAM IN ONE AT-RISK NEIGHBORHOOD, BY WORKING WITH INDIVIDUALS TO ADDRESS MEETING THEIR SELF-SUFFICIENCY MEASURES, HELPING CLIENTS IMPROVE THEIR SOCIAL DETERMINANTS OF HEALTH, AND GAINING UNDERSTANDING OF HOW TO ACCESS MEDICAL HEALTH SERVICES PAH CONTINUES TO PROVIDE SUPPORT TO THE MCHD STD CLINIC FOR PREVENTION, DETECTION AND TREATMENT OF STDs SECOND, MENTAL HEALTH ACCESS IS BEING EXPANDED THROUGH TELEHEALTH PSYCHIATRIC SERVICES IN OUR CENTER FOR PSYCHIATRIC HEALTH, CONTINUING TO OFFER MENTAL HEALTH FIRST AID TRAINING TO THE COMMUNITY, 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-PAH WILL CONTINUE OFFERING THE WEIGHT LOSS &amp; WELLNESS PROGRAM ALONG WITH THE WALKING FOR WELLNESS PARTNERSHIP WITH JACKSONVILLE HIGH SCHOOL AND FIRST CHRISTIAN CHURCH HOWEVER, PAH 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 PAH 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 &amp; 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</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
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)
<b>1</b> 1 - MEMORIAL PHYSICIAN SERVICES-KOKE MILL 3132 OLD JACKSONVILLE RD SPRINGFIELD, IL 62704	MPS PHYSICIAN
<b>1</b> 2 - MEMORIAL PHYS SVCS-JACKSONVILLE 15 FOUNDERS LANE SUITE 100 JACKSONVILLE, IL 62650	MPS PHYSICIAN
<b>2</b> 3 - MEMORIAL PHYSICIAN SERVICES-LINCOLN 515 NORTH COLLEGE STREET LINCOLN, IL 62526	MPS PHYSICIAN
<b>3</b> 4 - MEMORIAL EXPRESSCARE AT SOUTH SIXTH 2950 SOUTH SIXTH STREET SPRINGFIELD, IL 62703	ANCILLARY SERVICES
<b>4</b> 5 - MEMORIAL EXPRESSCARE AT NORTH DIRKSEN 3220 ATLANTA STREET SPRINGFIELD, IL 62702	ANCILLARY SERVICES
<b>5</b> 6 - MEMORIAL EXPRESSCARE AT KOKE MILL 3132 OLD JACKSONVILLE RD SPRINGFIELD, IL 62704	ANCILLARY SERVICES
<b>6</b> 7 - MEMORIAL PHYSICIAN SERVICES-VINE STREET 3225 HEDLEY RD SPRINGFIELD, IL 62711	MPS PHYSICIAN
<b>7</b> 8 - MEMORIAL PHYSICIAN SERVICES-CHATHAM 101 EAST PLUMMER CHATHAM, IL 62629	MPS PHYSICIAN
<b>8</b> 9 - SPORTSCARE AT YMCA 4550 WEST ILES SPRINGFIELD, IL 62711	OUTPATIENT SERVICES
<b>9</b> 10 - MEMORIAL EXPRESSCARE AT CHATHAM 101 EAST PLUMMER CHATHAM, IL 62629	ANCILLARY SERVICES
<b>10</b> 11 - MEMORIAL PHYS SVCS-WOMEN'S HEALTHCARE 747 NORTH RUTLEDGE SPRINGFIELD, IL 62701	MPS PHYSICIAN
<b>11</b> 12 - MEMORIAL PHYSICIAN SERVICES-PETERSBURG 1 CENTRE DRIVE PETERSBURG, IL 62675	MPS PHYSICIAN
<b>12</b> 13 - MEMORIAL INDUSTRIAL REHAB 775 ENGINEERING DRIVE SPRINGFIELD, IL 62703	OUTPATIENT SERVICES
<b>13</b> 14 - MEMORIAL PHYSICIAN SVCS-NORTH DIRKSEN 3220 ATLANTA STREET SPRINGFIELD, IL 62707	MPS PHYSICIAN
<b>14</b> 15 - WOUND HEALING CENTER 901 NORTH FIRST STREET SPRINGFIELD, IL 62702	OUTPATIENT SERVICES



**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)
<b>16</b> 16 - SPINEWORKS PAIN CENTER 501 NORTH FIRST STREET SPRINGFIELD, IL 62702	OUTPATIENT SERVICES
<b>1</b> 17 - MEMORIAL PHYSICIAN SERVICES-SOUTH SIXTH 2950 SOUTH SIXTH STREET SPRINGFIELD, IL 62703	MPS PHYSICIAN
<b>2</b> 18 - MEMORIAL PHYSICIAN SVCS-MACARTHUR 2115 SOUTH MACARTHUR BLVD SPRINGFIELD, IL 62704	MPS PHYSICIAN
<b>3</b> 19 - MEMORIAL NOW 701 NORTH FIRST STREET SPRINGFIELD, IL 62781	VIRTUAL CARE
<b>4</b> 20 - JBS BEARDSTOWN 8460 ST LUKES DRIVE BEARDSTOWN, IL 62618	OUTPATIENT SERVICES
<b>5</b> 21 - CONCORDIA VILLAGE 4101 WEST ILES AVENUE SPRINGFIELD, IL 62711	OUTPATIENT SERVICES

Note: To capture the full content of this document, please select landscape mode (11" x 8.5") when printing.

Schedule I  
(Form 990)

Department of the  
Treasury  
Internal Revenue Service

Grants and Other Assistance to Organizations,  
Governments and Individuals in the United States

Complete if the organization answered "Yes," on Form 990, Part IV, line 21 or 22.  
▶ Attach to Form 990.  
▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No 1545-0047

2018

Open to Public  
Inspection

Name of the organization  
MEMORIAL HEALTH SYSTEM GROUP

Employer identification number  
90-0756744

Part I General Information on Grants and Assistance

- 1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . . . ☒ Yes ☐ No
- 2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of 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 . . . . . 18

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

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

Part III can be duplicated if additional space is needed

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of 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)	73,548				SEE PART IVCONTRIBUTION TO THE ILLINOIS HEALTH RESEARCH EDUCATIONAL FUND TO DONATE TO GRANT PROGRAM FOR HOSPITALS TO COVER A PORTION OF THE NET LOSS SUSTAINED FROM THE ILLINOIS PROVIDER ASSESSMENT PROGRAM
KUMLER OUTREACH MINISTRIES 303 NORTH GRAND AVE EAST SPRINGFIELD, IL 62702	37-0695489	501(C)(3)	12,000				SEE PART IVPHARMACEUTICAL 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		12,000				SEE PART IV HEALTHCARE SAFETY SYMPOSIUM
MEMORIAL HOME SERVICES 701 NORTH FIRST STREET SPRINGFIELD, IL 62781	37-0714225	501(C)(3)	16,573				SEE PART IV PROVIDE GENERAL SUPPORT

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

<b>(a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section if applicable	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Purpose of grant or assistance
MEMORIAL MEDICAL CENTER 701 NORTH FIRST STREET SPRINGFIELD, IL 62781	37-0661220	501(C)(3)	695,189				SEE PART IV PROVIDE DIABETES EDUCATION SCHOLARSHIPS, CULINARY MEDICINE EQUIPMENT & TRAINING, LYMPHEDEMA CERTIFICATION, SIMULATION EQUIPMENT, INNOVATION LAB, SUPPORT FOR MCLI, AND GENERAL SUPPORT
MENTAL HEALTH CENTERS OF CENTRAL ILLINOIS 710 NORTH EIGHTH STREET SPRINGFIELD, IL 62702	37-0646367	501(C)(3)	196,122				SEE PART IV PROVIDE GENERAL SUPPORT, MOSAIC PROGRAM TO PROVIDE CHILDREN'S MENTAL HEALTH SERVICES BY INCREASING THE NUMBER OF BEHAVIORAL HEALTH CLINICIANS SERVING SPRINGFIELD 186 SCHOOLS, AND COMMUNITY OUTREACH AND ENGAGEMENT TEAM (COET) TO RESPOND TO CRISIS CALLS WITH SIU MEDICINE AND THE SPRINGFIELD POLICE DEPARTMENT

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)	305,759				SEE PART IV PROVIDE GENERAL SUPPORT, CARDIOLOGY EQUIPMENT AND SUPPLIES, COMMUNITY EMS TRAINING AND EQUIPMENT, COMMUNITY HEALTH IMPROVEMENT, COMMUNITY HEALTH SUPPORT, AND LIFELINE SUPPORT
SIU PHYSICIANS & SURGEONS INC DBA SIU HEALTHCARE PO BOX 19639 SPRINGFIELD, IL 62794	36-4143823	501(C)(3)	2,254,624				SEE PART IV 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.**

<b>(a)</b> Name and address of organization or government	<b>(b)</b> EIN	<b>(c)</b> IRC section if applicable	<b>(d)</b> Amount of cash grant	<b>(e)</b> Amount of non-cash assistance	<b>(f)</b> Method of valuation (book, FMV, appraisal, other)	<b>(g)</b> Description of non-cash assistance	<b>(h)</b> Purpose of grant or assistance
SIU SCHOOL OF MEDICINE 801 NORTH RUTLEDGE SPRINGFIELD, IL 62702	37-6005961	501(C)(3)	316,886				SEE PART IV PROVIDE GENERAL SUPPORT, HYPERBARIC OXYGEN EFFECTS, RESEARCH LAB EQUIPMENT, TARGETED MUSCLE REINNERVATION, ASSESSMENT OF ROBOTIC COLONRECTAL SURGERIES, LVRS FOR EMPHYSEMA PATIENTS, EMERGENCY MEDICINE REGIONAL MEETING, SCHIZOPHRENIA PATIENT STUDY, ANTIBIOTICS SYNERGY TESTING, AND ULTRASOUND EDUCATION
TAYLORVILLE MEMORIAL HOSPITAL 201 E PLEASANT ST TAYLORVILLE, IL 62568	37-0661250	501(C)(3)	36,611				SEE PART IV 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
YMCA 701 SOUTH FOURTH STREET SPRINGFIELD, IL 62703	37-0661263	501(C)(3)	5,219,370				SEE PART IVTO 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 AND SUMMER CAMP FOR MATTHEW PROJECT KIDS
COMPASS FOR KIDS 501 S 4TH ST SPRINGFIELD, IL 62701	81-2892902	501(C)(3)	5,758				SEE PART IVCAMP CARE-A-LOT

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)	58,749				SEE PART IVNURSING LEARNING LAB
SPRINGFIELD FIRE DEPARTMENT 825 E CAPITOL AVE SPRINGFIELD, IL 62701	37-6002037	501(C)(3)	8,700				SEE PART IVPROVIDE SMOKE & CARBON MONOXIDE DETECTORS

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
MACMURRAY COLLEGE 447 E COLLEGE AVE JACKSONVILLE, IL 62650	37-0661217	501(C)(3)	89,800				SEE PART IVNURSING LEARNING LAB AND COMMUNITY HEALTH IMPROVEMENT
HELPING HANDS OF SPRINGFIELD 1023 E WASHINGTON ST SPRINGFIELD, IL 62703	37-1255889	501(C)(3)	25,000				SEE PART IVHOUSING FOR THE HOMELESS

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 CRITICAL ACCESS HOSPITAL NETWORK (ICAHN) 1945 VANS WAY PRINCETON, IL 61356	55-0809159	501(C)(3)	9,296				SEE PART IV TO PURCHASE RYCEN BILLING SOFTWARE
BROTHER JAMES COURT 2508 ST JAMES ROAD SPRINGFIELD, IL 62707	37-1007739	501(C)(3)	6,335				SEE PART IV DINAMAPS

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
JACKSONVILLE PUBLIC SCHOOL DISTRICT #117	37-6004176	501(C)(3)	21,000				SEE PART IV COMMUNITY HEALTH IMPROVEMENT

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

<b>(a)</b> Type of grant or assistance	<b>(b)</b> Number of recipients	<b>(c)</b> Amount of cash grant	<b>(d)</b> Amount of non-cash assistance	<b>(e)</b> Method of valuation (book, FMV, appraisal, other)	<b>(f)</b> Description of non-cash assistance
EDUCATIONAL ASSISTANCE PAYMENTS	291	1,046,885			
PRESCRIPTION DRUGS FOR PATIENTS	51	7,466			
SHELTER AND UTILITY ASSISTANCE FOR PATIENTS	100	56,157			
DIRECT CASH ASSISTANCE TO PATIENTS	71	28,031			
TRANSPORTATION ASSISTANCE FOR PATIENTS	119	27,491			

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	41	26,602			
TAYLORVILLE CUPS ASSISTANCE	62	18,480			
PEDIATRIC DENTISTRY	4	3,803			
COMMUNITY HEALTH OUTREACH	12	3,000			
MEALS AND GROCERIES FOR PATIENTS	49	19,325			

Schedule J  
(Form 990)

Department of the Treasury  
Internal Revenue Service

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees  
▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23.  
▶ Attach to Form 990.  
▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization  
MEMORIAL HEALTH SYSTEM GROUP

Employer identification number  
90-0756744

Part I Questions Regarding Compensation		Yes	No
<b>1a</b> Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a Complete Part III to provide any relevant information regarding these items			
<input checked="" type="checkbox"/> First-class or charter travel	<input 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>b</b> If any of the boxes in line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	<b>1b</b>	Yes	
<b>2</b> Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?	<b>2</b>	Yes	
<b>3</b> Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director Check all that apply Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III			
<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		
<b>4</b> During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization			
<b>a</b> Receive a severance payment or change-of-control payment?	<b>4a</b>		No
<b>b</b> Participate in, or receive payment from, a supplemental nonqualified retirement plan?	<b>4b</b>	Yes	
<b>c</b> Participate in, or receive payment from, an equity-based compensation arrangement?	<b>4c</b>		No
If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III			
<b>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</b>			
<b>5</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of			
<b>a</b> The organization?	<b>5a</b>		No
<b>b</b> Any related organization?	<b>5b</b>		No
If "Yes," on line 5a or 5b, describe in Part III			
<b>6</b> For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of			
<b>a</b> The organization?	<b>6a</b>		No
<b>b</b> Any related organization?	<b>6b</b>		No
If "Yes," on line 6a or 6b, describe in Part III			
<b>7</b> 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	<b>7</b>		No
<b>8</b> Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	<b>8</b>		No
<b>9</b> If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	<b>9</b>		



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**Schedule J (Form 990) 2018**

**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	CHARTER TRAVEL IS OCCASIONALLY PROVIDED FOR THE CONVENIENCE OF EXECUTIVES/KEY EMPLOYEES ATTENDING OFF-SITE BUSINESS RELATED MEETINGS CHARTER TRAVEL IS NOT TAXABLE INCOME TO THE INDIVIDUAL BECAUSE IT IS RELATED TO BUSINESS TRAVEL

Return Reference	Explanation
PART I, LINE 3	<p>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, WHICH IS A COMMITTEE OF THE MHS BOARD CONSISTING ENTIRELY OF MHS BOARD MEMBERS WHO ARE INDEPENDENT AND WHO ARE FREE OF ANY CONFLICTS OF INTEREST. BASE COMPENSATION IS SET AT OR AROUND THE MIDDLE OF THE MARKET BASE SALARY DATA FOR HEALTHCARE ORGANIZATIONS SIMILAR TO MHS, AS MEASURED AND PRESENTED TO THE COMMITTEE BY AN INDEPENDENT COMPENSATION CONSULTANT. INCENTIVE COMPENSATION WAS CONDITIONED ON ACHIEVEMENT OF SPECIFIC, RIGOROUS PERFORMANCE MEASURES ACROSS ALL OF MHS, AND THOSE PERFORMANCE MEASURES WERE REVIEWED AND APPROVED IN ADVANCE BY THE LEADERSHIP COMPENSATION COMMITTEE. RETIREMENT BENEFITS IN COLUMN (B)(III) IS THE DISTRIBUTION OF VESTED AMOUNTS THAT WERE EARNED OVER MANY YEARS OF SERVICE, AND ARE REPORTED AT THEIR FULL VALUE WHEN THEY BECOME VESTED. THESE RETIREMENT BENEFITS WERE PREVIOUSLY REPORTED IN COLUMN (C) WHEN THE BENEFITS WERE FIRST EARNED AND CREDITED TO THE EMPLOYEE, AND THEN THE BENEFITS MUST BE REPORTED AGAIN IN COLUMN (B)(III) WHEN VESTED AND TAXED. A READER SHOULD TAKE NOTE THAT THE AMOUNT IN COLUMN (F) SHOWS THE PORTION OF RETIREMENT BENEFITS ALREADY REPORTED ON MANY PRIOR FORM 990 RETURNS WHEN THOSE AMOUNTS WERE FIRST EARNED, AND THE READER SHOULD SUBTRACT THOSE AMOUNTS FROM THE TOTAL TO DETERMINE TOTAL COMPENSATION FOR THE YEAR BEING REPORTED. IN THE CASE OF MR. CURTIS, THE TOTAL COMPENSATION FOR THE YEAR BEING REPORTED, WITHOUT THE PRIOR YEAR AMOUNTS IN COLUMN (F), IS \$2,263,183. IN THE CASE OF MR. KAY AND MS. PRATER, THE TOTAL COMPENSATION FOR THE YEAR BEING REPORTED, WITHOUT THE PRIOR YEAR AMOUNTS IN COLUMN (F), IS \$1,662,474 AND \$1,490,588. IN EACH CASE, THESE COMPENSATION AMOUNTS INCLUDED RETIREMENT BENEFITS THAT WERE EARNED IN PART DUE TO THE INDIVIDUAL'S MANY YEARS OF SERVICE WITH MHS.</p>

Return Reference	Explanation
PART I, LINE 4B	<p>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 EDGAR CURTIS \$9,326,185, DOLAN DALPOAS \$34,423, VIRGINIA DOLAN, M D \$35,407, J TRAVIS DOWELL \$27,712, ANNA EVANS, J D \$43,530, NICOLE FLORENCE, M D \$60,236, ANTHONY GRIFFIN, M D \$24,171, DAVID GRAHAM, M D \$64,143, MARK HANSEN, M D \$89,070, LINDA JONES, D N S \$274,697, ROBERT KAY \$3,955,474, STEVEN LILLPOP, M D \$70,369, GUSTAVO MOSQUERA, M D \$51,557, MARSHA PRATER, PH D \$3,445,157, CHRISTOPHER RIVERA, M D \$18,306, FERDINAND SALVACION, M D \$83,132, DAVID SANDERCOCK, M D \$86,826, CHRISTINA SCHEIBLER-VENTRESS, M D \$60,862, ROBERT SCOTT \$6,138, AND AMIR WAHAB, M D \$142,108 AGAIN, THE READER SHOULD NOTE THAT THE RETIREMENT BENEFIT AMOUNTS BECAME VESTED IN THE YEAR BEING REPORTED, AND WERE EARNED AND ALREADY REPORTED ON PREVIOUS FORM 990 RETURNS THE AMOUNT IN COLUMN (F) SHOWS THE PORTION OF RETIREMENT BENEFITS REPORTED ON PRIOR FORM 990 RETURNS WHEN THOSE AMOUNTS WERE FIRST EARNED, AND THE READER SHOULD SUBTRACT THOSE AMOUNTS FROM THE TOTAL TO DETERMINE TOTAL COMPENSATION FOR THE YEAR BEING REPORTED IN THE CASE OF MR CURTIS, THE TOTAL COMPENSATION FOR THE YEAR BEING REPORTED, WITHOUT THE PRIOR YEAR AMOUNTS IN COLUMN (F), IS \$2,263,183 IN THE CASE OF MR KAY AND MS PRATER, THE TOTAL COMPENSATION FOR THE YEAR BEING REPORTED, WITHOUT THE PRIOR YEAR AMOUNTS IN COLUMN (F), IS \$1,662,474 AND \$1,490,588 IN EACH CASE, THESE COMPENSATION AMOUNTS INCLUDED RETIREMENT BENEFITS THAT WERE EARNED IN PART DUE TO THE INDIVIDUAL'S MANY YEARS OF SERVICE WITH MHS 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 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, M D , TRACY MIZEUR, M D , ANTHONY GRIFFIN, M D , CHRISTOPHER RIVERA, M D , MARK HANSEN, M D , J TRAVIS DOWELL, RAEDENA RYAN, VIRGINIA DOLAN, M D , NICOLE FLORENCE, M D , JAMESON ROSZHART, TAMAR KUTZ, HARRY SCHMIDT, DOLAN DALPOAS, KIMBERLY BOURNE, EVAN DAVIS, KATHRYN KEIM, EDGAR CURTIS, ROBERT KAY, KEVIN ENGLAND, CHARLES CALLAHAN, AND JANICE GAMBACH</p>



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				
AMIR JOHN WAHAB MD BOARD MEMBER ALMH/MPS PHYSICIAN	(i)	412,704	45,978	168,742	27,150	49,038	703,612	31,927
	(ii)	0	0	0	0	0	0	0
TRACY MIZEUR MD BOARD MEMBER ALMH/MPS PHYSICIAN	(i)	202,252	18,028	220	19,445	9,330	249,275	0
	(ii)	0	0	0	0	0	0	0
ANTHONY GRIFFIN MD BOARD MEMBER MPS/MPS PHYSICIAN	(i)	324,913	25,381	49,993	23,286	37,678	461,251	24,093
	(ii)	0	0	0	0	0	0	0
CHRISTOPHER RIVERA MD BOARD MEMBER MPS/MPS PHYSICIAN	(i)	238,722	27,191	19,298	19,292	32,872	337,375	0
	(ii)	0	0	0	0	0	0	0
MARK HANSEN MD CHAIR MPS/MPS PHYSICIAN	(i)	369,940	22,000	107,265	27,150	37,218	563,573	72,089
	(ii)	0	0	0	0	0	0	0
J TRAVIS DOWELL PRESIDENT MPS & VP MPS	(i)	0	0	0	0	0	0	0
	(ii)	241,097	74,460	89,804	51,914	37,714	494,989	21,681
VIRGINIA DOLAN MD BOARD MEMBER SRS (FROMMAR19)	(i)	429,633	13,223	53,887	27,138	35,827	559,708	27,018
	(ii)	0	0	0	0	0	0	0
NICOLE FLORENCE MD BOARD MEMBER SRS (FROMMAR19)	(i)	373,711	39,105	78,470	24,450	35,616	551,352	49,682
	(ii)	0	0	0	0	0	0	0
TAMAR KUTZ BOARD MEMBER MHSVC	(i)	0	0	0	0	0	0	0
	(ii)	175,213	26,475	1,095	11,303	2,619	216,705	0
JAMESON ROSZHART BMMHVMPSCRMHSVC/VPAMNT (TRMY19)PRSAMG	(i)	0	0	0	0	0	0	0
	(ii)	252,988	78,180	7,195	47,170	26,828	412,361	0
HARRY SCHMIDT BMMHSVC(TRJN19)PRSCFOPAHCRNA (TRJN19)	(i)	0	0	0	0	0	0	0
	(ii)	246,561	75,250	30,770	144,024	2,202	498,807	0
DOLAN DALPOAS PRESIDENT ALMH/BRDMEM MHSVC/CEOALMH	(i)	0	0	0	0	0	0	0
	(ii)	281,518	84,450	57,106	55,454	405	478,933	22,240
KIMBERLY BOURNE PRES TMH&TMHF/BRDMMHMSVC/CEOTMH	(i)	0	0	0	0	0	0	0
	(ii)	250,752	77,760	18,350	52,783	27,640	427,285	0
EVAN DAVIS BMMHV/ADMINORTH (TRMAY19)/VPCLINOPS	(i)	191,812	29,565	5,732	17,726	5,981	250,816	0
	(ii)	0	0	0	0	0	0	0
KATHRYN KEIM SCTRSMHVMHSVCMP/VPFN (TRDC18)/SVPCFO	(i)	0	0	0	0	0	0	0
	(ii)	234,193	72,510	10,580	45,701	26,788	389,772	0
EDGAR CURTIS PRES&CEOMHS/PRESMMC (THRUMAY19)/BMMPS	(i)	0	0	0	0	0	0	0
	(ii)	907,415	480,743	9,413,029	120,655	19,737	10,941,579	8,678,396
ROBERT KAY SVPCFO(TRMR19)/SCTRSMHSVCMP (TRDC18)	(i)	0	0	0	0	0	0	0
	(ii)	490,144	209,454	3,972,143	192,469	21,324	4,885,534	3,223,060
KEVIN ENGLAND VCP/SMHV/VC/MSVC/SVPBD (TRMY19)/SVPCAO	(i)	0	0	0	0	0	0	0
	(ii)	263,765	143,682	22,559	157,258	30,621	617,885	0
CHARLES CALLAHAN PHD EVP/COMMC(TRMY19) PRCEOMMC/PRSMH/VCCRMH	(i)	472,752	203,175	71,455	175,196	29,701	952,279	0
	(ii)	0	0	0	0	0	0	0
JANICE GAMBACH PRESIDENT SRS, ADMIN MBH	(i)	0	0	0	0	0	0	0
	(ii)	184,931	28,331	7,676	15,136	10,597	246,671	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				
MELISSA HANSEN-SCHMADEKE EXECDIRMMCF(FROMJAN18)	(i)	135,737	14,700	164	4,641	10,802	166,044	0
	(ii)	0	0	0	0	0	0	0
MARSHA PRATER PHD SVP & CNO MMC	(i)	323,242	137,088	3,461,396	91,561	9,595	4,022,882	2,532,294
	(ii)	0	0	0	0	0	0	0
LINDA JONES DNS VP OPS MMC (THRUMAY19)/VP ANCOPS	(i)	272,118	82,350	303,728	47,114	9,396	714,706	139,369
	(ii)	0	0	0	0	0	0	0
DREW EARLY VP OPERATIONS (THRUMAY19)/VP,INT&SPE	(i)	241,725	75,450	12,750	46,431	28,937	405,293	0
	(ii)	0	0	0	0	0	0	0
ANNA EVANS JD GENCO/VPIACOMPMS (TRMAY19)/SVP&GENCO	(i)	0	0	0	0	0	0	0
	(ii)	365,527	112,590	50,002	121,191	29,049	678,359	29,415
RAJESH GOVINDAIAH MD SVP & CMO MHS	(i)	0	0	0	0	0	0	0
	(ii)	460,525	196,770	29,332	81,271	9,252	777,150	0
DAVID GRAHAM MD SVP & CIO MHS (THRUMAY19)/SVP&CQ&IO M	(i)	0	0	0	0	0	0	0
	(ii)	433,815	184,632	77,877	164,606	17,055	877,985	47,216
ROBERT SCOTT VP & CHRO MHS (THRUMAY19)/SVP & CHRO	(i)	0	0	0	0	0	0	0
	(ii)	322,252	97,920	29,908	48,109	25,099	523,288	0
JENNIFER HARRIS ADMIN,PERIOP (TRMAY19)/SYSADM,PERIOP	(i)	205,801	30,870	159	15,457	725	253,012	0
	(ii)	0	0	0	0	0	0	0
MITCHELL ROGERS SYSTEM ADMIN CARDIO SVCS	(i)	225,996	68,174	8,170	39,720	1,689	343,749	0
	(ii)	0	0	0	0	0	0	0
FERDINAND SALVACION MD PHYSICIAN MMC	(i)	480,925	87,252	112,771	87,986	42,450	811,384	72,843
	(ii)	0	0	0	0	0	0	0
STEVEN LILLOP MD PHYSICIAN MPS	(i)	478,418	49,583	118,889	26,673	49,638	723,201	58,040
	(ii)	0	0	0	0	0	0	0
CHRISTINA SCHEIBLER-VENTRESS MD PHYSICIAN MPS	(i)	468,151	50,020	92,993	21,954	30,574	663,692	50,198
	(ii)	0	0	0	0	0	0	0
DAVID SANDERCOCK MD PHYSICIAN MPS	(i)	449,875	49,728	114,094	24,450	45,972	684,119	27,373
	(ii)	0	0	0	0	0	0	0
GUSTAVO MOSQUERA MD PHYSICIAN MPS	(i)	474,996	49,049	79,180	21,513	9,264	634,002	0
	(ii)	0	0	0	0	0	0	0

Schedule L

(Form 990 or 990-EZ)

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.  
▶Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No 1545-0047

2018

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

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 \$50,376 (D) MEMORIAL MEDICAL CENTER PAID COMPENSATION AND BENEFITS OF \$50,376 TO MADELINE CALLAHAN RELATED TO EMPLOYMENT SERVICES FOR THE FISCAL YEAR ENDED 9/30/2019 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 \$239,774 (D) MEMORIAL MEDICAL CENTER PAID FEES TO SPRINGFIELD ELECTRIC SUPPLY FOR GOODS AND SERVICES FOR THE YEAR ENDED SEPTEMBER 30, 2019 IN THE AMOUNT OF \$239,774 RANDALL S GERMERAAD 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 \$593,581 (D) MEMORIAL MEDICAL CENTER PAID FEES TO CLINICAL RADIOLOGISTS, SC FOR THE YEAR ENDED SEPTEMBER 30, 2019 IN THE AMOUNT OF \$593,581 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 \$130,232 (D) PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION PAID COMPENSATION AND BENEFITS OF \$130,232 TO SHERYL ROBERTS RELATED TO EMPLOYMENT SERVICES FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 2019 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 \$20,474 (D) PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION PAID COMPENSATION AND BENEFITS OF \$20,474 TO AMANDA CHUKIN RELATED TO EMPLOYMENT SERVICES FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 2019 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 LEVI, RAY & SHOUP INC	(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION EMPLOYEE, SON OF MMC BOARD MEMBER(C) AMOUNT OF TRANSACTION \$24,278 (D) MEMORIAL HEALTH SYSTEM PAID FEES OF \$24,278 TO LEVI, RAY & SHOUP INC FOR SERVICES THE YEAR ENDED 9/30/2019 MEMORIAL MEDICAL CENTER BOARD MEMBER RICHARD LEVI IS A PARTNER AT LEVI, RAY & SHOUP INC ALL FEES ARE NEGOTIATED AT 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 \$60,985 (D) MEMORIAL MEDICAL CENTER PAID COMPENSATION AND BENEFITS OF \$60,985 TO BRITTANY LIBKA RELATED TO EMPLOYMENT SERVICES FOR THE FISCAL YEAR ENDED 9/30/2019 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
MADELINE CALLAHAN	SEE PART V	50,376	SEE PART V		No
SPRINGFIELD ELECTRIC SUPPLY	SEE PART V	239,774	SEE PART V		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons					
(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
CLINICAL RADIOLOGISTS SC	SEE PART V	593,581	SEE PART V		No
SHERYL ROBERTS	SEE PART V	130,232	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
AMANDA CHUKIN	SEE PART V	20,474	SEE PART V		No
LEVI RAY & SHOUP INC	SEE PART V	24,278	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
BRITTANY LIBKA	SEE PART V	60,985	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.  
►Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No 1545-0047

2018

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	2	1,577,688	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 . . . .				
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

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?

Yes

No

30a

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?

Yes

31

32a

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

Yes

32a

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)	LINE 9 - COLUMN B REPRESENTS THE NUMBER OF CONTRIBUTIONS EACH DONOR EXECUTED A TRANSFER OF SECURITIES ON A SPECIFIC DATE
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

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.

▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No 1545-0047

**2018**

**Open to Public Inspection**

**Employer identification number**

90-0756744

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART V, LINE 2A	THE NUMBER OF EMPLOYEES REPORTED ON THE W-3 IS FOR ALL MEMORIAL HEALTH SYSTEM AFFILIATES MEMORIAL HEALTH SYSTEM IS A COMMON PAY AGENT FOR ALL THE AFFILIATES AND REPORTS ALL EMPLOYEES UNDER ITS EIN



# 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 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 EDGAR CURTIS, NINA HARRIS, SUSAN KOCH AND SERGIO PECORI HAVE A BUSINESS RELATIONSHIP

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, SECTION A, LINE 6	MEMORIAL HEALTH SYSTEM IS THE SOLE CORPORATE MEMBER OF THE AFFILIATES REPORTED IN THIS GROUP RETURN EXCLUDING SPRINGFIELD RESIDENTIAL SERVICES, MEMORIAL MEDICAL CENTER FOUNDATION, JACKSONVILLE CRNA'S, PASSAVANT AREA HOSPITAL FOUNDATION AND TAYLORVILLE MEMORIAL HOSPITAL FOUNDATION. MEMORIAL HEALTH SYSTEM CORPORATION CONTAINS 103 INDIVIDUAL MEMBERS WHO ELECT THE BOARD OF DIRECTORS. SPRINGFIELD RESIDENTIAL SERVICES HAS A SELF-PERPETUATING BOARD OF DIRECTORS WHOSE MEMBERSHIP SHALL BE APPROVED BY OR BE MEMBERS OF THE BOARD OF DIRECTORS FOR MENTAL HEALTH CENTERS OF CENTRAL ILLINOIS. MEMORIAL MEDICAL CENTER FOUNDATION'S MEMBERS ARE ITS BOARD OF DIRECTORS. MEMORIAL MEDICAL CENTER FOUNDATION'S BOARD OF DIRECTORS CONTAINS 15 DIRECTORS. JACKSONVILLE CRNA'S AND PASSAVANT AREA HOSPITAL FOUNDATION'S SOLE CORPORATE MEMBER IS PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION, WHICH IS INCLUDED IN THE GROUP RETURN. TAYLORVILLE MEMORIAL HOSPITAL IS 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
FORM 990, PART IX, LINE 11G	PHYSICIAN SERVICES PROGRAM SERVICE EXPENSES 99,732,193 MANAGEMENT AND GENERAL EXPENSES 1,360,130 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 101,092,323 CONTRACT LABOR PROGRAM SERVICE EXPENSES 7,668,901 MANAGEMENT AND GENERAL EXPENSES 66,692 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 7,735,593 PURCHASED SERVICES PROGRAM SERVICE EXPENSES 26,118,707 MANAGEMENT AND GENERAL EXPENSES 7,901,770 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 34,020,477 PROFESSIONAL FEES PROGRAM SERVICE EXPENSES 910,046 MANAGEMENT AND GENERAL EXPENSES 2,780,918 FUNDRAISING EXPENSES 0 TOTAL EXPENSES 3,690,964

## 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	CHANGE IN MINIMUM PENSION LIABILITY -17,478,472 TRANSFERS TO RELATED ORGANIZATIONS -5,469,082 BOOK/TAX DIFFERENCE -440,650 OTHER -141,259 NONOPERATING NET PERIOD BENEFIT COST -4,872,275 CHANGE IN FAIR VALUE OF INTEREST RATE SWAP -1,202,372

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.  
▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No 1545-0047

2018

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

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
<b>(1)</b> MEMORIAL HOME SERVICES OF CENTRAL ILLINOIS INC 701 NORTH FIRST STREET SPRINGFIELD, IL 62781 37-1190216	PROVIDE DURABLE MEDICAL EQUIPMENT AND SUPPLIES TO PATIENTS	IL	MEMORIAL HOME SERVICES	C	10,769,817	8,458,055	100 000 %	Yes	
<b>(2)</b> PASSAVANT PHYSICIAN ASSOCIATION 1600 WEST WALNUT STREET JACKSONVILLE, IL 62650 26-1200566	PHYSICIAN SERVICES	IL	PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION	C	623,263	255,720	100 000 %	Yes	

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

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

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1) MEMORIAL HOME SERVICES OF CENTRAL ILLINOIS INC	O	190,667	COST BASIS
(2) MEMORIAL HOME SERVICES OF CENTRAL ILLINOIS INC	K	115,259	COST - RENTAL EQUIPMENT
(3) MEMORIAL HOME SERVICES OF CENTRAL ILLINOIS INC	H	147,533	COST BASIS
(4) PASSAVANT PHYSICIAN ASSOCIATION	R	705,641	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)

Return Reference	Explanation