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CHANGE OF ACCOUNTING PERIOD

Form **990****Return of Organization Exempt From Income Tax**

OMB No. 1545-0047

2020

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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 2020 calendar year, or tax year beginning JUL 1, 2020 and ending SEP 30, 2020

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization METHODIST HEALTH, INC		D Employer identification number 61-0461753
	Doing business as DEACONESS HENDERSON HOSPITAL		E Telephone number (270) 827-7700
	Number and street (or P.O. box if mail is not delivered to street address) P.O. BOX 48	Room/suite	G Gross receipts 29,807,890.
	City or town, state or province, country, and ZIP or foreign postal code HENDERSON, KY 42419-0048		H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	F Name and address of principal officer DR. DENNIS BECK SAME AS C ABOVE		H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c)() (insert no) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527			
J Website: WWW.DEACONESS.COM/DEACONESS-HENDERSON-HOS			
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other			
L Year of formation: 1948 M State of legal domicile: KY			

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: METHODIST HEALTH PROVIDES QUALITY HEALTHCARE SERVICES WITH A COMPASSIONATE AND CARING SPIRIT	
	2 Check this box <input type="checkbox"/> 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)	9
	4 Number of independent voting members of the governing body (Part VI, line 1b)	7
	5 Total number of individuals employed in calendar year 2020 (Part V, line 2a)	0
	6 Total number of volunteers (estimate if necessary)	42
Revenue	7a Total unrelated business revenue from Part VIII column (C), line 12	0.
	7b Net unrelated business taxable income from Form 990 T, Part I, line 11	0.
Expenses	8 Contributions and grants (Part VIII line 1h)	1,358,013.
	9 Program service revenue (Part VIII, line 2g)	108,297,346.
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	391,642.
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	3,910,135.
	12 Total revenue add lines 8 through 11 (must equal Part VIII, column (A), line 12)	113,957,136.
	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	83,937.
	14 Benefits paid to or for members (Part IX, column (A), line 4)	0.
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	59,486,483.
	16a Professional fundraising fees (Part IX, column (A), line 11e)	0.
	16b Total fundraising expenses (Part IX, column (D), line 25)	0.
Net Assets or Fund Balances	17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-11g)	75,980,370.
	18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	135,550,790.
	19 Revenue less expenses Subtract line 18 from line 12	-21,593,654.
	20 Total assets (Part X, line 16)	117,520,188.
Net Assets or Fund Balances	21 Total liabilities (Part X, line 26)	97,300,790.
	22 Net assets or fund balances Subtract line 21 from line 20	20,219,398.

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 DR. DENNIS BECK	Date 7/29/21
	Type or print name and title DR. DENNIS BECK, INTERIM CAO	
Paid Preparer Use Only	Print/Type preparer's name CARRIE A. MERRILL, CPA	Preparer's signature CARRIE A. MERRILL, C
	Firm's name BLUE & CO., LLC	Firm's EIN 35-1178661
	Firm's address 2650 EASTPOINT PKWY, SUITE 300	Phone no. 502-992-3500
	LOUISVILLE, KY 40223	

May the IRS discuss this return with the preparer shown above? See instructions

☒ Yes ☐ No

032001 12-23-20

LHA For Paperwork Reduction Act Notice, see the separate instructions.

Form 990 (2020)

SEE SCHEDULE O FOR ORGANIZATION MISSION STATEMENT CONTINUATION

SCANNED MAY 06 2022

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Part III Statement of Program Service Accomplishments

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

☒ X**1** Briefly describe the organization's mission

METHODIST HEALTH PROVIDES QUALITY HEALTHCARE SERVICES WITH A
 COMPASSIONATE AND CARING SPIRIT TO PERSONS, FAMILIES AND COMMUNITIES
 OF THE TRI-STATE. AT METHODIST HEALTH, OUR VALUES ARE BASED ON OUR
 COMMITMENT TO QUALITY. WE DEFINE QUALITY AS THE CONTINUOUS IMPROVEMENT

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 \$ 25,605,314. including grants of \$ 31,816.) (Revenue \$ 28,244,991.)

METHODIST HEALTH, INC. OFFERS A BROAD RANGE OF INPATIENT AND OUTPATIENT
 MEDICAL SERVICES INCLUDING INTENSIVE CARE, OBSTETRICAL SERVICES,
 NEONATOLOGY, SWING BED, EMERGENCY CARE, SURGICAL SERVICES, AMBULATORY
 CARE, RADIOLOGY SERVICES, LABORATORY SERVICES, THERAPY SERVICES, SLEEP
 DISORDERS, AND WOUND CARE SERVICES. THE COMMUNITIES WE SERVE INCLUDE
 HENDERSON, UNION, AND WEBSTER COUNTIES. DEACONESS HENDERSON HOSPITAL
 IS AN ACUTE CARE HOSPITAL LOCATED IN HENDERSON, KY WITH 192 LICENSED
 BEDS. DURING THE THREE-MONTH PERIOD OF JULY 1, 2020 SEPTEMBER 30,
 2020, METHODIST HOSPITAL SERVED 884 INPATIENTS FOR A TOTAL OF 3,874
 INPATIENT DAYS OF SERVICE. DEACONESS HENDERSON HOSPITAL ALSO PROVIDED
 5,510 EMERGENCY ROOM VISITS. DEACONESS UNION COUNTY HOSPITAL IS A
 CRITICAL ACCESS HOSPITAL IN UNION COUNTY, KY. DURING FY 2020, UNION

4b (Code _____) (Expenses \$ _____ including grants of \$ _____) (Revenue \$ _____)**4c** (Code _____) (Expenses \$ _____ including grants of \$ _____) (Revenue \$ _____)**4d** Other program services (Describe on Schedule O.)

(Expenses \$ _____ including grants of \$ _____) (Revenue \$ _____)

4e Total program service expenses **25,605,314.**

Part IV Checklist of Required Schedules

- 1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)?
If "Yes," complete Schedule A
- 2 Is the organization required to complete *Schedule B, Schedule of Contributors*?
- 3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*
- 4 **Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*
- 5 Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*
- 6 Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*
- 7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*
- 8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*
- 9 Did the organization report an amount in Part X, line 21, for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services?
If "Yes," complete Schedule D, Part IV
- 10 Did the organization, directly or through a related organization, hold assets in donor-restricted endowments or in quasi endowments? *If "Yes," complete Schedule D, Part V*
- 11 If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable
 - a Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*
 - 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*
 - c Did the organization report an amount for investments - program related in Part X, line 13, that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*
 - d Did the organization report an amount for other assets in Part X, line 15, that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*
 - e Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*
 - f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*
- 12a Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*
- 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
- 13 Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*
- 14a Did the organization maintain an office, employees, or agents outside of the United States?
- 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*
- 15 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*
- 16 Did the organization report on Part IX, column (A), line 3, more than \$5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV*
- 17 Did the organization report a total of more than \$15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I*
- 18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*
- 19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*
- 20a Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*
- b If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?
- 21 Did the organization report more than \$5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*

	Yes	No
1	X	
2	X	
3		X
4	X	
5		X
6		X
7		X
8		X
9		X
10		X
11a	X	
11b	X	
11c		X
11d		X
11e	X	
11f	X	
12a		X
12b	X	
13		X
14a		X
14b		X
15		X
16		X
17		X
18		X
19		X
20a	X	
20b	X	
21		X

Part IV Checklist of Required Schedules (continued)

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

Note: All Form 990 filers are required to complete Schedule O

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

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

Part V Statements Regarding Other IRS Filings and Tax Compliance (continued)

		Yes	No
2a Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a 0		
b If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note: If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	2b		
3a Did the organization have unrelated business gross income of \$1,000 or more during the year?	3a		X
b If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation on Schedule O	3b		
4a At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a		X
b If "Yes," enter the name of the foreign country See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)			
5a Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a		X
b Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b		X
c If "Yes" to line 5a or 5b, did the organization file Form 8886-T?	5c		
6a Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a		X
b If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b		
7 Organizations that may receive deductible contributions under section 170(c).			
a Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?	7a		X
b If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b		
c Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8822?	7c		X
d If "Yes," indicate the number of Forms 8822 filed during the year	7d		
e Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e		X
f Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f		X
g If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g		
h If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h		
8 Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	8		
9 Sponsoring organizations maintaining donor advised funds.			
a Did the sponsoring organization make any taxable distributions under section 4966?	9a		
b Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	9b		
10 Section 501(c)(7) organizations. Enter			
a Initiation fees and capital contributions included on Part VIII, line 12	10a		
b Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b		
11 Section 501(c)(12) organizations. Enter			
a Gross income from members or shareholders	11a		
b Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)	11b		
12a Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?	12a		
b If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b		
13 Section 501(c)(29) qualified nonprofit health insurance issuers.			
a Is the organization licensed to issue qualified health plans in more than one state? Note: See the instructions for additional information the organization must report on Schedule O	13a		
b Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b		
c Enter the amount of reserves on hand	13c		
14a Did the organization receive any payments for indoor tanning services during the tax year?	14a		X
b If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation on Schedule O	14b		
15 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.	15		X
16 Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O	16		X

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

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

☒ X

Section A. Governing Body and Management

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

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

	Yes	No
10a Did the organization have local chapters, branches, or affiliates?		X
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?		
11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	X	
b Describe in Schedule O the process, if any, used by the organization to review this Form 990		
12a Did the organization have a written conflict of interest policy? If "No," go to line 13	X	
b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	X	
c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done	X	
13 Did the organization have a written whistleblower policy?	X	
14 Did the organization have a written document retention and destruction policy?	X	
15 Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?		
a The organization's CEO, Executive Director, or top management official	X	
b Other officers or key employees of the organization	X	
If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions)		
16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	X	
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?		X

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed **► KY**

18 Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A, if applicable), 990, and 990-T (Section 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 on Schedule O)

19 Describe on 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 **►**
CHERYL A. WATHEN - 812-450-3296
600 ST. MARY'S STREET, EVANSVILLE, IN 47747

Part VIII Statement of RevenueCheck 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	1 a Federated campaigns	1a					
	b Membership dues	1b					
	c Fundraising events	1c					
	d Related organizations	1d					
	e Government grants (contributions)	1e	496,000.				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	58,810.				
	g Noncash contributions included in lines 1a-1f	1g	\$				
	h Total. Add lines 1a-1f			554,810.			
Program Service Revenue			Business Code				
	2 a NET PATIENT SERVICES		621110	28,195,782.	28,195,782.		
	b						
	c						
	d						
	e						
	f All other program service revenue						
	g Total. Add lines 2a-2f			28,195,782.			
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)			485,593.			485,593.
	4 Income from investment of tax-exempt bond proceeds						
	5 Royalties						
	6 a Gross rents	(i) Real	(ii) Personal				
	6b Less rental expenses	320,407.					
	c Rental income or (loss)	0.					
	6c	320,407.					
	d Net rental income or (loss)			320,407.			320,407.
	7 a Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other				
	7a	30,567.	109,304.				
	b Less cost or other basis and sales expenses	0.	0.				
	7b						
	7c	30,567.	109,304.				
	d Net gain or (loss)			139,871.			139,871.
	8 a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18						
8a							
b Less direct expenses							
8b							
c Net income or (loss) from fundraising events							
9 a Gross income from gaming activities. See Part IV, line 19							
9a							
b Less direct expenses							
9b							
c Net income or (loss) from gaming activities							
10 a Gross sales of inventory, less returns and allowances							
10a							
b Less cost of goods sold							
10b							
c Net income or (loss) from sales of inventory							
Miscellaneous Revenue			Business Code				
	11 a CAFETERIA		900099	62,218.			62,218.
	b MISCELLANEOUS		900099	49,209.	49,209.		
	c						
	d All other revenue						
	e Total. Add lines 11a-11d			111,427.			
12 Total revenue. See instructions				29,807,890.	28,244,991.	0.	1,008,089.

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

☒ X

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21				
2 Grants and other assistance to domestic individuals. See Part IV, line 22	31,816.	31,816.		
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees				
6 Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	9,218,113.	8,225,151.	992,962.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	282,378.	251,961.	30,417.	
9 Other employee benefits	852,690.	760,839.	91,851.	
10 Payroll taxes	627,309.	559,736.	67,573.	
11 Fees for services (nonemployees)				
a Management				
b Legal	5,828.		5,828.	
c Accounting				
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)	6,302,797.	4,365,476.	1,937,321.	
12 Advertising and promotion	10,554.	9,417.	1,137.	
13 Office expenses	130,888.	116,789.	14,099.	
14 Information technology				
15 Royalties				
16 Occupancy	1,121,987.	1,001,128.	120,859.	
17 Travel	18,359.	16,381.	1,978.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	43,360.	38,689.	4,671.	
20 Interest	831,041.	741,522.	89,519.	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	2,195,469.	1,958,976.	236,493.	
23 Insurance	367,810.	328,190.	39,620.	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses on line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES	3,726,927.	3,726,927.		
b TAXES & LICENSES	1,085,553.	968,619.	116,934.	
c PROVIDER TAX	634,826.	634,826.		
d				
e All other expenses	2,074,573.	1,868,871.	205,702.	
25 Total functional expenses. Add lines 1 through 24e	29,562,278.	25,605,314.	3,956,964.	0.
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation.				

Check here ☐ if following SOP 98-2 (ASC 958-720)

Part X Balance SheetCheck if Schedule O contains a response or note to any line in this Part X ☐

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	14,103,934.	1	26,926,375.
	2 Savings and temporary cash investments	10,503,093.	2	23,328.
	3 Pledges and grants receivable, net		3	
	4 Accounts receivable, net	10,901,493.	4	13,212,262.
	5 Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons		5	
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)		6	
	7 Notes and loans receivable, net	25,833.	7	375,329.
	8 Inventories for sale or use	2,518,351.	8	2,414,674.
	9 Prepaid expenses and deferred charges	1,451,920.	9	1,425,940.
	10a Land, buildings, and equipment cost or other basis. Complete Part VI of Schedule D	10a 72,278,372.		
	b Less accumulated depreciation	10b 2,195,469.	10c	70,082,903.
	11 Investments - publicly traded securities		11	
	12 Investments - other securities. See Part IV, line 11	4,984,931.	12	14,827,282.
	13 Investments - program-related. See Part IV, line 11		13	
	14 Intangible assets		14	
	15 Other assets. See Part IV, line 11	878,261.	15	1,101,741.
16 Total assets. Add lines 1 through 15 (must equal line 33)	117,520,188.	16	130,389,834.	
Liabilities	17 Accounts payable and accrued expenses	13,098,520.	17	12,999,150.
	18 Grants payable		18	
	19 Deferred revenue	13,520,071.	19	12,974,071.
	20 Tax-exempt bond liabilities		20	
	21 Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22 Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons		22	
	23 Secured mortgages and notes payable to unrelated third parties	34,618,674.	23	32,658,866.
	24 Unsecured notes and loans payable to unrelated third parties		24	
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	36,063,525.	25	43,503,347.
	26 Total liabilities. Add lines 17 through 25	97,300,790.	26	102,135,434.
	Net Assets or Fund Balances	Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33.		
27 Net assets without donor restrictions		19,171,412.	27	17,317,295.
28 Net assets with donor restrictions		1,047,986.	28	10,937,105.
Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33.				
29 Capital stock or trust principal, or current funds			29	
30 Paid-in or capital surplus, or land, building, or equipment fund			30	
31 Retained earnings, endowment, accumulated income, or other funds			31	
32 Total net assets or fund balances		20,219,398.	32	28,254,400.
33 Total liabilities and net assets/fund balances	117,520,188.	33	130,389,834.	

Form 990 (2020)

Part XI Reconciliation of Net Assets

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

☒

1	Total revenue (must equal Part VIII, column (A), line 12)	1	29,807,890.
2	Total expenses (must equal Part IX, column (A), line 25)	2	29,562,278.
3	Revenue less expenses Subtract line 2 from line 1	3	245,612.
4	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	4	20,219,398.
5	Net unrealized gains (losses) on investments	5	548,172.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain on Schedule O)	9	7,241,218.
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 32, column (B))	10	28,254,400.

Part XII Financial Statements and Reporting

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

☒

	Yes	No
1 Accounting method used to prepare the Form 990 <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____ If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O		
2a Were the organization's financial statements compiled or reviewed by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		X
b Were the organization's financial statements audited by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	X	
c If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain on Schedule O	X	
3a As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?		X
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 on Schedule O and describe any steps taken to undergo such audits		

Form 990 (2020)

SCHEDULE A
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.

▶ Attach to Form 990 or Form 990-EZ.

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

OMB No 1545-0047

2020

**Open to Public
Inspection**

Name of the organization

METHODIST HEALTH, INC

Employer identification number

61-0461753

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

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

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

f Enter the number of supported organizations

g Provide the following information about the supported organization(s)

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

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

(Complete only if you checked the box on line 5, 7, or 8 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) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 Total. Add lines 1 through 3						
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)						
6 Public support. Subtract line 5 from line 4						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First 5 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 ► <input type="checkbox"/>						

Section C. Computation of Public Support Percentage

14 Public support percentage for 2020 (line 6, column (f), divided by line 11, column (f))	14	%
15 Public support percentage from 2019 Schedule A, Part II, line 14	15	%
16a 33 1/3% support test - 2020. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization ► <input type="checkbox"/>		
b 33 1/3% support test - 2019. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization ► <input type="checkbox"/>		
17a 10% -facts-and-circumstances test - 2020. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and stop here. Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization ► <input type="checkbox"/>		
b 10% -facts-and-circumstances test - 2019. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and stop here. Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization ► <input type="checkbox"/>		
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ► <input type="checkbox"/>		

Schedule A (Form 990 or 990-EZ) 2020

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) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(f) Total
1 Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 Public support. (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2016	(b) 2017	(c) 2018	(d) 2019	(e) 2020	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						

14 First 5 years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and **stop here** ☐

Section C. Computation of Public Support Percentage

15 Public support percentage for 2020 (line 8, column (f), divided by line 13, column (f))	15	%
16 Public support percentage from 2019 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2020 (line 10c, column (f), divided by line 13, column (f))	17	%
18 Investment income percentage from 2019 Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2020. 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 - 2019. 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 in line 12 on Part I. If you checked box 12a, Part I, complete Sections A and B. If you checked box 12b, Part I, complete Sections A and C. If you checked box 12c, Part I, complete Sections A, D, and E. If you checked box 12d, Part I, complete Sections A and D, and complete Part V.)

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

	Yes	No
1 Did the governing body, members of the governing body, officers acting in their official capacity, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's officers, directors, or trustees at all times during the tax year? 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 officers, directors, or trustees were allocated among the supported organizations and what conditions or restrictions, if any, applied to such powers during the tax year.		
1		
2 Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? 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.		
2		

Section C. Type II Supporting Organizations

	Yes	No
1 Were a majority of the organization's directors or trustees during the tax year also a majority of the directors or trustees of each of the organization's supported organization(s)? 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).		
1		

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions).		
a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a governmental entity (see instructions).		
2 Activities Test. Answer lines 2a and 2b below.		
a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? 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.		
2a		
b Did the activities described in line 2a, above, constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? 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.		
2b		
3 Parent of Supported Organizations. Answer lines 3a and 3b below.		
a Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? If "Yes" or "No" provide details in Part VI .		
3a		
b Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? If "Yes," describe in Part VI the role played by the organization in this regard.		
3b		

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

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

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

Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year)		
a	Average monthly value of securities	1a	
b	Average monthly cash balances	1b	
c	Fair market value of other non-exempt-use assets	1c	
d	Total (add lines 1a, 1b, and 1c)	1d	
e	Discount claimed for blockage or other factors (explain in detail in Part VI)		
2	Acquisition indebtedness applicable to non-exempt-use assets	2	
3	Subtract line 2 from line 1d	3	
4	Cash deemed held for exempt use Enter 0.015 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 0.035.	6	
7	Recoveries of prior-year distributions	7	
8	Minimum Asset Amount (add line 7 to line 6)	8	

Section C - Distributable Amount		Current Year	
1	Adjusted net income for prior year (from Section A, line 8, column A)	1	
2	Enter 0.85 of line 1	2	
3	Minimum asset amount for prior year (from Section B, line 8, column A)	3	
4	Enter greater of line 2 or line 3	4	
5	Income tax imposed in prior year	5	
6	Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	
7	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions)		

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

Section D - Distributions		Current Year
1	Amounts paid to supported organizations to accomplish exempt purposes	1
2	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	2
3	Administrative expenses paid to accomplish exempt purposes of supported organizations	3
4	Amounts paid to acquire exempt-use assets	4
5	Qualified set-aside amounts (prior IRS approval required - <i>provide details in Part VI</i>)	5
6	Other distributions (<i>describe in Part VI</i>) See instructions	6
7	Total annual distributions. Add lines 1 through 6	7
8	Distributions to attentive supported organizations to which the organization is responsive (<i>provide details in Part VI</i>) See instructions	8
9	Distributable amount for 2020 from Section C, line 6	9
10	Line 8 amount divided by line 9 amount	10

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2020	(iii) Distributable Amount for 2020
1 Distributable amount for 2020 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2020 (reasonable cause required - <i>explain in Part VI</i>) See instructions			
3 Excess distributions carryover, if any, to 2020			
a From 2015			
b From 2016			
c From 2017			
d From 2018			
e From 2019			
f Total of lines 3a through 3e			
g Applied to underdistributions of prior years			
h Applied to 2020 distributable amount			
i Carryover from 2015 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from line 3f			
4 Distributions for 2020 from Section D, line 7			
a Applied to underdistributions of prior years			
b Applied to 2020 distributable amount			
c Remainder. Subtract lines 4a and 4b from line 4			
5 Remaining underdistributions for years prior to 2020, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, <i>explain in Part VI</i> . See instructions			
6 Remaining underdistributions for 2020. Subtract lines 3h and 4b from line 1. For result greater than zero, <i>explain in Part VI</i> . See instructions			
7 Excess distributions carryover to 2021. Add lines 3j and 4c			
8 Breakdown of line 7			
a Excess from 2016			
b Excess from 2017			
c Excess from 2018			
d Excess from 2019			
e Excess from 2020			

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)

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 for instructions and the latest information.**

OMB No 1545-0047

2020

**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 organization

METHODIST HEALTH, INC

Employer identification number

61-0461753

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
- 2 Political campaign activity expenditures ▶ \$
- 3 Volunteer hours for political campaign activities

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

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

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

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

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

For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.

Schedule C (Form 990 or 990-EZ) 2020

LHA

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 (grassroots 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															
<table border="1"> <thead> <tr> <th>If the amount on line 1e, column (a) or (b) is:</th> <th>The lobbying nontaxable amount is:</th> </tr> </thead> <tbody> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000.</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000</td> </tr> </tbody> </table>		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		
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?		<input type="checkbox"/> Yes	<input type="checkbox"/> No												

4-Year Averaging Period Under Section 501(h)

(Some organizations that made a section 501(h) election do not have to complete all of the five columns below.)

See the separate instructions for lines 2a through 2f.)

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2017	(b) 2018	(c) 2019	(d) 2020	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

Schedule C (Form 990 or 990-EZ) 2020

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

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

	(a)		(b)
	Yes	No	Amount
1 During the year, did the filing organization attempt to influence foreign, national, state, or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		2,252.
j Total. Add lines 1c through 1i			2,252.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

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

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.

PART II-B, LINE 1, LOBBYING ACTIVITIES:

MEMBERSHIP DUES TO HOSPITAL ASSOCIATIONS OF WHICH A PORTION OF THE DUES ARE USED FOR LOBBYING EXPENSES BY THE TRADE ORGANIZATION.

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 for instructions and the latest information.

OMB No 1545-0047

2020

Open to Public Inspection

Name of the organization

METHODIST HEALTH, INC

Employer identification number
61-0461753

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

	(a) Donor advised funds	(b) Funds and other accounts
1 Total number at end of year		
2 Aggregate value of contributions to (during year)		
3 Aggregate value of grants from (during year)		
4 Aggregate value at end of year		
5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control?		<input type="checkbox"/> Yes <input type="checkbox"/> No
6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?		<input type="checkbox"/> Yes <input type="checkbox"/> No

Part II Conservation Easements. Complete if the organization answered "Yes" on Form 990, Part IV, line 7

1 Purpose(s) of conservation easements held by the organization (check all that apply)

<input type="checkbox"/> Preservation of land for public use (for example, recreation or education)	<input type="checkbox"/> Preservation of a historically important land area
<input type="checkbox"/> Protection of natural habitat	<input type="checkbox"/> Preservation of a certified historic structure
<input type="checkbox"/> Preservation of open space	

2 Complete lines 2a through 2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year

	Held at the End of the Tax 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 FASB 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 FASB 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 FASB 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 make 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 program
 e ☐ Other _____

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

5 During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? ☐ Yes ☐ No

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

1a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? ☐ Yes ☐ No

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

- c Beginning balance
 d Additions during the year
 e Distributions during the year
 f Ending balance

	Amount
1c	
1d	
1e	
1f	

2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? ☐ Yes ☐ No

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

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

- 1a Beginning of year balance
 b Contributions
 c Net investment earnings, gains, and losses
 d Grants or scholarships
 e Other expenditures for facilities and programs
 f Administrative expenses
 g End of year balance

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a					
1b					
1c					
1d					
1e					
1f					
1g					

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

- a Board designated or quasi-endowment ☐ _____ %
 b Permanent endowment ☐ _____ %
 c Term endowment ☐ _____ %

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

	Yes	No
3a(i)		
3a(ii)		
3b		

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

Part VI Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		800,816.		800,816.
b Buildings		53,714,641.	861,477.	52,853,164.
c Leasehold improvements				
d Equipment		17,678,805.	1,333,992.	16,344,813.
e Other		84,110.		84,110.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				70,082,903.

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) INV IN JOINT VENTURE	184,063.	COST
(B) INV IN PREMIER	415,077.	COST
(C) INV IN NET ASSETS OF		
(D) FOUNDATION	1,561,377.	COST
(E) SELF INSURED INSURANCE		
(F) RETENTION	3,132,868.	COST
(G) AWUL TRUSTEE HELD	9,533,897.	COST
(H)		
Total. (Col. (b) must equal Form 990, Part X, col. (B) line 12.)	14,827,282.	

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. (Col. (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	
(2) OTHER CURRENT LIABILITIES	2,582,769.
(3) PENSION LIABILITY	29,121,970.
(4) THIRD PARTY PAYOR	9,870,652.
(5) DUE TO RELATED PARTY	1,927,956.
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.)	43,503,347.

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 FASB ASC 740. Check here if the text of the footnote has been provided in Part XIII ☒

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

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

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

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

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

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

Part XIII Supplemental Information.

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

PART X, LINE 2:

ACCOUNTING PRINCIPLES GENERALLY ACCEPTED IN THE UNITED STATES OF AMERICA REQUIRE MANAGEMENT TO EVALUATE TAX POSITIONS TAKEN BY THE SYSTEM AND RECOGNIZE A TAX LIABILITY IF THE SYSTEM HAS TAKEN AN UNCERTAIN POSITION THAT MORE LIKELY THAN NOT WOULD NOT BE SUSTAINED UPON EXAMINATION BY VARIOUS FEDERAL AND STATE TAXING AUTHORITIES. MANAGEMENT HAS ANALYZED THE TAX POSITIONS TAKEN BY THE SYSTEM AND HAS CONCLUDED THAT AS OF SEPTEMBER 30, 2020 AND 2019, THERE ARE NO UNCERTAIN POSITIONS TAKEN OR EXPECTED TO BE TAKEN THAT WOULD REQUIRE RECOGNITION OF A LIABILITY OR DISCLOSURE IN THE ACCOMPANYING CONSOLIDATED FINANCIAL STATEMENTS. THE SYSTEM IS SUBJECT TO ROUTINE AUDITS BY TAXING JURISDICTIONS; HOWEVER, THERE ARE CURRENTLY NO AUDITS FOR ANY TAX PERIODS IN PROGRESS.

Part XIII	Supplemental Information <i>(continued)</i>
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Year	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044	2045	2046	2047	2048	2049	2050	2051	2052	2053	2054	2055	2056	2057	2058	2059	2060	2061	2062	2063	2064	2065	2066	2067	2068	2069	2070	2071	2072	2073	2074	2075	2076	2077	2078	2079	2080	2081	2082	2083	2084	2085	2086	2087	2088	2089	2090	2091	2092	2093	2094	2095	2096	2097	2098	2099
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**SCHEDULE H
(Form 990)**

OMB No 1545-0047

Hospitals

2020

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

- **Complete if the organization answered "Yes" on Form 990, Part IV, question 20.**
► **Attach to Form 990.**
► **Go to www.irs.gov/Form990 for instructions and the latest information.**

Name of the organization

METHODIST HEALTH, INC

Employer identification number

61-0461753

Part I Financial Assistance and Certain Other Community Benefits at Cost

	Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	<input checked="" type="checkbox"/>	
1b If "Yes," was it a written policy?	<input checked="" type="checkbox"/>	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year		
<input checked="" type="checkbox"/> Applied uniformly to all hospital facilities		
<input type="checkbox"/> Applied uniformly to most hospital facilities		
<input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year		
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care?	<input checked="" type="checkbox"/>	
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 checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %		
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 checked="" type="checkbox"/>	
<input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input checked="" type="checkbox"/> 400% <input type="checkbox"/> Other _____ %		
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	<input checked="" type="checkbox"/>	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?		<input checked="" type="checkbox"/>
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		
6a Did the organization prepare a community benefit report during the tax year?	<input checked="" type="checkbox"/>	
b If "Yes," did the organization make it available to the public?	<input checked="" type="checkbox"/>	

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Financial Assistance and Certain Other Community Benefits at Cost						
Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			337,045.		337,045.	1.14%
b Medicaid (from Worksheet 3, column a)			6922005.	5708881.	1213124.	4.10%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total. Financial Assistance and Means-Tested Government Programs			7259050.	5708881.	1550169.	5.24%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			922.		922.	.00%
f Health professions education (from Worksheet 5)			51,025.	31,147.	19,878.	.07%
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			19,118.		19,118.	.06%
j Total. Other Benefits			71,065.	31,147.	39,918.	.13%
k Total. Add lines 7d and 7j			7330115.	5740028.	1590087.	5.37%

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)

[illegible]

Part V Facility Information *(continued)*

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, 20a, 20b, 20c, 20d, 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.

DEACONESS HENDERSON HOSPITAL:

PART V, SECTION B, LINE 5: DEACONESS HENDERSON HOSPITAL CONSULTED WITH
THE FOLLOWING GROUPS TO GATHER INPUT AND DATA:

-GREEN RIVER DISTRICT HEALTH DEPARTMENT

-GREEN RIVER REGIONAL HEALTH COUNCIL

-HEALTHY HENDERSON HEALTH COALITION

-RIVER VALLEY BEHAVIORAL HEALTH

-UNION COUNTY HEALTH COALITION

-WEBSTER COUNTY EXTENSION OFFICE

-WEBSTER COUNTY HEALTH COALITION

TO INCLUDE VOICES OF PEOPLE REPRESENTING THE COMMUNITY, DIALOGUE
ASSESSMENTS WERE COMPLETED AT A VARIETY OF LOCAL EVENTS INCLUDING A
MULTICULTURAL FESTIVAL, WORLD'S GREATEST BABY SHOWER, COMMUNITY DRUG
FORUM, RESOURCE FAIR, AND SENIOR CENTER RESOURCE FAIR. CASPER FIELD
SURVEYS WERE GIVEN IN THE COMMUNITY WITH 185 INTERVIEWS COMPLETED FOR THE
7-COUNTY DISTRICT.

THE GREEN RIVER DISTRICT HEALTH DEPARTMENT ALSO HOSTED FORUMS IN EACH
COUNTY TO GATHER INPUT FROM COMMUNITY MEMBERS AND THOSE WITH SPECIAL
KNOWLEDGE OF OR EXPERTISE IN PUBLIC HEALTH.

DEACONESS UNION COUNTY HOSPITAL:

PART V, SECTION B, LINE 5: DEACONESS UNION COUNTY HOSPITAL CONSULTED
WITH THE FOLLOWING GROUPS TO GATHER INPUT AND DATA:

-GREEN RIVER DISTRICT HEALTH DEPARTMENT

-GREEN RIVER REGIONAL HEALTH COUNCIL

Part V Facility Information (continued)

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, 20a, 20b, 20c, 20d, 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.

-HEALTHY HENDERSON HEALTH COALITION

-RIVER VALLEY BEHAVIORAL HEALTH

-UNION COUNTY HEALTH COALITION

-WEBSTER COUNTY EXTENSION OFFICE

-WEBSTER COUNTY HEALTH COALITION

TO INCLUDE VOICES OF PEOPLE REPRESENTING THE COMMUNITY, DIALOGUE

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THE GREEN RIVER DISTRICT HEALTH DEPARTMENT ALSO HOSTED FORUMS IN EACH

COUNTY TO GATHER INPUT FROM COMMUNITY MEMBERS AND THOSE WITH SPECIAL

KNOWLEDGE OF OR EXPERTISE IN PUBLIC HEALTH.

DEACONESS HENDERSON HOSPITAL:

PART V, SECTION B, LINE 6B: KEY PARTNER ORGANIZATIONS INCLUDED GREEN

RIVER DISTRICT HEALTH DEPARTMENT, GREEN RIVER REGIONAL HEALTH COUNCIL,

HEALTHY HENDERSON HEALTH COALITION, RIVER VALLEY BEHAVIORAL HEALTH, UNION

COUNTY HEALTH COALITION, WEBSTER COUNTY EXTENSION OFFICE, AND WEBSTER

COUNTY HEALTH COALITION.

DEACONESS UNION COUNTY HOSPITAL:

PART V, SECTION B, LINE 6B: KEY PARTNER ORGANIZATIONS INCLUDED GREEN

RIVER DISTRICT HEALTH DEPARTMENT, GREEN RIVER REGIONAL HEALTH COUNCIL,

HEALTHY HENDERSON HEALTH COALITION, RIVER VALLEY BEHAVIORAL HEALTH, UNION

Part V Facility Information *(continued)*

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, 20a, 20b, 20c, 20d, 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.

COUNTY HEALTH COALITION, WEBSTER COUNTY EXTENSION OFFICE, AND WEBSTER

COUNTY HEALTH COALITION.

DEACONESS HENDERSON HOSPITAL:

PART V, SECTION B, LINE 7D: HARD COPIES WERE AVAILABLE AT THE GREEN RIVER
DISTRICT HEALTH DEPARTMENT OFFICE.

DEACONESS UNION COUNTY HOSPITAL:

PART V, SECTION B, LINE 7D: HARD COPIES WERE AVAILABLE AT THE GREEN RIVER
DISTRICT HEALTH DEPARTMENT OFFICE.

DEACONESS HENDERSON HOSPITAL:

PART V, SECTION B, LINE 11: THE GREEN RIVER DISTRICT COMMUNITY HEALTH
IMPROVEMENT PLAN (2018-2021) ADOPTED THREE ITEMS WITH SLIGHT CHANGES FROM
THE EARLIER PLAN - MENTAL HEALTH AND TEEN ISSUES;
OBESITY/DIABETES/PHYSICAL ACTIVITY; AND SUBSTANCE ABUSE OF
ALCOHOL/TOBACCO/OTHER DRUGS. A COMMITTEE FOR EACH OF THESE ISSUES EXISTS
AND MEETS ON A REGULAR BASIS.

DUE TO COVID, MEETINGS, TRAININGS, AND EVENTS FOR THE DIABETES COALITION
WERE POSTPONED. THE MENTAL HEALTH AND TEEN ISSUES GROUP FOCUSED ON SHARING
DETAILS ABOUT THE NEW CELEBRATING FAMILIES ADDICTION PROGRAM. THE GRDHD
LED COMMUNITY CLASSES FOR SMOKING CESSATION.

SEVERAL OTHER PLANS FOR COMMUNITY TRAININGS AND PROGRAMS WERE POSTPONED

Part V Facility Information (continued)

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, 20a, 20b, 20c, 20d, 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.

DUE TO COVID RESTRICTIONS.

DEACONESS UNION COUNTY HOSPITAL:

PART V, SECTION B, LINE 11: THE GREEN RIVER DISTRICT COMMUNITY HEALTH

IMPROVEMENT PLAN (2018-2021) ADOPTED THREE ITEMS WITH SLIGHT CHANGES FROM

THE EARLIER PLAN - MENTAL HEALTH AND TEEN ISSUES;

OBESITY/DIABETES/PHYSICAL ACTIVITY; AND SUBSTANCE ABUSE OF

ALCOHOL/TOBACCO/OTHER DRUGS. A COMMITTEE FOR EACH OF THESE ISSUES EXISTS

AND MEETS ON A REGULAR BASIS.

DUE TO COVID, MEETINGS, TRAININGS, AND EVENTS FOR THE DIABETES COALITION

WERE POSTPONED. THE MENTAL HEALTH AND TEEN ISSUES GROUP FOCUSED ON SHARING

DETAILS ABOUT THE NEW CELEBRATING FAMILIES ADDICTION PROGRAM. THE GRDHD

LED COMMUNITY CLASSES FOR SMOKING CESSATION.

SEVERAL OTHER PLANS FOR COMMUNITY TRAININGS AND PROGRAMS WERE POSTPONED

DUE TO COVID RESTRICTIONS.

DEACONESS HENDERSON HOSPITAL:

PART V, SECTION B, LINE 15E: MEDASSIST IS AVAILABLE TO DEACONESS HENDERSON

HOSPITAL PATIENTS TO ASSIST WITH APPLYING FOR MEDICAID OR EXCHANGE

PRODUCTS.

DEACONESS UNION COUNTY HOSPITAL:

PART V, SECTION B, LINE 15E: MEDASSIST IS AVAILABLE TO DEACONESS UNION

COUNTY HOSPITAL PATIENTS TO ASSIST WITH APPLYING FOR MEDICAID OR EXCHANGE

Part V Facility Information (continued)

Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20a, 20b, 20c, 20d, 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.

PRODUCTS.

DEACONESS HENDERSON HOSPITAL

PART V, LINE 16A, FAP WEBSITE:

[HTTPS://WWW.DEACONESS.COM/PAY-MY-BILL/FINANCIAL-ASSISTANCE](https://www.deaconess.com/pay-my-bill/financial-assistance)

DEACONESS UNION COUNTY HOSPITAL

PART V, LINE 16A, FAP WEBSITE:

[HTTPS://WWW.DEACONESS.COM/PAY-MY-BILL/FINANCIAL-ASSISTANCE](https://www.deaconess.com/pay-my-bill/financial-assistance)

DEACONESS HENDERSON HOSPITAL

PART V, LINE 16B, FAP APPLICATION WEBSITE:

[HTTPS://WWW.DEACONESS.COM/PAY-MY-BILL/FINANCIAL-ASSISTANCE](https://www.deaconess.com/pay-my-bill/financial-assistance)

DEACONESS UNION COUNTY HOSPITAL

PART V, LINE 16B, FAP APPLICATION WEBSITE:

[HTTPS://WWW.DEACONESS.COM/PAY-MY-BILL/FINANCIAL-ASSISTANCE](https://www.deaconess.com/pay-my-bill/financial-assistance)

DEACONESS HENDERSON HOSPITAL

PART V, LINE 16C, FAP PLAIN LANGUAGE SUMMARY WEBSITE:

[HTTPS://WWW.DEACONESS.COM/PAY-MY-BILL/FINANCIAL-ASSISTANCE](https://www.deaconess.com/pay-my-bill/financial-assistance)

DEACONESS UNION COUNTY HOSPITAL

PART V, LINE 16C, FAP PLAIN LANGUAGE SUMMARY WEBSITE:

[HTTPS://WWW.DEACONESS.COM/PAY-MY-BILL/FINANCIAL-ASSISTANCE](https://www.deaconess.com/pay-my-bill/financial-assistance)

Part V Facility Information (continued)

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, 20a, 20b, 20c, 20d, 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.

DEACONESS HENDERSON HOSPITAL:

PART V, SECTION B, LINE 24: ALL PAYERS, INCLUDING ENTITLEMENT PROGRAMS, INSURANCE COMPANIES AND PATIENTS WITHOUT INSURANCE ARE BILLED AT HOSPITAL'S STANDARD RATE. REIMBURSEMENT AND DISCOUNTS ARE BASED ON ENTITLEMENT ALLOWABLE CONTRACTUALLY, MUTUALLY AGREEABLE REDUCTIONS OF CHARGES WITH INSURANCE COMPANIES AND MUTUALLY AGREEABLE REDUCTIONS OF CHARGES WITH PATIENTS.

DEACONESS UNION COUNTY HOSPITAL:

PART V, SECTION B, LINE 24: ALL PAYERS, INCLUDING ENTITLEMENT PROGRAMS, INSURANCE COMPANIES AND PATIENTS WITHOUT INSURANCE ARE BILLED AT HOSPITAL'S STANDARD RATE. REIMBURSEMENT AND DISCOUNTS ARE BASED ON ENTITLEMENT ALLOWABLE CONTRACTUALLY, MUTUALLY AGREEABLE REDUCTIONS OF CHARGES WITH INSURANCE COMPANIES AND MUTUALLY AGREEABLE REDUCTIONS OF CHARGES WITH PATIENTS.

SCH H PART V PART B LINE 16 A, B & C

THE FAP, THE FAP APPLICATION AND THE FAP PLAIN LANGUAGE SUMMARY ARE AVAILABLE AT

[HTTPS://WWW.DEACONESS.COM/PAY-MY-BILL/FINANCIAL-ASSISTANCE](https://www.deaconess.com/pay-my-bill/financial-assistance)

Part V Facility Information (continued)**Section B. Facility Policies and Practices**

(complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or letter of facility reporting group DEACONESS HENDERSON HOSPITALLine number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1

	Yes	No
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		X
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		X
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	X	
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input checked="" type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA <u>20 18</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	X	
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C		X
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	X	
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	X	
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>WWW.DEACONESS.COM/CHNA</u>		
b <input checked="" type="checkbox"/> Other website (list url) <u>WWW.HEALTHDEPARTMENT.ORG</u>		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	X	
9 Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 18</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	X	
a If "Yes," (list url) <u>WWW.DEACONESS.COM/CHNA</u>		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		X
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c If "Yes" to 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)**Name of hospital facility or letter of facility reporting group DEACONESS HENDERSON HOSPITAL

- 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
- a** ☒ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200 %
and FPG family income limit for eligibility for discounted care of 400 %
- b** ☐ Income level other than FPG (describe in Section C)
- c** ☒ Asset level
- d** ☒ Medical indigency
- e** ☐ Insurance status
- f** ☐ Underinsurance status
- g** ☐ Residency
- h** ☐ Other (describe in Section C)
- 14** Explained the basis for calculating amounts charged to patients?
- 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)
- a** ☒ Described the information the hospital facility may require an individual to provide as part of his or her application
- b** ☒ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application
- c** ☒ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process
- d** ☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications
- e** ☒ 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)
- a** ☒ The FAP was widely available on a website (list url) SEE PART V, PAGE 8
- b** ☒ The FAP application form was widely available on a website (list url) SEE PART V, PAGE 8
- c** ☒ A plain language summary of the FAP was widely available on a website (list url) SEE PART V, PAGE 8
- d** ☒ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)
- e** ☒ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)
- f** ☒ 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** ☒ 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** ☒ Notified members of the community who are most likely to require financial assistance about availability of the FAP
- i** ☒ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations
- j** ☐ Other (describe in Section C)

	Yes	No
13	X	
14	X	
15	X	
16	X	

Part V Facility Information (continued)**Billing and Collections**Name of hospital facility or letter of facility reporting group DEACONESS HENDERSON HOSPITAL

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**Name of hospital facility or letter of facility reporting group DEACONESS HENDERSON HOSPITAL**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
23		X
24	X	

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Part V Facility Information (continued)**Section B. Facility Policies and Practices**

(complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or letter of facility reporting group DEACONESS UNION COUNTY HOSPITALLine number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 2

	Yes	No
Community Health Needs Assessment		
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?		X
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		X
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply)	X	
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA		20 <u>18</u>
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	X	
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C		X
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	X	
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply)	X	
a <input checked="" type="checkbox"/> Hospital facility's website (list url) <u>WWW.DEACONESS.COM/CHNA</u>		
b <input checked="" type="checkbox"/> Other website (list url) <u>WWW.HEALTHDEPARTMENT.ORG</u>		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	X	
9 Indicate the tax year the hospital facility last adopted an implementation strategy		20 <u>18</u>
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	X	
a If "Yes," (list url) <u>WWW.DEACONESS.COM/CHNA</u>		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		X
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c If "Yes" to 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)**Name of hospital facility or letter of facility reporting group DEACONESS UNION COUNTY HOSPITAL

	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?	X	
If "Yes," indicate the eligibility criteria explained in the FAP		
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>400</u> %		
b <input type="checkbox"/> Income level other than FPG (describe in Section C)		
c <input checked="" type="checkbox"/> Asset level		
d <input checked="" type="checkbox"/> Medical indigency		
e <input type="checkbox"/> Insurance status		
f <input type="checkbox"/> Underinsurance status		
g <input type="checkbox"/> Residency		
h <input type="checkbox"/> Other (describe in Section C)		
14 Explained the basis for calculating amounts charged to patients?	X	
15 Explained the method for applying for financial assistance?	X	
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)		
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 checked="" type="checkbox"/> Other (describe in Section C)		
16 Was widely publicized within the community served by the hospital facility?	X	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply)		
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>SEE PART V, PAGE 8</u>		
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>SEE PART V, PAGE 8</u>		
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>SEE PART V, PAGE 8</u>		
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations		
j <input type="checkbox"/> Other (describe in Section C)		

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Part V Facility Information (continued)**Billing and Collections**Name of hospital facility or letter of facility reporting group DEACONESS UNION COUNTY HOSPITAL

	Yes	No
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	X	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP		
a <input type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d <input type="checkbox"/> Actions that require a legal or judicial process		
e <input type="checkbox"/> Other similar actions (describe in Section C)		
f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?		X
If "Yes," check all actions in which the hospital facility or a third party engaged		
a <input type="checkbox"/> Reporting to credit agency(ies)		
b <input type="checkbox"/> Selling an individual's debt to another party		
c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d <input type="checkbox"/> Actions that require a legal or judicial process		
e <input type="checkbox"/> Other similar actions (describe in Section C)		
20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply)		
a <input 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 (if not, describe in Section C)		
b <input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)		
c <input checked="" type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C)		
d <input checked="" type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C)		
e <input type="checkbox"/> Other (describe in Section C)		
f <input type="checkbox"/> None of these efforts were made		
Policy Relating to Emergency Medical Care		
21 Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?	X	
If "No," indicate why		
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions		
b <input type="checkbox"/> The hospital facility's policy was not in writing		
c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)		
d <input type="checkbox"/> Other (describe in Section C)		

Part V Facility Information *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**Name of hospital facility or letter of facility reporting group DEACONESS UNION COUNTY HOSPITAL**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
23		X
24	X	

Schedule H (Form 990) 2020

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

PART II, COMMUNITY BUILDING ACTIVITIES:

COMMUNITY BUILDING ACTIVITIES INCLUDE THE HOSPITAL'S PARTICIPATION WITH GREEN RIVER AREA DISTRICT DEVELOPMENT, A LOCAL GROUP DEDICATED TO ADDRESSING THE HEALTHCARE NEEDS OF COMMUNITIES SERVED. ALSO, A PART OF COMMUNITY BUILDING ACTIVITIES, VARIOUS HOSPITAL ADMINISTRATION STAFF VOLUNTEER TIME AS BOARD MEMBERS OR MEMBERS OF COMMUNITY ORGANIZATION AND COALITIONS TO KEEP ABREAST OF HEALTHCARE NEEDS, CONCERNS AND ISSUES WITHIN THE AREA.

PART III, LINE 2:

THE HOSPITAL HAS AGREEMENTS WITH THIRD PARTY PAYORS THAT PROVIDE FOR PAYMENTS TO THE HOSPITAL AT AMOUNTS DIFFERENT FROM ITS ESTABLISHED RATES. PAYMENT ARRANGEMENTS INCLUDE PROSPECTIVELY DETERMINED RATES PER DISCHARGE, REIMBURSED COSTS, DISCOUNTED CHARGES, AND PER DIEM PAYMENTS. NET PATIENT SERVICE REVENUE IS REPORTED AT THE ESTIMATED NET REALIZABLE AMOUNTS FROM PATIENTS, THIRD PARTY PAYORS, AND OTHER FOR SERVICES RENDERED, INCLUDING ESTIMATED RETROACTIVE ADJUSTMENTS UNDER REIMBURSEMENT AGREEMENTS WITH THIRD PARTY PAYORS. RETROACTIVE ADJUSTMENTS ARE ACCRUED ON AN ESTIMATED

Part VI Supplemental Information (Continuation)

BASIS IN THE PERIOD THE RELATED SERVICES ARE RENDERED AND ADJUSTED IN FUTURE PERIODS AS FINAL SETTLEMENTS ARE DETERMINED. THE HOSPITAL ESTIMATES AN ALLOWANCE FOR UNCOLLECTIBLE PATIENT ACCOUNTS RECEIVABLE BASED ON EVALUATION OF THE AGING OF THE ACCOUNTS, HISTORICAL LOSSES, CURRENT ECONOMIC CONDITIONS AND OTHER FACTORS UNIQUE TO THE SERVICE AREA AND THE HEALTHCARE INDUSTRY. THE COSTING METHODOLOGY USED TO DETERMINE THE AMOUNTS REPORTED ON LINE 2 IS USING THE COST-TO-CHARGE RATIO. THE RATIO WAS CALCULATED FROM WORKSHEET A, ESTIMATED BAD DEBT EXPENSE (AT COST).

PART III, LINE 4:

THE FOOTNOTE DESCRIBING BAD DEBT EXPENSE IS INCLUDED IN THE ATTACHED AUDITED FINANCIAL STATEMENTS UNDER FOOTNOTE "CHARITY CARE, COMMUNITY BENEFIT AND ASSISTANCE TO THE UNISURED" STARTING ON PAGE 11 AND 'PATIENT ACCOUNTS RECEIVABLE AND PATIENT SERVICE REVENUE" ON PAGE 11.

PART III, LINE 8:

MEDICARE ALLOWABLE COSTS WERE TAKEN DIRECTLY OFF MEDICARE COST REPORT FILED WITH THE 6/30/20 YEAREND. THE CALCULATION INCLUDED MEDICARE INPATIENT AND OUTPATIENT CHARGES LESS MEDICARE REIMBURSEMENT LESS GME RECEIVED. THE SHORTFALL SHOULD BE TREATED AS COMMUNITY BENEFIT AS THE REIMBURSEMENT RECEIVED DID NOT COVER THE COST OF PROVIDING SERVICES.

PART III, LINE 9B:

HOSPITAL POLICY ON CHARITY CARE PROVIDES GUIDANCE ON HOW TO PROVIDE FINANCIAL ASSISTANCE FOR PATIENTS IN NEED. HOSPITAL POLICY ON INDIGENT CARE OUTLINES THE DISPROPORTIONATE SHARE HOSPITAL (DSH) PROGRAM THROUGH THE STATE OF KENTUCKY TO SERVE THE INDIGENT CARE NEEDS OF ALL PATIENTS WITHOUT ANY TYPE OF HEALTH INSURANCE. PATIENTS MUST COMPLETE A DSH

Part VI Supplemental Information (Continuation)

APPLICATION AND MEET THE KENTUCKY DEPARTMENT OF MEDICAID SERVICES DSH
PROGRAM MANUAL GUIDELINES.

PART VI, LINE 2:

DEACONESS UTILIZES A VARIETY OF SOURCES TO GATHER DATA ON LOCAL HEALTH
CARE NEEDS. WE USE DATA FROM THE UNITED WAY OF SOUTHWESTERN INDIANA'S
COMPREHENSIVE NEEDS ASSESSMENT, COUNTY HEALTH RANKINGS WEBSITE, INDIANA
STATE DEPARTMENT OF HEALTH, KENTUCKY DEPARTMENT FOR PUBLIC HEALTH, CENTERS
FOR DISEASE CONTROL AND PREVENTION, NATIONAL CENTER FOR HEALTH STATISTICS,
AND THE U.S. CENSUS BUREAU. ADDITIONAL INFORMATION COMES FROM OUR OWN
ELECTRONIC MEDICAL RECORD SYSTEM AND THROUGH OUR INTERACTION WITH LOCAL
SERVICE PROVIDERS AND OTHER NON-PROFIT ORGANIZATIONS.

PART VI, LINE 3:

HOSPITAL HAS FINANCIAL COUNSELORS TO INTERVIEW PATIENTS WHO MAY HAVE
FINANCIAL NEED. THE PROCESS IS PART OF PATIENT REGISTRATION. AN INTERVIEW
CAN TAKE PLACE AT ANY TIME THE PATIENT IS IN THE HOSPITAL. AFTER THE
PATIENT LEAVES THE HOSPITAL, CONTACT IS MADE IN AN EFFORT TO ASSIST THE
INDIVIDUAL WITH APPLYING FOR GOVERNMENT ENTITLEMENT PROGRAMS. EACH PATIENT
REGISTERED AS A SELF-PAY AUTOMATICALLY RECEIVES PRINTED INFORMATION TITLED
"ELIGIBILITY FOR FINANCIAL ASSISTANCE." THIS DOCUMENT EXPLAINS ABOUT THE
KENTUCKY MEDICAID DISPROPORTIONATE SHARE HOSPITAL DSH PROGRAM. IT CONTAINS
A LIST OF INFORMATION THE PATIENT IS REQUIRED TO PROVIDE WITH THE DSH
APPLICATION, ELIGIBILITY FOR THE PROGRAM IS DETERMINED FROM THE SUBMITTED
DOCUMENTS. IF THE PATIENT DOES NOT QUALIFY FOR THE DSH PROGRAM THEN THE
DOCUMENTATION IS USED BY THE HOSPITAL FOR FINANCIAL ASSISTANCE
DETERMINATION. IN ADDITION, DISCUSSION WITH PATIENTS CONCERNING VARIOUS
PROGRAMS, HOSPITAL ASSISTANCE, ETC.

Part VI Supplemental Information (Continuation)

PART VI, LINE 4:

FOR THIS ASSESSMENT, DEACONESS DESCRIBES ITS COMMUNITY AS ALL PEOPLE LIVING IN HENDERSON AND UNION COUNTIES IN KY AT ANY TIME DURING THE YEAR.

HENDERSON COUNTY IS LOCATED IN WESTERN KENTUCKY ALONG THE OHIO RIVER.

POPULATION ESTIMATES (FROM CENSUS.GOV) FOR JULY 1, 2019 INCLUDE A GENERAL POPULATION OF 45,210 PEOPLE. THE COUNTY IDENTIFIES AS 88.4% WHITE, 8.4% BLACK OR AFRICAN AMERICAN, 2.8% HISPANIC OR LATINO, AND 2.1% TWO OR MORE RACES.

COUNTY HEALTH RANKINGS 2021 REPORTS HENDERSON AS #60 OUT OF 120 COUNTIES FOR HEALTH OUTCOMES AND #31 OUT OF 120 COUNTIES FOR HEALTH FACTORS. STATISTICS FOR DIABETES PREVALENCE, TEEN BIRTHS, AND SUICIDE RANK HIGHER THAN THE STATE AVERAGE.

UNION COUNTY IS ALSO LOCATED IN WESTERN KENTUCKY AND BORDERS SOUTHEASTERN ILLINOIS. POPULATION ESTIMATES (FROM CENSUS.GOV) FOR JULY 1, 2019 INCLUDE A GENERAL POPULATION OF 14,381 PEOPLE. THE COUNTY IDENTIFIES AS 83.8% WHITE, 13.2% BLACK OR AFRICAN AMERICAN, 2.1% HISPANIC OR LATINO, 2.0% TWO OR MORE RACES.

COUNTY HEALTH RANKINGS 2021 REPORTS UNION COUNTY AS #88 OUT OF 120 COUNTIES FOR HEALTH OUTCOMES AND #69 OUT OF 120 COUNTIES FOR HEALTH FACTORS.

STATISTICS FOR LOW BIRTHWEIGHT, ACCESS TO EXERCISE OPPORTUNITIES, INJURY DEATH, FIREARM FATALITIES, AND SUICIDE RANK HIGHER THAN THE STATE AVERAGE. UNION COUNTY IS MORE RURAL THAN MOST OF THE STATE (65.3% AND 41.6%

Part VI Supplemental Information (Continuation)

RESPECTIVELY).

PART VI, LINE 5:

COVID INFORMATION FOR THE COMMUNITY

DEACONESS CREATED SPECIFIC WEBPAGES FOR THE COMMUNITY AND BUSINESSES SO THEY HAD THE MOST CURRENT INFORMATION ABOUT TESTING, REGULATIONS, AND EVENTUALLY VACCINES. WE ALSO CREATED A SEPARATE COPING PAGE THAT LINKED PEOPLE TO A VARIETY OF RESOURCES ABOUT MENTAL AND EMOTIONAL HEALTH.

WE COLLABORATED WITH A VARIETY OF HEALTH AND ACADEMIC INSTITUTIONS TO OPERATE A CONVALESCENT PLASMA PROGRAM AND COMMUNITY PREVALENCE STUDY.

ADDITIONALLY, WE CREATED AND DISTRIBUTED CONTENT THAT ADDRESSED SPECIFIC ISSUES AND CONCERNS OUR COMMUNITY HAD REGARDING COVID-19.

7/16/2020 COVID TESTING DR. GINA HUHNKE

7/16/2020 MASK MYTHS DR. BRAD SCHEU

7/16/2020 FB LIVE WITH DR. PORTER MAYOR WINNECKE, DR. PORTER

7/20/2020 HPV PANEL DISCUSSION DRS. SCHUMAN, CAPRI WEYER

7/21/2020 FB LIVE WITH DR. HUHNKE DR. GINA HUHNKE

7/30/2020 FB LIVE WITH DR. PORTER DR. PORTER, BRIAN SPENCER PHARM D

E-NEWSLETTER ARTICLES 7/15/2020

LYME DISEASE T. GEHLHAUSEN, DO, OAKLAND CITY

KEEPING PAIN IN CHECK NP, PAIN CENTER

ABCS OF HEPATITIS MD, DC GASTRO

PREPARING TO GO BACK TO SCHOOL MD, DC PEDIATRICS

SUPER SUMMER NUTRITION RD DIETICIAN

8/27/2020 FB LIVE WITH DR. PORTER DRS. PORTER AND DAVID RYON

Part VI Supplemental Information (Continuation)

E-NEWSLETTER ARTICLES 8/15/2020

EXPERIENCING HEEL PAIN MD, DC PODIATRY

ADULT VACCINES MD, DC MARY STREET

KEEP MOVING FOR BETTER HEALTH DO, DC OAKLAND CITY

HELPING CHILDREN NAVIGATE DIFFICULT TIMES S. BRANAM, CAO CROSS POINTE

9/2/2020 COVID TESTING PROCESS APRIL ABBOTT, PHIL GAMBLE

9/10/2020 FLU SHOTS DURING PANDEMIC DR. BRAD SCHEU

9/24/2020 FB LIVE DR. PORTER AND SHAWN MCCOY

E-NEWSLETTER ARTICLES 9/15/2020

GET A FLU SHOT DURING COVID PANDEMIC DR. SHEU, DC ADMIN

MAMMOGRAMS, WHO NEEDS THEM AND WHEN MD, BREAST RADIOLOGIST

TIPS ON WEARING A FACE MASK MARKETING STAFF

PREVENTING SUICIDE JANIE CHAPPELL, CROSS POINTE

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:

KY

**SCHEDULE J
(Form 990)**

Department of the Treasury
Internal Revenue Service

Name of the organization

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 for instructions and the latest information.

OMB No 1545-0047

2020

Open to Public
Inspection

Employer identification number
61-0461753

Part I Questions Regarding Compensation

1a Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.

- | | |
|--|--|
| <input 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 (such as maid, chauffeur, chef) |

b If any of the boxes on 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

2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked on line 1a?

3 Indicate which, if any, of the following the 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 checked="" type="checkbox"/> Compensation committee | <input type="checkbox"/> Written employment contract |
| <input type="checkbox"/> Independent compensation consultant | <input checked="" type="checkbox"/> Compensation survey or study |
| <input checked="" type="checkbox"/> Form 990 of other organizations | <input checked="" type="checkbox"/> Approval by the board or compensation committee |

4 During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization

- a** Receive a severance payment or change-of-control payment?
- b** Participate in or receive payment from a supplemental nonqualified retirement plan?
- c** Participate in or receive payment from an equity-based compensation arrangement?

If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.

Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.

5 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of

- a** The organization?
- b** Any related organization?

If "Yes" on line 5a or 5b, describe in Part III.

6 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of

- a** The organization?
- b** Any related organization?

If "Yes" on line 6a or 6b, describe in Part III.

7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described on lines 5 and 6? If "Yes," describe in Part III.

8 Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III.

9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?

	Yes	No
1b		
2	X	
4a	X	
4b		X
4c		X
5a		X
5b		X
6a		X
6b		X
7	X	
8		X
9		

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990.

Schedule J (Form 990) 2020

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.

PART I, LINE 7:

PHYSICIANS ARE ELIGIBLE FOR INCENTIVE COMPENSATION. THE PHYSICIAN IS
COMPENSATED FOR EACH WORK RVU PERFORMED BY A PHYSICIAN IN A CALENDAR YEAR
IN EXCESS OF THE PHYSICIAN'S WORK RVU INCENTIVE THRESHOLD FOR THE CALENDAR
YEAR MULTIPLIED BY THE INCENTIVE RVU PAYMENT.

SCHEDULE L
(Form 990 or 990-EZ)
Transactions With Interested Persons

OMB No 1545-0047

2020
Open To Public Inspection

 Department of the Treasury
Internal Revenue Service

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 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 for instructions and the latest information.**

Name of the organization

METHODIST HEALTH, INC

Employer identification number

61-0461753
Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and section 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 the 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

LHA For Paperwork Reduction Act Notice, see the Instructions for Form 990 or 990-EZ.

Schedule L (Form 990 or 990-EZ) 2020

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
MIKE HAZELWOOD	FORMER BOARD MEMBER	325,339.	FORMER BOAR		X
MELANIE HUMBERT	RELATED FORMER BOAR	7,390.	SALARY - ME		X
TONIA LILES	RELATED FORMER BOAR	14,047.	SALARY - TO		X
ROBERTA PHILLIPS	RELATED FORMER BOAR	7,388.	SALARY - RO		X
DREW CLEMENTS	RELATED FORMER BOAR	18,247.	SALARY - DR		X

Part V Supplemental Information.

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

SCH L, PART IV, BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS:

(A) NAME OF PERSON: MIKE HAZELWOOD

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

FORMER BOARD MEMBER/OWNER

(D) DESCRIPTION OF TRANSACTION: FORMER BOARD MEMBER MIKE HAZELWOOD IS THE OWNER OF EM FORD & COMPANY. EM FORD & COMPANY PROVIDES INSURANCE COVERAGE TO THE HOSPITAL AND THE EXPENSE IS 303,963

(A) NAME OF PERSON: MELANIE HUMBERT

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

RELATED FORMER BOARD MEMBER

(D) DESCRIPTION OF TRANSACTION: SALARY - MELANIE HUMBERT IS AN EMPLOYEE OF THE HOSPITAL. SHE IS ALSO RELATED TO DR. VERNON HUMBERT, A FORMER BOARD MEMBER.

(A) NAME OF PERSON: TONIA LILES

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

RELATED FORMER BOARD MEMBER

(D) DESCRIPTION OF TRANSACTION: SALARY - TONIA LILES IS AN EMPLOYEE OF THE HOSPITAL. SHE IS RELATED TO DR. VERNON HUMBERT, A FORMER BOARD

Part V Supplemental Information

Complete this part to provide additional information for responses to questions on Schedule L (see instructions)

MEMBER.

(A) NAME OF PERSON: ROBERTA PHILLIPS

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

RELATED FORMER BOARD MEMBER

(D) DESCRIPTION OF TRANSACTION: SALARY - ROBERTA PHILLIPS IS AN EMPLOYEE OF THE HOSPITAL. SHE IS ALSO RELATED TO JIMMY PHILLIPS, A FORMER BOARD MEMBER.

(A) NAME OF PERSON: DREW CLEMENTS

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

RELATED FORMER BOARD MEMBER

(D) DESCRIPTION OF TRANSACTION: SALARY - DREW CLEMENTS IS AN EMPLOYEE OF THE HOSPITAL. HE IS RELATED TO MELISSA CLEMENTS, A FORMER BOARD MEMBER.

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

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 for the latest information.

OMB No 1545-0047

2020

Open to Public
Inspection

Name of the organization

METHODIST HEALTH, INC

Employer identification number
61-0461753

FORM 990, PART I, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

TO PERSONS, FAMILIES AND COMMUNITIES OF THE TRI-STATE. AT METHODIST
HEALTH, OUR VALUES ARE BASED ON OUR COMMITMENT TO QUALITY. WE DEFINE
QUALITY AS THE CONTINUOUS IMPROVEMENT OF SERVICES TO MEET THE NEEDS AND
EXCEED THE EXPECTATIONS FO THE CUSTOMERS WE SERVE. OUR VALUES ARE
QUALITY IN EVERYTHING WE DO, RESPECT FOR ALL PEOPLE, EFFICIENCY AND
EFFECTIVENESS IN THE USE OF RESOURCES, INNOATION TOWARD CONTINUOUS
SYSTEM IMPROVEMENT, PARTNERSHIP WITH THOSE WE SERVE AND WITH SUPPLIERS,
EDUCATION FOR CONTINUOUS GROWTH AND KNOWLEDGE AND PRIDE IN
WORKAMANSHIP. TO ACCOMPLISH ITS MISSION, METHODIST HEALTH IS COMMIITED
TO IMPROVING THE QUALITY OF LIFE FOR THE PEOPLE OF THE TRI-STATE BY
DEMONSTRATING EXCELLENCE IN HEALTHCARE SERVICES, PROVIDING ACCESS TO
HEALTHCARE, PROVIDING CHARITY CARE TO THOSE IN NEED, PROMOTING HEALTHY
LIFESTYLES, OFFERING SPIRITUAL AND PSYCHOLOGICAL SUPPORT, SUPPORTING
HEALTH RELATED

FORM 990, PART I, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

EDUCATION, AND ADVANCING HEALTH KNOWLEDGE THROUGH RESEARCH.

FORM 990, PART III, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

OF SERVICES TO MEET THE NEEDS AND EXCEED THE EXPECTATIONS FO THE
CUSTOMERS WE SERVE. OUR VALUES ARE QUALITY IN EVERYTHING WE DO, RESPECT
FOR ALL PEOPLE, EFFICIENCY AND EFFECTIVENESS IN THE USE OF RESOURCES,
INNOVATION TOWARD CONTINUOUS SYSTEM IMPROVEMENT, PARTNERSHIP WITH THOSE
WE SERVE AND WITH SUPPLIERS, EDUCATION FOR CONTINUOUS GROWTH AND

Name of the organization

METHODIST HEALTH, INC

Employer identification number

61-0461753

KNOWLEDGE AND PRIDE IN WORKMANSHIP. TO ACCOMPLISH ITS MISSION,
METHODIST HEALTH IS COMMITTED TO IMPROVING THE QUALITY OF LIFE FOR THE
PEOPLE OF THE TRI-STATE BY DEMONSTRATING EXCELLENCE IN HEALTHCARE
SERVICES, PROVIDING ACCESS TO HEALTHCARE, PROVIDING CHARITY CARE TO
THOSE IN NEED, PROMOTING HEALTHY LIFESTYLES, OFFERING SPIRITUAL AND
PSYCHOLOGICAL SUPPORT, SUPPORTING HEALTH RELATED

FORM 990, PART III, LINE 4A, PROGRAM SERVICE ACCOMPLISHMENTS:

COUNTY SERVED 106 INPATIENTS FOR A TOTAL OF 1,051 INPATIENT DAYS. UNION
COUNTY ALSO PROVIDED 1,503 EMERGENCY ROOM VISITS.

FORM 990, PART VI, SECTION A, LINE 4:

EFFECTIVE JULY 1, 2020 DEACONESS HEALTH, KENTUCKY BECAME SOLE MEMBER OWNER
OF METHODIST HEALTH, INC. DUE TO THE NEW OWNERSHIP, THE GOVERNING
DOCUMENTS FOR METHODIST HEALTH, INC. INCLUDING THE BYLAWS AND THE ARTICLES
OF INCORPORATION WERE AMENDED.

THE ARTICLES OF INCORPORATION WERE AMENDED IN SECTION 7.1 TO ADD LANGUAGE
"THE CORPORATION SHALL HAVE A SINGLE MEMBER, DEACONESS HEALTH, KENTUCKY,
INC., A KENTUCKY NONPROFIT CORPORATION."

CHANGES TO THE BYLAWS CONSIST OF THE FOLLOWING: SECTION 2.01 WAS CHANGED TO
ADD SINGLE MEMBER DEACONESS HEALTH, KENTUCKY, INC (DHKY). SECTION 3.01
ADDED "SUBJECT TO THE RIGHTS OF DHKY AND OTHER LIMITATIONS AS SET FORTH
HEREIN, THE BOARD OF DIRECTORS OF THE CORPORATION, SHALL BE PRIMARILY
RESPONSIBLE FOR MANAGEMENT AND OVERSIGHT" BOARD MEMBERSHIP WAS CHANGED FROM
3 MEMBERS BEING APPOINTED BY DHKY TO 5 MEMBERS. SECTION 3.09 CHANGED THE
MATTERS THAT REQUIRED APPROVAL FROM BOARD APPROVAL TO DHKY APPROVAL AND
ADDED THE APPROVAL OF ANNUAL OR LONG-TERM CAPITAL BUDGETS, OPERATING BUDGETS
AND STRATEGIC PLANS, OR ANY EXPENDITURE IN EXCESS OF \$50,000 NOT INCLUDED

Name of the organization

METHODIST HEALTH, INC

Employer identification number

61-0461753

IN AN APPROVED BUDGET. SECTION 5.06 ADDED THE CEO APPOINTMENT BY THE BOARD IS SUBJECT TO THE APPROVAL OF DHKY. EXHIBIT 6.02 THE FUNCTIONS OF THE AUDIT COMMITTEE, THE COMPLIANCE COMMITTEE, AND THE COMPENSATION COMMITTEE SHALL BE PERFORMED ON BEHALF OF THE BOARD BY THE AUDIT COMMITTEE OF DEACONESS HEALTH SYSTEM.

FORM 990, PART VI, SECTION A, LINE 6:

DEACONESS HEALTH KENTUCKY, INC. IS THE SOLE CORPORATE MEMBER OF METHODIST HEALTH, INC.

FORM 990, PART VI, SECTION A, LINE 7A:

FIVE INDIVIDUALS ARE APPOINTED TO THE BOARD BY THE SOLE MEMBER, DEACONESS HEALTH OF KENTUCKY, INC. FOUR INDIVIDUALS ARE APPOINTED TO THE BOARD BY A MAJORITY VOTE OF THE MEMBERS PRESENT AT A MEETING OF THE ADVISORY BOARD CALLED FOR SUCH PURPOSE AT WHICH A QUORUM IS PRESENT AND COLLECTIVELY WITH THE DHKY DIRECTORS.

FORM 990, PART VI, SECTION B, LINE 11B:

THE IRS FORM 990 IS PRESENTED TO THE CFO AND CEO OF THE ORGANIZATION FOR REVIEW. AFTER THIS REVIEW AND ALL QUESTIONS HAVE BEEN ANSWERED, THE FORM 990 IS PRESENTED TO THE BOARD OF DIRECTORS OF DEACONESS HEALTH SYSTEM PRIOR TO FILING. ANY ADDITIONAL QUESTIONS ARE ANSWERED AND THE FILING OF THE FORM IS COMPLETED.

FORM 990, PART VI, SECTION B, LINE 12C:

CONFLICT OF INTEREST REVIEW AND COMPLIANCE ACTIVITIES ARE CONDUCTED THROUGHOUT THE YEAR UNDER THE DIRECTION OF DEACONESS HEALTH'S CORPORATE COMPLIANCE OFFICER. UPON APPOINTMENT AND ANNUALLY THEREAFTER, OFFICERS,

Name of the organization

METHODIST HEALTH, INC

Employer identification number

61-0461753

TRUSTEES, DIRECTORS, AND KEY EMPLOYEES, ALSO KNOWN AS INTERESTED PERSONS ARE REQUIRED TO COMPLETE THE CONFLICTS OF INTEREST AND/OR THE DISCLOSURE QUESTIONNAIRE. THESE DOCUMENTS SERVE TO ENSURE INTERESTED PERSONS HAVE AN APPROPRIATE AND TIMELY MANNER IN WHICH TO DISCLOSE ANY POTENTIAL CONFLICTS. CONFLICTS ARE CONSIDERED WITH RESPECT TO OUTSIDE INTEREST, INVESTMENTS, OUTSIDE ACTIVITIES, AND BUSINESS INTERESTS AMONG THE INTERESTED PERSONS AS WELL AS THEIR FAMILY MEMBERS ON A PERIODIC BASES. REVIEWS OCCUR TO ENSURE METHODIST HEALTH OPERATES IN A MANNER CONSISTENT WITH ITS CHARITABLE PURPOSE. SUBJECTS THAT ARE REVIEWED ON A PERIODIC BASIS INCLUDE COMPENSATION, PHYSICIAN RELATIONSHIPS, PARTNERSHIP AND JOINT VENTURE ARRANGEMENTS.

FORM 990, PART VI, SECTION B, LINE 15:

COMPENSATION FOR TOP OFFICIALS AND OTHER OFFICERS METHODIST HEALTH UTILIZES THE DEACONESS HEALTH COMPENSATION COMMITTEE TO APPROVE EXECUTIVE, DIRECTOR AND PHYSICIAN COMPENSATION AS WELL AS EXECUTIVE AND PHYSICIAN BENEFITS PROGRAMS. THE COMPENSATION COMMITTEE IS APPOINTED BY THE BOARD OF DIRECTORS OF DEACONESS HEALTH AND MUST MEET THE INDEPENDENCE REQUIREMENTS OF THE SEC. THE COMMITTEE HAS THE POWER AND AUTHORITY TO:

- 1) ANNUALLY REVIEW AND APPROVE AND RECOMMEND TO THE BOARD OF DIRECTORS FOR ITS FINAL APPROVAL FOR THE CEO AND EACH OTHER EXECUTIVE OFFICER OF THE SYSTEM ALL ELEMENTS OF EXECUTIVE COMPENSATION
- 2) MONITOR BROADLY THE STRUCTURE, PHILOSOPHY OR COMPETITIVENESS OF THE SYSTEM'S GENERAL HIRING OR COMPENSATION PRACTICES
- 3) OVERSEE THE ESTABLISHMENT AND ADMINISTRATION OF THE COMPANY'S BROAD-BASED BENEFIT PLANS AND PROGRAMS
- 4) REVIEW OR APPROVE SIGNIFICANT AMENDMENTS OR CHANGES TO THE PLANS AND PROGRAMS

Name of the organization

METHODIST HEALTH, INC

Employer identification number

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5) RETAIN AND TERMINATE ANY COMPENSATION CONSULTANT TO BE USED TO ASSIST IN THE EVALUATION OF DIRECTOR, CEO OR EXECUTIVE OFFICE COMPENSATION

6) SOLE AUTHORITY TO APPROVE THE CONSULTANT'S FEES AND OTHER RETENTION TERMS

7) OBTAIN ADVICE AND ASSISTANCE FROM INTERNAL OR EXTERNAL LEGAL, ACCOUNTING OR OTHER ADVISORS

8) APPROVE ALL PHYSICIAN AND PHYSICIAN RELATED CONTRACTS

9) MAKE REGULAR REPORTS TO THE BOARD

FORM 990, PART VI, SECTION C, LINE 19:

METHODIST HEALTH'S ARTICLES OF INCORPORATION ARE ON THE SECRETARY OF STATE'S WEBSITE. METHODIST HEALTH IS PART OF A CONSOLIDATED FINANCIAL STATEMENT WHICH IS AVAILABLE WITH THE PUBLIC DISCLOSURE COPY OF THE IRS FORM 990. ALSO, AS REQUIRED BY LAW, METHODIST HEALTH SUBMITS ITS CONSOLIDATED FINANCIAL STATEMENTS TO THE KENTUCKY DEPARTMENT OF HEALTH WHICH ARE PUBLISHED ON ITS WEBSITE. GOVERNING DOCUMENTS, ASIDE FROM THE ARTICLES OF INCORPORATION, AND THE CONFLICT-OF-INTEREST POLICY ARE NOT AVAILABLE FOR PUBLIC INSPECTION.

FORM 990, PART IX, LINE 11G, OTHER FEES:

MEDICAL FEES:

PROGRAM SERVICE EXPENSES	68,136.
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MANAGEMENT AND GENERAL EXPENSES	0.
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FUNDRAISING EXPENSES	0.
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TOTAL EXPENSES	68,136.
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PROFESSIONAL FEES:

PROGRAM SERVICE EXPENSES	3,022,399.
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Name of the organization

METHODIST HEALTH, INC

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MANAGEMENT AND GENERAL EXPENSES	1,362,554.
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FUNDRAISING EXPENSES	0.
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TOTAL EXPENSES	4,384,953.
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CONTRACT SERVICES:

PROGRAM SERVICE EXPENSES	1,237,916.
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MANAGEMENT AND GENERAL EXPENSES	558,076.
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FUNDRAISING EXPENSES	0.
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TOTAL EXPENSES	1,795,992.
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TEMPORARY SERVICES:

PROGRAM SERVICE EXPENSES	37,025.
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MANAGEMENT AND GENERAL EXPENSES	16,691.
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FUNDRAISING EXPENSES	0.
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TOTAL EXPENSES	53,716.
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TOTAL OTHER FEES ON FORM 990, PART IX, LINE 11G, COL A	6,302,797.
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FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

CHANGE IN PENSION LIABILITY	-1,092,492.
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CAPITAL CONTRIBUTED	8,333,710.
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TOTAL TO FORM 990, PART XI, LINE 9	7,241,218.
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FORM 990, PART XII

THE BOARD OF DIRECTORS OF DEACONESS HEALTH, INC. ASSUMES RESPONSIBILITY
FOR OVERSIGHT

OF THE AUDIT OF THE FINANCIAL STATEMENTS AND SELECTION OF THE
INDEPENDENT ACCOUNTANT. THE BOARD OF DIRECTORS OF METHODIST HEALTH
SHALL TAKE NECESSARY STEPS TO ENSURE IMPLEMENTATION OF AND COMPLIANCE

Employer identification number
61-0461753

WITH THE RECOMMENDATIONS OF THE DEACONESS BOARD.

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?

a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity

b Gift, grant, or capital contribution to related organization(s)

c Gift, grant, or capital contribution from related organization(s)

d Loans or loan guarantees to or for related organization(s)

e Loans or loan guarantees by related organization(s)

f Dividends from related organization(s)

g Sale of assets to related organization(s)

h Purchase of assets from related organization(s)

i Exchange of assets with related organization(s)

j Lease of facilities, equipment, or other assets to related organization(s)

k Lease of facilities, equipment, or other assets from related organization(s)

l Performance of services or membership or fundraising solicitations for related organization(s)

m Performance of services or membership or fundraising solicitations by related organization(s)

n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)

o Sharing of paid employees with related organization(s)

p Reimbursement paid to related organization(s) for expenses

q Reimbursement paid by related organization(s) for expenses

r Other transfer of cash or property to related organization(s)

s Other transfer of cash or property from related organization(s)

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)				
(2)				
(3)				
(4)				
(5)				
(6)				

Part VII	Supplemental Information
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Provide additional information for responses to questions on Schedule R. See instructions

Provide additional information in response to questions or comments on this information.