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Form 990

Return of Organization Exempt From Income Tax

OMB No. 1545-0047

2019

Open to Public Inspection

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

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

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

A For the 2019 calendar year, or tax year beginning 10-01-2019 , and ending 09-30-2020

B Check if applicable:
☐ Address change
☐ Name change
☐ Initial return
☐ Final return/terminated
☐ Amended return
☐ Application pending

C Name of organization
MEMORIAL HEALTH SYSTEM GROUP

Doing business as

Number and street (or P.O. box if mail is not delivered to street address) Room/suite
701 NORTH FIRST STREET

City or town, state or province, country, and ZIP or foreign postal code
SPRINGFIELD, IL 62781

D Employer identification number

90-0756744

E Telephone number

(217) 788-3000

G Gross receipts \$ 2,837,472,634

F Name and address of principal officer:
EDGAR J CURTIS
701 NORTH FIRST STREET
SPRINGFIELD, IL 62781

H(a) Is this a group return for subordinates?
☒ Yes ☐ No
H(b) Are all subordinates included?
☐ Yes ☒ No
If "No," attach a list. (see instructions)
H(c) Group exemption number ▶ 5670

I Tax-exempt status: ☒ 501(c)(3) ☐ 501(c) () ◀ (insert no.) ☐ 4947(a)(1) or ☐ 527

J Website: ▶ WWW.CHOOSMEMORIAL.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation:

M State of legal domicile:

Part I Summary

1 Briefly describe the organization's mission or most significant activities:
TO IMPROVE THE HEALTH OF THE PEOPLE AND COMMUNITIES WE SERVE.

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

3 Number of voting members of the governing body (Part VI, line 1a) 3 179

4 Number of independent voting members of the governing body (Part VI, line 1b) 4 141

5 Total number of individuals employed in calendar year 2019 (Part V, line 2a) 5 10,999

6 Total number of volunteers (estimate if necessary) 6 2,426

7a Total unrelated business revenue from Part VIII, column (C), line 12 7a 9,439,827

b Net unrelated business taxable income from Form 990-T, line 39 7b 0

Revenue

8 Contributions and grants (Part VIII, line 1h) 6,660,344

9 Program service revenue (Part VIII, line 2g) 1,010,061,527

10 Investment income (Part VIII, column (A), lines 3, 4, and 7d) 19,222,793

11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e) 18,025,005

12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12) 1,053,969,669

13 Grants and similar amounts paid (Part IX, column (A), lines 1–3) 10,641,948

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) 427,884,744

16a Professional fundraising fees (Part IX, column (A), line 11e) 0

b Total fundraising expenses (Part IX, column (D), line 25) ▶246,239

17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e) 571,498,817

18 Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25) 1,010,025,509

19 Revenue less expenses. Subtract line 18 from line 12 43,944,160

Net Assets or Fund Balances

20 Total assets (Part X, line 16) 1,711,737,458

21 Total liabilities (Part X, line 26) 600,993,645

22 Net assets or fund balances. Subtract line 21 from line 20 1,110,743,813

Part II Signature Block

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

Sign Here

Signature of officer
KATHRYN J KEIM SR VICE PRESIDENT & CFO
Type or print name and title

2021-08-16
Date

Paid Preparer Use Only

Print/Type preparer's name
Firm's name ▶ ERNST & YOUNG US LLP
Firm's address ▶ 155 N WACKER DRIVE
CHICAGO, IL 60606

Preparer's signature
Date

Check ☐ if self-employed
Firm's EIN ▶ 34-6565596
Phone no. (312) 879-2000

PTIN P01622613

May the IRS discuss this return with the preparer shown above? (see instructions) ☒ Yes ☐ No

For Paperwork Reduction Act Notice, see the separate instructions.

Cat. No. 11282Y

Form 990 (2019)

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

TO IMPROVE THE HEALTH OF THE PEOPLE AND COMMUNITIES WE SERVE.

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

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

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

If "Yes," describe these changes on Schedule O.

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

4a	(Code:) (Expenses \$	1,059,420,009	including grants of \$	21,083,304) (Revenue \$	1,203,903,501)
See Additional Data					

4b	(Code:) (Expenses \$	78,002,822	including grants of \$	41,877) (Revenue \$	48,233,683)
See Additional Data					

4c	(Code:) (Expenses \$	6,411,517	including grants of \$	2,100) (Revenue \$	7,206,307)
See Additional Data					

(Code:) (Expenses \$	1,847,054	including grants of \$	1,697,814) (Revenue \$)
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FOUNDATIONS MEMORIAL HEALTH SYSTEM UTILIZES FOUNDATIONS TO PROVIDE GRANTS TO SUPPORT PATIENT CARE, EDUCATION, AND COMMUNITY HEALTH OUTREACH IN ADDITION TO FACILITATING PARTNERSHIPS AND COLLABORATION TO IMPROVE THE HEALTH OF THE COMMUNITY. THE FOUR FOUNDATIONS INCLUDED IN THE MEMORIAL HEALTH SYSTEM GROUP 990 RETURN ARE MEMORIAL MEDICAL CENTER FOUNDATION (MMCF), DECATUR MEMORIAL HEALTH FOUNDATION (DMHF), TAYLORVILLE MEMORIAL HOSPITAL FOUNDATION (TMHF), AND PASSAVANT AREA HOSPITAL FOUNDATION (PAHF). IN FY2020, MMCF PROVIDED \$549,380 IN GRANTS TO ORGANIZATIONS. THIS INCLUDED \$377,166 IN GRANTS TO MEMORIAL HEALTH SYSTEM AFFILIATES AND \$172,214 IN GRANTS TO SIU SCHOOL OF MEDICINE. IN FY2020, MMCF PROVIDED \$236,371 IN GRANTS TO INDIVIDUALS. THESE GRANTS INCLUDE PATIENT ASSISTANCE OF \$153,665, EDUCATIONAL GRANTS OF \$55,144, AND ASSISTANCE TO EMPLOYEES WITH CATASTROPHIC EVENTS AND COVID RELIEF OF \$27,562. IN FY2020, DMHF PROVIDED \$190,305 IN GRANTS TO ORGANIZATIONS. THIS INCLUDED \$175,055 IN GRANTS TO DECATUR MEMORIAL HOSPITAL AND \$7,000 IN GRANTS TO CHILDREN'S MUSEUM OF ILLINOIS. IN FY2020, DMHF PROVIDED \$35,674 IN GRANTS TO INDIVIDUALS. THESE GRANTS INCLUDED EDUCATIONAL GRANTS OF \$6,898 AND ASSISTANCE TO EMPLOYEES WITH CATASTROPHIC EVENTS AND COVID RELIEF OF \$26,526. IN FY2020, TMHF PROVIDED \$180,565 IN GRANTS TO TAYLORVILLE MEMORIAL HOSPITAL. IN FY2020, TMHF PROVIDED \$61,882 IN GRANTS TO INDIVIDUALS. THESE GRANTS INCLUDED EDUCATIONAL GRANTS OF \$46,879 AND PEDIATRIC DENTISTRY OF \$6,252. IN FY2020, PAHF PROVIDED \$425,400 IN GRANTS TO ORGANIZATIONS. THIS INCLUDED \$354,453 IN GRANTS TO MEMORIAL HEALTH SYSTEM AFFILIATES AND \$70,947 IN GRANTS TO COMMUNITY ORGANIZATIONS. IN FY2020, PAHF PROVIDED \$18,237 IN GRANTS TO INDIVIDUALS. THESE GRANTS INCLUDED EDUCATIONAL ASSISTANCE OF \$9,480 AND ASSISTANCE TO EMPLOYEES WITH CATASTROPHIC EVENTS AND COVID RELIEF OF \$8,757.

4d Other program services (Describe in Schedule O.)

(Expenses \$	1,847,054	including grants of \$	1,697,814) (Revenue \$)
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4e Total program service expenses 1,145,681,402

Part IV Checklist of Required Schedules

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

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

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

		Yes	No	
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	546	
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	1	
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c	Yes	

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

Form **990** (2019)

Part VI

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

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

Section A. Governing Body and Management

		Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	179	
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.		
b	Enter the number of voting members included in line 1a, above, who are independent	141	
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?	Yes	
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?		No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	Yes	
5	Did the organization become aware during the year of a significant diversion of the organization's assets?		No
6	Did the organization have members or stockholders?	Yes	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	Yes	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	Yes	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:		
a	The governing body?	Yes	
b	Each committee with authority to act on behalf of the governing body?	Yes	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O		No

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

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

Section C. Disclosure

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

18 Section 6104 requires an organization to make its Form 1023 (or 1024-A if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

☐ Own website ☐ Another's website ☒ Upon request ☐ Other (explain in Schedule O)

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

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

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

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

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

See instructions for the order in which to list the persons above.

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

[illegible]

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
See Additional Data Table										
1b Sub-Total										
c Total from continuation sheets to Part VII, Section A										
d Total (add lines 1b and 1c)								17,092,971	10,111,965	3,685,354

2 Total number of individuals (including but not limited to those listed above) who received more than \$100,000 of reportable compensation from the organization ▶ 644

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
SIU SCHOOL OF MEDICINE PO BOX 19607 SPRINGFIELD, IL 627949607	PHYSICIAN SERVICES	45,564,223
HAROLD O'SHEA BUILDERS INC 3401 CONSTITUTION DR SPRINGFIELD, IL 62711	CONSTRUCTION	14,304,984
SPRINGFIELD CLINIC PO BOX 19260 SPRINGFIELD, IL 627049260	PHYSICIAN SERVICES	13,481,515
CERNER CORPORATION 2800 ROCK CREEK PARKWAY KANSAS CITY, MO 64117	COMPUTER SOFTWARE/SUPPORT	9,356,549
FOCUSONE SOLUTIONS LLC 13609 CALIFORNIA STREET OMAHA, NE 68154	CONTRACT LABOR	7,406,151

2 Total number of independent contractors (including but not limited to those listed above) who received more than \$100,000 of compensation from the organization ▶ 171

Form 990 (2019)		Page 9			
Part VIII		Statement of Revenue			
Check if Schedule O contains a response or note to any line in this Part VIII					
		(A)	(B)	(C)	(D)
		Total revenue	Related or exempt function revenue	Unrelated business revenue	Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	1a	Federated campaigns	1a	3,629	
	b	Membership dues	1b		
	c	Fundraising events	1c	273,942	
	d	Related organizations	1d	1,217,858	
	e	Government grants (contributions)	1e	57,645,434	
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	8,793,085	
	g	Noncash contributions included in lines 1a - 1f:\$	1g	5,140,710	
	h	Total. Add lines 1a-1f		67,933,948	
Program Service Revenue	2a	PATIENT SERVICE REV	Business Code		
			900099	1,173,201,322	1,173,201,322
	b	PROGRAM RELATED REV	900099	63,895,171	63,895,171
	c	HOSPICE SERVICES	621610	3,596,756	3,596,756
	d	HOME HEALTH SERVICES	621610	3,449,894	3,449,894
	e	PROGRAM RELATED RENT	621110	223,268	223,268
	f	All other program service revenue.		1,577,905	1,577,905
	g	Total. Add lines 2a-2f		1,245,944,316	
Other Revenue	3	Investment income (including dividends, interest, and other similar amounts)		9,595,190	
	4	Income from investment of tax-exempt bond proceeds			
	5	Royalties			
	6a	Gross rents	(i) Real	(ii) Personal	
		6a	5,677,105		
	b	Less: rental expenses	6b	3,378,333	
	c	Rental income or (loss)	6c	2,298,772	
	d	Net rental income or (loss)		2,298,772	275,533
					1,036,613
					986,626
	7a	Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other	
		7a	1,478,775,150	79,322	
	b	Less: cost or other basis and sales expenses	7b	1,448,077,506	480,583
	c	Gain or (loss)	7c	30,697,644	-401,261
	d	Net gain or (loss)		30,296,383	
					30,296,383
	8a	Gross income from fundraising events (not including \$ 273,942 of contributions reported on line 1c). See Part IV, line 18	8a	427,207	
	b	Less: direct expenses	8b	263,520	
	c	Net income or (loss) from fundraising events		163,687	
					163,687
	9a	Gross income from gaming activities. See Part IV, line 19	9a	116,800	
	b	Less: direct expenses	9b	105,104	
c	Net income or (loss) from gaming activities		11,696		
				11,696	
10a	Gross sales of inventory, less returns and allowances	10a	1,167,539		
b	Less: cost of goods sold	10b	486,809		
c	Net income or (loss) from sales of inventory		680,730		
				680,730	
Miscellaneous Revenue		Business Code			
11a	340B PHARMACY	622110	7,293,523	7,293,523	
b	REFERENCE LAB REVENUE	621500	6,542,286	6,542,286	
c	CAFETERIA REVENUE	722320	5,313,958	1,050,479	
				228,742	
d	All other revenue		8,606,290	4,779,640	
				951,456	
e	Total. Add lines 11a-11d		27,756,057		
12	Total revenue. See instructions		1,384,680,779	1,259,343,491	
				9,439,827	
				47,963,513	
Form 990 (2019)					

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	21,722,850	21,722,850		
2 Grants and other assistance to domestic individuals. See Part IV, line 22	1,102,245	1,102,245		
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	10,753,943	7,185,315	3,478,844	89,784
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	1,083,191	968,533	114,658	
7 Other salaries and wages	455,003,672	396,094,810	58,816,778	92,084
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	17,184,114	15,218,685	1,964,326	1,103
9 Other employee benefits	71,469,650	62,526,589	8,916,453	26,608
10 Payroll taxes	34,798,959	29,750,414	5,037,550	10,995
11 Fees for services (non-employees):				
a Management				
b Legal	490,836	100	490,736	
c Accounting	1,161,283		1,161,283	
d Lobbying	180,524		180,524	
e Professional fundraising services. See Part IV, line 17				
f Investment management fees	1,230,703		1,230,703	
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.)	199,032,310	173,119,120	25,913,190	
12 Advertising and promotion	1,979,365	459,273	1,519,098	994
13 Office expenses	19,567,130	17,246,811	2,310,872	9,447
14 Information technology	24,101,979	15,506,488	8,593,600	1,891
15 Royalties	13,797	13,797		
16 Occupancy	27,806,424	22,014,381	5,792,043	
17 Travel	997,751	807,501	190,250	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings	741,180	250,526	490,654	
20 Interest	9,022,785	8,864,036	158,749	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	52,809,552	42,650,086	10,159,466	
23 Insurance	10,682,322	1,818,754	8,863,568	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a PATIENT SERV. SUPPLIES	137,137,241	137,135,556	1,685	
b MANAGEMENT FEE	69,143,743		69,143,743	
c PHARMACEUTICAL SUPPLIES	51,156,055	51,156,055		
d PURCHASED MEDICAL SERVI	39,871,168	39,871,168		
e All other expenses	106,138,165	100,198,309	5,926,523	13,333
25 Total functional expenses. Add lines 1 through 24e	1,366,382,937	1,145,681,402	220,455,296	246,239
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

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

				(A) Beginning of year		(B) End of year
Assets	1	Cash—non-interest-bearing		8,357,647	1	8,216,121
	2	Savings and temporary cash investments		126,273,101	2	125,904,660
	3	Pledges and grants receivable, net		296,487	3	127,959
	4	Accounts receivable, net		214,335,924	4	190,884,251
	5	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			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		28,660,642	7	16,644,727
	8	Inventories for sale or use		17,650,240	8	18,791,908
	9	Prepaid expenses and deferred charges		9,845,974	9	9,928,608
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 1,036,357,403			
	b	Less: accumulated depreciation	10b 535,992,164	456,471,688	10c	500,365,239
	11	Investments—publicly traded securities		676,673,201	11	773,479,588
	12	Investments—other securities. See Part IV, line 11		67,717,610	12	221,713,234
	13	Investments—program-related. See Part IV, line 11		8,346,368	13	8,818,651
	14	Intangible assets			14	
	15	Other assets. See Part IV, line 11		97,108,576	15	84,258,331
16	Total assets. Add lines 1 through 15 (must equal line 34)		1,711,737,458	16	1,959,133,277	
Liabilities	17	Accounts payable and accrued expenses		164,894,302	17	141,609,879
	18	Grants payable		986,679	18	388,193
	19	Deferred revenue		1,889,203	19	4,458,460
	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		31,479,090	23	67,480,807
	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		401,744,371	25	501,962,709
	26	Total liabilities. Add lines 17 through 25		600,993,645	26	715,900,048
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		989,742,817	27	1,114,072,065
	28	Net assets with donor restrictions		121,000,996	28	129,161,164
	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		1,110,743,813	32	1,243,233,229	
33	Total liabilities and net assets/fund balances		1,711,737,458	33	1,959,133,277	

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	1,384,680,779
2	Total expenses (must equal Part IX, column (A), line 25)	2	1,366,382,937
3	Revenue less expenses. Subtract line 2 from line 1	3	18,297,842
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	1,110,743,813
5	Net unrealized gains (losses) on investments	5	30,503,648
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	71,421,545
9	Other changes in net assets or fund balances (explain in Schedule O)	9	12,266,381
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	1,243,233,229

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

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

Additional Data

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

Form 990 (2019)

Form 990, Part III, Line 4a:

HOSPITALSMEMORIAL HEALTH SYSTEM INCLUDES FIVE HOSPITALS, MEMORIAL MEDICAL CENTER (MMC), DECATUR MEMORIAL HOSPITAL (DMH), PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION (PAH), THE ABRAHAM LINCOLN MEMORIAL HOSPITAL (ALMH), AND TAYLORVILLE MEMORIAL HOSPITAL (TMH). THE HOSPITALS PROVIDE A WIDE VARIETY OF HEALTH CARE SERVICES TO INPATIENTS, OUTPATIENTS AND EMERGENCY DEPARTMENT SERVICES. 169,029 PATIENT DAYS, 33,138 DISCHARGES, AND 764,755 OUTPATIENT VISITS WERE PROVIDED BY THE HOSPITALS IN FY2020. IN FY2020, \$21 MILLION IN CHARITY CARE WAS PROVIDED BY MHS HOSPITALS. JACKSONVILLE CRNA PROVIDES PROFESSIONAL CERTIFIED REGISTERED NURSE ANESTHETIST SERVICES TO THE COMMUNITIES IN THE PAH SERVICE AREA. FOR FY2020, SERVICES WERE PROVIDED FOR 4,301 CASES. IN FY2020, ALL FIVE HOSPITALS SUSPENDED ELECTIVE PROCEDURES FROM MARCH THRU MAY 2020 DUE TO COVID-19. REDEPLOYED COLLEAGUES HELPED WITH ENTRANCE SCREENING, SAFETY MONITORING, AND PERSONAL PROTECTIVE EQUIPMENT CONSERVATION.IN FY2020, MMC OPENED A NEW 15-BED INTENSIVE CARE UNIT AND RENOVATED 4 OPERATING ROOMS. THE COMPREHENSIVE STROKE CENTER EARNED THE AMERICAN HEART ASSOCIATION'S/AMERICAN STROKE ASSOCIATION'S GET WITH THE GUIDELINES - STROKE GOLD PLUS WITH TARGET STROKE HONOR ROLL DESIGNATION WHICH RECOGNIZES MMC'S STROKE PATIENTS RECEIVE THE MOST APPROPRIATE TREATMENT ACCORDING TO NATIONALLY RECOGNIZED, RESEARCH-BASED GUIDELINES. IN FY2020, DMH EARNED THE GOLD SEAL OF APPROVAL FROM THE JOINT COMMISSION AS A DESIGNATED PRIMARY STROKE CENTER. ALSO IN FY2020, DMH WAS ADDED TO THE HEALTHY COMMUNITIES INSTITUTE DATABASE WHICH INCLUDES CRUCIAL INFORMATION ABOUT THE HEALTH NEEDS AND DISPARITIES FOR THE COMMUNITY.IN FY2020, PAH EARNED DESIGNATION AS A BABY-FRIENDLY HOSPITAL, RECOGNIZING OPTIMAL CARE FOR MOTHERS WHO WANT TO BREASTFEED THEIR NEWBORNS. TO EARN THIS HONOR, FAMILY MATERNITY SUITES NURSES IMPLEMENTED POLICIES THAT ENCOURAGE BREASTFEEDING AND PROVIDE SUPPORT AND EDUCATION FOR NURSING MOTHERS.IN FY2020, ALMH WAS HONORED WITH A PERFORMANCE LEADERSHIP AWARD BY THE CHARTIS CENTER FOR RURAL HEALTH AND THE NATIONAL ORGANIZATION OF STATE OFFICES OF RURAL HEALTH WITH SPECIAL RECOGNITION FOR OVERALL EXCELLENCE IN THE OUTCOMES AND PATIENT PERSPECTIVE CATEGORIES. ALMH WAS ALSO NAMED TO THE PRACTICE GREENHEALTH TOP 25 ENVIRONMENTAL EXCELLENCE LIST IN FY2020, WHICH IS THE MOST PRESTIGIOUS HONOR GIVEN TO HEALTHCARE ORGANIZATIONS FOR SUSTAINABILITY. PRACTICE GREENHEALTH PROVIDES TOOLS AND RESOURCES TO PROMOTE ENVIRONMENTAL STEWARDSHIP WITHIN THE HEALTHCARE INDUSTRY NATIONWIDE.ON MARCH 11, 2020, TMH MOVED INTO ITS NEW FACILITY. THE MOVE MARKED THE COMPLETION OF THE FIRST PHASE OF THE TWO-PHASE CONSTRUCTION PROJECT TO REPLACE THE ORIGINAL 1954 HOSPITAL. BEFORE THE BUILDING OPENED TO PATIENTS, TMH HOSTED SEVERAL COMMUNITY EVENTS TO SHOWCASE THE NEW FACILITY, WHICH FEATURES 25 PRIVATE ROOMS AND PROVIDES MORE CONVENIENT ACCESS TO AN ARRAY OF OUTPATIENT SERVICES.ALSO IN FY2020, TMH WAS HONORED BY THE ILLINOIS CRITICAL ACCESS HOSPITAL NETWORK (ICAHN) FOR ITS ONGOING COMMITMENT TO QUALITY CARE. TMH RANKED HIGHLY IN ALL FOUR OF ICAHN'S QUALITY OUTCOMES AREAS AND WAS ALSO AWARDED A FOUR-STAR HOSPITAL CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (HCAHPS) RATING FOR A HIGH-QUALITY PATIENT EXPERIENCE.

Form 990, Part III, Line 4b:

PHYSICIANS MEMORIAL PHYSICIAN SERVICES (MPS) IS A PROVIDER NETWORK OF 11 BRANCH CLINICS THAT SUPPORT A VARIETY OF OUTPATIENT SERVICES THROUGHOUT CENTRAL ILLINOIS. PATIENTS MAY BE CARED FOR IN A CLINIC, NURSING HOME, HOSPITAL OR VIRTUAL SETTING. MPS ALSO OFFERS FOUR WALK-IN EXPRESSCARE LOCATIONS TO IMPROVE PATIENT ACCESS, AS WELL AS A WALK-IN CLINIC IN A RETAIL SETTING. COMPRISED OF MORE THAN 165 PHYSICIANS, ADVANCED PRACTICE REGISTERED NURSES, DOCTOR OF NURSING PRACTICE AND PHYSICIAN ASSISTANTS. MPS EMPLOYS MORE THAN 450 SUPPORT PERSONNEL AND PROVIDED 244,585 PRIMARY CARE PATIENTS VISITS AND 106,876 URGENT CARE VISITS FOR FY2020. PHYSICIAN OFFICES AND CLINICS ARE LOCATED IN SPRINGFIELD, JACKSONVILLE, LINCOLN, PETERSBURG AND CHATHAM. MPS ALSO HAS AN ON-SITE CLINIC AT A LOCAL NURSING HOME TO IMPROVE ACCESS FOR ELDERLY RESIDENTS AND AN EMPLOYER-BASED CLINIC LOCATED IN BEARDSTOWN. ALL OF THE MPS PRIMARY CARE CLINICS ARE NCQA DESIGNATED LEVEL 3 PATIENT CENTERED MEDICAL HOMES. MPS PROVIDES COMMUNITY BENEFITS BY MENTORING AND PROVIDING HEALTH PROFESSION EDUCATIONAL OPPORTUNITIES FOR MEDICAL STUDENTS, ADVANCED PRACTICE REGISTERED NURSES, DOCTOR OF NURSING PRACTICE, PHYSICIAN ASSISTANTS AND CERTIFIED MEDICAL ASSISTANTS. DMH IS THE EMPLOYER OF 87 PHYSICIANS PLUS A COMPLEMENT OF OTHER PROVIDERS. THIS ALLOWS DMH TO OFFER A WIDE RANGE OF PROFESSIONAL PATIENT CARE AT APPROXIMATELY 30 OFFICES LOCATED THROUGHOUT THE SERVICE AREA. THESE SITES INCLUDE TWO EXPRESSCARE LOCATIONS OFFERING CARE FOR CASES THAT ARE TIME-SENSITIVE BUT NOT LIFE-THREATENING OR EMERGENT. IN FY2020, STANDING UP RESPIRATORY CLINICS IN SPRINGFIELD AND DECATUR PROVIDED COVID-19 TESTS TO THE COMMUNITIES. STAFF LOGGED MORE THAN 47,000 PATIENT ENCOUNTERS, INCLUDING MORE THAN 20,000 COVID-19 TESTS AND MORE THAN 21,000 TELEHEALTH VISITS.

Form 990, Part III, Line 4c:

AMBULATORY & OTHER MEMORIAL HEALTH SYSTEM OPERATES THREE AMBULATORY AFFILIATES THAT ARE INCLUDED IN THE GROUP 990 RETURN: MEMORIAL HOME SERVICES (MHSVC), MEMORIAL HEALTH VENTURES (MHV), AND SPRINGFIELD RESIDENTIAL SERVICES (SRS). MHSVC PROVIDES HOME HEALTH, HOSPICE AND MEDICAL EQUIPMENT SERVICES ACROSS A 14-COUNTY REGION IN CENTRAL ILLINOIS. HOME HEALTH SERVICES INCLUDE SKILLED, HIGH-TECH NURSING, HOME HEALTH AIDES, PALLIATIVE CARE, SPECIALIZED WOUND CARE, TELEHEALTH, NUTRITIONAL SERVICES, SOCIAL SERVICES, AND REHABILITATION. HOSPICE SERVICES INCLUDE PAIN AND SYMPTOM MANAGEMENT, BEREAVEMENT CARE, VOLUNTEER SERVICES, AS WELL AS EMOTIONAL AND SPIRITUAL CARE FOR TERMINALLY ILL PATIENTS AND THEIR FAMILIES. THE HOSPICE PROGRAM ALSO HAS ON-STAFF MEDICAL SOCIAL WORKERS, HOME HEALTH AIDES, A CHAPLAIN AND DIETARY COUNSELING. HOME HEALTH RECORDED A TOTAL OF 21,834 VISITS IN FY2020 AND 1,371 ADMISSIONS. THE HOSPICE AVERAGE DAILY CENSUS IN FY2020 WAS 74.4 DAYS WITH 632 ADMISSIONS, FOR A TOTAL OF 27,222 DAYS. MHV OWNS AND PROVIDES OVERSIGHT FOR JOINT VENTURES WITH ENTITIES ENTERED INTO BY MEMORIAL HEALTH SYSTEM. ALL OF THESE VENTURES MUST BE IN KEEPING WITH THE HEALTH CARE SYSTEM MISSION OF PROVIDING CONTINUUM OF CARE TO PATIENTS IN CENTRAL ILLINOIS. THEY INCLUDE A LONG TERM CARE FACILITY, AN AMBULATORY SURGICAL TREATMENT CENTER, AND EQUIPMENT LEASING. THE PARTNERSHIP WITH THE EQUIPMENT LEASING COMPANY WAS DISSOLVED ON SEPTEMBER 1, 2020. IN FY2020, MEMORIAL HOSPICE AT HERITAGE, A 19 BED SKILLED NURSING UNIT, CONTINUED TO HELP MEET THE UNIQUE NEEDS OF HOSPICE PATIENTS AND FAMILIES WHO MAY NEED A FACILITY SETTING FOR END-OF-LIFE CARE. THE AMBULATORY SURGICAL TREATMENT CENTER COMPLETED 3,548 SURGICAL AND PAIN PROCEDURES IN FY2020. SRS PROVIDES HOUSING FACILITIES AND SERVICES TO NON-ELDERLY ADULTS DIAGNOSED WITH MENTAL ILLNESSES BY MEANS OF CONSTRUCTING A HUD HOUSING PROJECT. DURING FY2020, A TOTAL OF 17 CLIENTS RESIDED IN THE FACILITY.

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
EDGAR CURTIS PRESIDENT&CEO MHS; BRDMBR MPS	25.00 25.00	X		X				0	1,647,768	49,361
DOUGLAS RAHN DBA FORMER PRESIDENT&CEO PAH	0.00 0.00						X	0	1,263,270	0
STEVEN SOBOL MD PHYSICIAN DMH	50.00 0.00					X		1,096,654	0	30,276
CHARLES CALLAHAN PHD MHSOSHOPRES;PRESMMC/MMCF/MHSVC;CHRMHV	25.00 25.00	X		X				829,533	0	221,430
RAYCHAUDHURI RATUL MD PHYSICIAN DMH	50.00 0.00					X		967,073	0	25,214
JOHN WATERS MD PHYSICIAN DMH	50.00 0.00					X		902,250	0	22,296
DAVID GRAHAM MD MHS SVP&CHIEF QLTY&INNOVATION OFF.	25.00 25.00				X			0	678,915	189,207
JAMES BOHAN MD PHYSICIAN MPS	50.00 0.00					X		789,258	0	95,581
TURGUT TANSEL MD PHYSICIAN DMH	50.00 0.00					X		842,698	0	37,467
TIMOTHY STONE JR FORMER DMH PRESIDENT & CEO	0.00 0.00						X	733,073	0	77,372

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
AMIR JOHN WAHAB MD BRDMEM ALMH(THRUJAN20)/MPS PHYSICIAN	50.00 0.00	X						619,460	0	140,482
ANNA EVANS JD MHS SVP & GENERAL COUNSEL	25.00 25.00				X			0	572,544	161,107
ROBERT KAY FORMER MHS SVP & CFO	0.00 0.00						X	0	687,024	43,009
RAJESH GOVINDAIAH MD MHS SVP & CMO	25.00 25.00				X			0	632,072	93,900
KATHRYN KEIM MHS SVP&CFO; SEC&TREAS MHV/MHSVC/MPS	25.00 25.00	X		X				0	616,905	106,609
KEVIN ENGLAND MHS SVP&CAO; VCH&PRESMHV; VCHMHSVC	25.00 25.00	X		X				0	488,390	210,594
AIMEE DAILY PHD MHS SVP & CHIEF TRANSFORM. OFF.	50.00 0.00				X			530,817	0	85,734
VIRGINIA DOLAN MD BOARD MEMBER SRS	0.70 0.70	X						515,542	0	87,907
DAVID BAUMBERGER MD FORMER DMH CHIEF MEDICAL OFFICER	0.00 0.00						X	546,597	0	77,321
ROBERT SCOTT MHS SVP & CHRO	25.00 25.00				X			0	509,009	85,609

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
NICOLE FLORENCE MD BOARD MEMBER SRS	0.70 0.70	X						502,781	0	105,538
MARK HANSEN MD CHAIR MPS/MPS PHYSICIAN	50.00 0.00	X		X				453,251	0	126,763
DREW EARLY PRESIDENT&CEO DMH	50.00 0.00	X		X				267,985	202,956	87,713
MARSHA PRATER PHD MHS/MMC SVP & CNO	50.00 0.00				X			520,426	0	36,367
JAMESON ROSZHART MHS PRESAMBGRP; BM MHV/MPS/CHR MHSVC	35.00 15.00	X		X				0	460,078	90,502
J TRAVIS DOWELL PRESIDENT MPS & VP MPS	50.00 0.00	X		X				0	409,177	97,906
DOLAN DALPOAS PRESIDENT&CEO ALMH; BRDMBR MHSVC	49.30 0.70	X		X				0	419,729	58,683
ANTHONY GRIFFIN MD BOARD MEMBER MPS/MPS PHYSICIAN	50.00 0.00	X						411,230	0	55,931
GREG PAGLIUZZA FORMER DMH SVP & CFO	0.00 0.00						X	398,775	0	58,646
LARRY HEGLAND MD FORMER DMH CHIEF MEDICAL OFFICER	0.00 0.00						X	422,945	0	27,520

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JENNIFER BOND MMC VP OF NURSING	50.00 0.00				X			280,763	0	57,230
KATHERINE ANDERSON ESQ FRMRDMH OFF; MHSSRGENCOUNS(TRMAY20)	0.00 0.00						X	275,797	0	36,932
RANDALL BRYANT VP, DECATUR MEDICAL GROUP	50.00 0.00				X			201,195	61,151	36,634
TRACY MIZEUR MD BOARD MEMBER ALMH/MPS PHYSICIAN	50.00 0.00	X						259,157	0	29,261
SHARON NORRIS FORMER DMH OFFICER	50.00 0.00						X	235,838	0	49,974
DEBORAH BRAGG FORMER DMH OFFICER	50.00 0.00						X	250,785	0	33,145
KEVIN HORATH FORMER DMH OFFICER	50.00 0.00						X	247,725	0	32,300
HARRY SCHMIDT FRMR PRES/CEO PAH/CRNA; BM MHSVC	50.00 0.00						X	0	240,844	38,500
DAVID KING MHS VP SUPPORT OPERATIONS	50.00 0.00				X			225,187	0	40,124
JENNIFER HARRIS FORMER KE MMC SYSADM,PERIOP SVCS	50.00 0.00						X	239,321	0	16,887

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors										
(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Insttutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JANICE GAMBACH PRES SRS(TRDEC19);ADMIN MBH(TRJAN20)	2.50 47.50	X		X				0	222,235	27,438
TAMAR KUTZ BOARD MEMBER MHSVC; VP QUAL&OPS	50.00 0.00	X						0	218,964	22,847
DAVID SAMPLES FORMER DMH OFFICER; MHS SYSDIRCAP	0.00 0.00						X	192,357	0	48,920
JIM BLACKWELL FORMER DMH OFFICER	50.00 0.00						X	164,328	0	35,664
MELISSA HANSEN-SCHMADEKE MMCF EXECUTIVE DIRECTOR	50.00 0.00				X			153,312	0	21,382
MIKE EDWARDS FORMER DMH VP REVENUE CYCLE	0.00 0.00						X	137,733	0	26,058
PETER RUSSOTTO DPM BOARD MEMBER PAH	0.70 0.00	X						119,055	0	0
RAEDENA RYAN EXECUTIVE DIRECTOR TMHF	50.00 0.00	X						75,577	0	38,987
D JANE DAVIS BOARD MEMBER TMHF	0.70 0.00	X						51,469	0	20,808
LEIGH STEINER PHD CHAIR SRS	1.40 1.40	X		X				0	375	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
GREG EIMER BOARD MEMBER ALMH	0.70 0.00	X						0	0	0
ANDREW HAYES BOARD MEMBER ALMH	0.70 0.70	X						0	0	0
DON SIELAFF BOARD MEMBER ALMH	0.70 0.00	X						0	0	0
DENNIS CARROLL MD BOARD MEMBER ALMH(FROMFEB20)	0.70 0.00	X						0	0	0
CHRISTOPHER GRAUE BOARD MEMBER ALMH	0.70 0.00	X						0	0	0
WILLIAM BATES BOARD MEMBER ALMH(THRUJAN20)	1.40 0.00	X						0	0	0
MICHELLE BAUR BOARD MEMBER ALMH	0.70 0.00	X						0	0	0
CHRISTINE SHORT BRDMEM ALMH(THRUJAN20)/TREASALMH	0.70 0.70	X		X				0	0	0
JUNE KIDD TREASALMH(THRUJAN20)/CHRELECTALMH	1.40 0.00	X		X				0	0	0
KEITH SNYDER SECALMH(THRUJAN20)/CHRALMH	1.40 0.00	X		X				0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
DAVID IRWIN CHRALMH(THRUJAN20)/IMPASTCHRALMH	1.40 0.00	X		X				0	0	0
BRUCE CARMITCHEL CHRELECTALMH(THRUJAN20)/SECALMH	1.40 0.00	X		X				0	0	0
DAVID CAMPBELL IMPASTCHRALMH(THRUJAN20)/BRDMEMALMH	1.40 0.70	X		X				0	0	0
SUSAN KOCH EDD BOARD MEMBER MMC(THRUJUNE20)	0.70 0.70	X						0	0	0
LYNNE BARKMEIER MD BOARD MEMBER MMC	0.70 0.00	X						0	0	0
JOSEPH HURWITZ BOARD MEMBER MMC	0.70 0.70	X						0	0	0
RICHARD LEVI BOARD MEMBER MMC(THRUDEC19)	0.70 0.70	X						0	0	0
WILLIAM PUTMAN MD BOARD MEMBER MMC(FROMJAN20)	0.70 0.70	X						0	0	0
NINA HARRIS BOARD MEMBER MMC	0.70 0.70	X						0	0	0
SERGIO PECORI BOARD MEMBER MMC	0.70 0.00	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JARROD WALL MD PHD BOARD MEMBER MMC	0.70 0.00	X						0	0	0
LISA HARTZLER BOARD MEMBER MMC	0.70 0.00	X						0	0	0
JOHN BLACKBURN BOARD MEMBER MMC	0.70 0.70	X						0	0	0
RANDALL GERMERAAD BOARD MEMBER MMC	0.70 0.70	X						0	0	0
JAMES REED JR BRDMEEMMC/BRDMEEMMCF	1.10 0.00	X						0	0	0
TODD WISE 2VICECHRMHC(TRDEC19)/VCHRTSRMMC	1.40 1.40	X		X				0	0	0
DEAN ROBERT JR 1STVICECHRMHC(THRUDEC19)/CHRMHC	1.40 1.40	X		X				0	0	0
DALE BECKER TREASURER MMC(THRUDEC19)	1.40 1.40	X		X				0	0	0
DIANE RUTLEDGE PHD CHRMHC(THRUDEC19)/BRDMEEMMC	1.40 1.40	X		X				0	0	0
GEOFFREY ISRINGHAUSEN SECRETARY MMC	1.40 1.40	X		X				0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
KIRSTEN KIENZLER BOARD MEMBER MMCF(FROM JAN 20)	0.40 0.00	X						0	0	0
WENDI WILLS EL-AMIN MD BOARD MEMBER MMCF(FROM JAN 20)	0.40 0.00	X						0	0	0
HENRY DALE SMITH JR BRDMEMMCF(THRUDEC19)/VCHRRMMCF	0.40 0.00	X		X				0	0	0
CHERRILYN MAYFIELD TREASURER MMCF	0.40 0.00	X		X				0	0	0
G VIRGINIA CONLEE SECRETARY MMCF	0.40 0.00	X		X				0	0	0
BRIDGET LAMONT CHAIR MMCF(THRU DEC 19)	0.40 0.00	X		X				0	0	0
ROB PIETROBURGO VCHRRMMCF(THRUDEC19/CHRRMMCF	0.40 0.00	X		X				0	0	0
PAVI GILL MD JD BOARD MEMBER TMH	0.70 0.00	X						0	0	0
JOHN FERRY DDS BOARD MEMBER TMH	0.70 0.00	X						0	0	0
BETH BROTHERTON JD BOARD MEMBER TMH(THRUDEC19)	0.70 0.00	X						0	0	0

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(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
ERIC KAHLE BOARD MEMBER TMH	0.70 0.00	X						0	0	0
JOHN DANIEL LITTEKEN BOARD MEMBER TMH	0.70 0.00	X						0	0	0
GARY SPURLING BOARD MEMBER TMH(THRUDEC19)	0.70 0.00	X						0	0	0
N TERESA FRANCE BOARD MEMBER TMH	0.70 0.00	X						0	0	0
WILLIAM COPE BOARD MEMBER TMH(FROMJAN20)	0.70 0.00	X						0	0	0
ASHLEY BASSO BOARD MEMBER TMH (FROMJAN20)	0.70 0.00	X						0	0	0
M ADAM MATHIAS BRDMEMTMH(THRUDEC19)/TRESTMH	1.40 0.00	X		X				0	0	0
ADAM VOCKS TRESTMH(THRUDEC19)/VCHRTMH	1.40 0.00	X		X				0	0	0
LINDA SMITH SECRETARY TMH	1.40 0.00	X		X				0	0	0
JUDGE RONALD SPEARS VCHRTMH(THRUDEC19)/CHRTMH	1.40 0.00	X		X				0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JAMES ADCOCK CHAIR TMH(THRUDEC19)	1.40 0.00	X		X				0	0	0
JUDITH SWIGERT BOARD MEMBER TMHF(THRUDEC19)	0.70 0.00	X						0	0	0
KENT RICHARDSON BOARD MEMBER TMHF	0.70 0.00	X						0	0	0
SHIRLEY DEFRATIES BOARD MEMBER TMHF	0.70 0.00	X						0	0	0
BLAKE DAVIS BOARD MEMBER TMHF (FROMJAN20)	0.70 0.00	X						0	0	0
MATTHEW HUTCHISON BOARD MEMBER TMHF	0.70 0.00	X						0	0	0
GREGORY PATRICK BOARD MEMBER TMHF	0.70 0.00	X						0	0	0
DANIEL MCNEELY BOARD MEMBER TMHF (FROMJAN20)	0.70 0.00	X						0	0	0
JERRY GARDNER DDS BOARD MEMBER TMHF(THRUDEC19)	0.70 0.00	X						0	0	0
CHERYL HUGGINS BOARD MEMBER TMHF	0.70 0.00	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
WILLIAM PERKINS BOARD MEMBER TMHF (FROMJAN20)	0.70 0.00	X						0	0	0
DWAYNE WHEELER BOARD MEMBER TMHF (FROMJAN20)	0.70 0.00	X						0	0	0
MELISSA LIVINGSTON BOARD MEMBER TMHF	0.70 0.00	X						0	0	0
DUANNE STOCK BOARD MEMBER TMHF	0.70 0.00	X						0	0	0
LACY GLENN BOARD MEMBER TMHF	0.70 0.00	X						0	0	0
DENNIS KENNEDY BOARD MEMBER TMHF(THRUOCT20)	0.70 0.00	X						0	0	0
LORETTA KAHLE BOARD MEMBER TMHF	0.70 0.00	X						0	0	0
MICHAEL BLAKEMAN BOARD MEMBER TMHF	0.70 0.00	X						0	0	0
MICHELLE CAPELLIN BM TMHF(TRDEC19)/BM TMH(FMJAN20)	0.70 0.00	X						0	0	0
RONALD MIZER DDS BRDMENTMHF(THRUDEC19/SECTMHF	1.40 0.00	X		X				0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
DAVID BRUMMER TREASURER TMHF	1.40 0.00	X		X				0	0	0
LINDSAY BARRY SECTMHF(THRUDEC19)/VPRESTMHF	1.40 0.00	X		X				0	0	0
BILLY WILLIAMS VPRESTMHF(THRUDEC19)/PRESTMHF	1.40 0.00	X		X				0	0	0
SCOTT MCCLURE PRESIDENT TMHF(THRUDEC19)	1.40 0.00	X		X				0	0	0
VEA CRAWFORD BOARD MEMBER SRS(FROMMAR20)	0.70 0.70	X						0	0	0
JOSH SABO BOARD MEMBER SRS(FROMMAR20)	0.70 0.70	X						0	0	0
ANNE MORGAN PHD BOARD MEMBER SRS	0.70 0.70	X						0	0	0
SAIF MOUILISH BOARD MEMBER SRS	0.70 0.70	X						0	0	0
SCOTT SABIN BOARD MEMBER SRS	0.70 0.70	X						0	0	0
ERICA SMITH BOARD MEMBER SRS	0.70 0.70	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
JANET STOVER BOARD MEMBER SRS (THRU FEB20)	0.70 0.70	X						0	0	0
IRIS WESLEY BOARD MEMBER SRS	0.70 0.70	X						0	0	0
KENNY WINSLOW BOARD MEMBER SRS	0.70 0.70	X						0	0	0
KARI WOLF MD BOARD MEMBER SRS	0.70 0.70	X						0	0	0
SANDY ROBINSON II BOARD MEMBER SRS(THRU FEB20)	0.70 0.70	X						0	0	0
DANIEL WRIGHT BOARD MEMBER SRS	0.70 0.70	X						0	0	0
WANDA LEE ROHLFS TREASURER SRS	1.40 1.40	X		X				0	0	0
BRENT BORAH VICE CHAIR SRS	1.40 1.40	X		X				0	0	0
TIFFANY NIELSON SECRETARY SRS	1.40 1.40	X		X				0	0	0
DIANA KNAEBE PRES SRS(FMJAN20);ADMIN MBH(FMJAN20)	2.50 47.50	X		X				0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
KEITH BRADBURY BOARD MEMBER PAH	0.70 0.00	X						0	0	0
BARBARA FARLEY PHD BOARD MEMBER PAH	0.70 0.00	X						0	0	0
DANIEL HALLAM PHD MD BOARD MEMBER PAH	0.70 0.00	X						0	0	0
MARYJANE MILLION BOARD MEMBER PAH	0.70 0.00	X						0	0	0
STEPHEN SYMONS BOARD MEMBER PAH	0.70 0.00	X						0	0	0
BRADLEY WILSON BOARD MEMBER PAH	0.70 0.00	X						0	0	0
NANCY SPANGENBERG BRDMEMPAH/PAHF	0.70 0.00	X						0	0	0
DOUGLAS AWE SECPAHC RNA/BRDMPAHF	1.40 0.00	X		X				0	0	0
KELLY STAAKE TREASURER PAH/CRNA	1.40 0.00	X		X				0	0	0
GREG LEPPER BOARD MEMBER PAH	1.40 0.00	X		X				0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
IRIS BEASLEY BOARD MEMBER DMHF	0.70 0.00	X						0	0	0
JOE CAPUTO BOARD MEMBER DMHF	0.70 0.00	X						0	0	0
LAKSHIMI JYOTHINAGARAM BOARD MEMBER DMHF(THRUDEC19)	0.70 0.00	X						0	0	0
JIM MASEY BOARD MEMBER DMHF	0.70 0.00	X						0	0	0
KIMBERLY RYKHUS BOARD MEMBER DMHF(THRUDEC19)	0.70 0.00	X						0	0	0
CHRIS WHITE BOARD MEMBER DMHF(THRUDEC19)	0.70 0.00	X						0	0	0
RASHANDA BOND-PARTEE BOARD MEMBER DMHF(FROMJAN20)	0.70 0.00	X						0	0	0
ALI DOOLIN-HUPP BOARD MEMBER DMHF(FROMJAN20)	0.70 0.00	X						0	0	0
KARA JOHNSTON BOARD MEMBER DMHF(FROMJAN20)	0.70 0.00	X						0	0	0
CALEB JUMP BOARD MEMBER DMHF(FROMJAN20)	0.70 0.00	X						0	0	0

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		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
RACHEL STRODE BOARD MEMBER DMHF(FROMJAN20)	0.70 0.00	X						0	0	0
MARK WOOD BOARD MEMBER DMHF(FROMJAN20)	0.70 0.00	X						0	0	0
WILLIAM SHADE BRDMEMDMHF(THRUDEC19);VCHRDMHF	1.40 0.00	X		X				0	0	0
BRENT MCHUGH CHRD MHF(THRUDEC19);BRDMEMDMHF	1.40 0.00	X		X				0	0	0
RYAN AUPPERLE VCHRDMHF(THRUDEC19);CHRD MHF	1.40 0.00	X		X				0	0	0

TY 2019 Affiliate Listing

Name: MEMORIAL HEALTH SYSTEM GROUP
EIN: 90-0756744

TY 2019 Affiliate Listing

Name	Address	EIN	Name control
MEMORIAL MEDICAL CENTER	701 NORTH FIRST STREET SPRINGFIELD, IL 62781	37-0661220	MEMO
THE ABRAHAM LINCOLN MEMORIAL HOSPITAL	200 STAHLHUT DRIVE LINCOLN, IL 62656	37-0723793	ABRA
TAYLORVILLE MEMORIAL HOSPITAL	201 EAST PLEASANT TAYLORVILLE, IL 62568	37-0661250	TAYL
MEMORIAL HEALTH VENTURES	701 NORTH FIRST STREET SPRINGFIELD, IL 62781	36-3492266	MEMO
MEMORIAL HOME SERVICES	701 NORTH FIRST STREET SPRINGFIELD, IL 62781	37-0714225	MEMO
MEMORIAL PHYSICIAN SERVICES	701 NORTH FIRST STREET SPRINGFIELD, IL 62781	37-1181194	MEMO
MEMORIAL MEDICAL CENTER FOUNDATION	1 MEMORIAL PLAZA SPRINGFIELD, IL 62781	37-1110301	MEMO
TAYLORVILLE MEMORIAL HOSPITAL FOUNDATION INC	201 EAST PLEASANT TAYLORVILLE, IL 62568	37-1337485	TAYL
SPRINGFIELD RESIDENTIAL SERVICES	710 NORTH EIGHTH STREET SPRINGFIELD, IL 62702	37-1298589	SPRI
PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION	1600 WEST WALNUT STREET JACKSONVILLE, IL 62650	37-0661230	PASS
JACKSONVILLE CRNA'S INC	1600 WEST WALNUT STREET JACKSONVILLE, IL 62650	27-3083265	JACK
PASSAVANT AREA HOSPITAL FOUNDATION	1600 WEST WALNUT STREET JACKSONVILLE, IL 62650	46-1037396	PASS
DECATUR MEMORIAL HOSPITAL	2300 N EDWARD STREET DECATUR, IL 625264163	37-0661199	DECA
DECATUR MEMORIAL HEALTH FOUNDATION	2300 N EDWARD STREET DECATUR, IL 625264163	37-1169605	DECA

SCHEDULE A
(Form 990 or 990EZ)

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

2019

Open to Public Inspection

Name of the organization
MEMORIAL HEALTH SYSTEM GROUP

Employer identification number
90-0756744

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

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

- 1☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
- 2☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ).)
- 3☐ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state:
- 5☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)
- 6☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7☒ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
- 8☐ A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
- 9☐ An agricultural research organization described in **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 3
- 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		
See Additional Data Table						
Total	3				2,466,113	0

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 failed to qualify under the tests listed below, please complete Part III.)

Section A. Public Support							
	Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
1	Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grant.") . . .	2,108,711	1,969,241	1,627,489	3,586,238	2,003,444	11,295,123
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	2,108,711	1,969,241	1,627,489	3,586,238	2,003,444	11,295,123
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) . . .						3,626,443
6	Public support. Subtract line 5 from line 4.						7,668,680
Section B. Total Support							
	Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
7	Amounts from line 4. . .	2,108,711	1,969,241	1,627,489	3,586,238	2,003,444	11,295,123
8	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . . .	635,765	667,454	617,110	809,941	865,566	3,595,836
9	Net income from unrelated business activities, whether or not the business is regularly carried on. . .	10,053	10,269	6,619	6,055	1,438	34,434
10	Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.). . .	445,285	442,508	463,291	561,287	538,257	2,450,628
11	Total support. Add lines 7 through 10						17,376,021
12	Gross receipts from related activities, etc. (see instructions)					12	55,475,081
13	First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here ▶ <input type="checkbox"/>						
Section C. Computation of Public Support Percentage							
14	Public support percentage for 2019 (line 6, column (f) divided by line 11, column (f))					14	44.130 %
15	Public support percentage for 2018 Schedule A, Part II, line 14					15	48.640 %
16a	33 1/3% support test—2019. 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 checked="" type="checkbox"/>						
b	33 1/3% support test—2018. 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—2019. 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—2018. 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"/>						

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) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(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) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
9 Amounts from line 6. . .						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. .						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975.						
c Add lines 10a and 10b.						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on.						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) . .						
13 Total support. (Add lines 9, 10c, 11, and 12.) . .						
14 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here. ► <input type="checkbox"/>						

Section C. Computation of Public Support Percentage

15 Public support percentage for 2019 (line 8, column (f) divided by line 13, column (f))	15	
16 Public support percentage from 2018 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2019 (line 10c, column (f) divided by line 13, column (f))	17	
18 Investment income percentage from 2018 Schedule A, Part III, line 17	18	

19a 33 1/3% support tests—2019. 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—2018. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ► ☐

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV

Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

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?		
2 Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization (s) or (ii) serving on the governing body of a supported organization? <i>If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s).</i>		
3 By reason of the relationship described in (2), did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? <i>If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.</i>		

Section E. Type III Functionally-Integrated Supporting Organizations

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

Part V Type III Non-Functionally Integrated 509(a)(3) Supporting Organizations			
1 <input type="checkbox"/> Check here if the organization satisfied the Integral Part Test as a qualifying trust on Nov. 20, 1970 (explain in Part VI). See instructions. All other Type III non-functionally integrated supporting organizations must complete Sections A through E.			
Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1	Net short-term capital gain	1	
2	Recoveries of prior-year distributions	2	
3	Other gross income (see instructions)	3	
4	Add lines 1 through 3	4	
5	Depreciation and depletion	5	
6	Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6	
7	Other expenses (see instructions)	7	
8	Adjusted Net Income (subtract lines 5, 6 and 7 from line 4)	8	
Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):	1	
a	Average monthly value of securities	1a	
b	Average monthly cash balances	1b	
c	Fair market value of other non-exempt-use assets	1c	
d	Total (add lines 1a, 1b, and 1c)	1d	
e	Discount claimed for blockage or other factors (explain in detail in Part VI):		
2	Acquisition indebtedness applicable to non-exempt use assets	2	
3	Subtract line 2 from line 1d	3	
4	Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions).	4	
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5	
6	Multiply line 5 by .035	6	
7	Recoveries of prior-year distributions	7	
8	Minimum Asset Amount (add line 7 to line 6)	8	
Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1	
2	Enter 85% of line 1	2	
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3	
4	Enter greater of line 2 or line 3	4	
5	Income tax imposed in prior year	5	
6	Distributable Amount. Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6	
7	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)		

Part V

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

Section D - Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI). See instructions	
7 Total annual distributions. Add lines 1 through 6.	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions	
9 Distributable amount for 2019 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2019	(iii) Distributable Amount for 2019
1 Distributable amount for 2019 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2019 (reasonable cause required-- explain in Part VI). See instructions.			
3 Excess distributions carryover, if any, to 2019:			
a From 2014.			
b From 2015.			
c From 2016.			
d From 2017.			
e From 2018.			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2019 distributable amount			
i Carryover from 2014 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4 Distributions for 2019 from Section D, line 7:			
\$			
a Applied to underdistributions of prior years			
b Applied to 2019 distributable amount			
c Remainder. Subtract lines 4a and 4b from 4.			
5 Remaining underdistributions for years prior to 2019, if any. Subtract lines 3g and 4a from line 2. If the amount is greater than zero, explain in Part VI. See instructions.			
6 Remaining underdistributions for 2019. Subtract lines 3h and 4b from line 1. If the amount is greater than zero, explain in Part VI. See instructions.			
7 Excess distributions carryover to 2020. Add lines 3j and 4c.			
8 Breakdown of line 7:			
a Excess from 2015.			
b Excess from 2016.			
c Excess from 2017.			
d Excess from 2018.			
e Excess from 2019.			

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

Facts And Circumstances Test

990 Schedule A, Supplemental Information

Return Reference	Explanation
SCHEDULE A, PART I	<p>MEMBERS OF THE GROUP REASON FOR PUBLIC CHARITY STATUS BELOW: MEMORIAL MEDICAL CENTER PART I LINE 3 HOSPITALS OR COOPERATIVE HOSPITAL SERVICE ORGANIZATION DESCRIBED IN SECTION 170(B) (1) (A) (III). DECATER MEMORIAL HOSPITAL PART I LINE 3 HOSPITALS OR COOPERATIVE HOSPITAL SERVICE ORGANIZATION DESCRIBED IN SECTION 170(B) (1) (A) (III). PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION PART I LINE 3 HOSPITALS OR COOPERATIVE HOSPITAL SERVICE ORGANIZATION DESCRIBED IN SECTION 170(B) (1) (A) (III). JACKSONVILLE CRNA'S PART I LINE 10 AN ORGANIZATION THAT THE SUPPORT CRITERIA OF 509 (A)(2) AS SUPPORTED BY PART III OF SCHEDULE A. ABRAHAM LINCOLN MEMORIAL HOSPITAL PART I LINE 3 HOSPITALS OR COOPERATIVE HOSPITAL SERVICE ORGANIZATION DESCRIBED IN SECTION 170(B) (1) (A) (III). TAYLORVILLE MEMORIAL HOSPITAL PART I LINE 3 HOSPITALS OR COOPERATIVE HOSPITAL SERVICE ORGANIZATION DESCRIBED IN SECTION 170(B) (1) (A) (III). MEMORIAL PHYSICIAN SERVICES PART I LINE 10 AN ORGANIZATION THAT THE SUPPORT CRITERIA OF 509 (A)(2) AS SUPPORTED BY PART III OF SCHEDULE A. SPRINGFIELD RESIDENTIAL SERVICES PART I LINE 7 IS AN ORGANIZATION THAT NORMALLY RECEIVES A SUBSTANTIAL PART OF ITS SUPPORT FROM A GOVERNMENTAL UNIT OR FROM THE GENERAL PUBLIC DESCRIBED IN SECTION 170(B)(1)(A)(V). MEMORIAL HOME SERVICES PART I LINE 7 IS AN ORGANIZATION THAT NORMALLY RECEIVES A SUBSTANTIAL PART OF ITS SUPPORT FROM A GOVERNMENTAL UNIT OR FROM THE GENERAL PUBLIC DESCRIBED IN SECTION 170(B)(1)(A)(VI). MEMORIAL HEALTH VENTURES PART I LINE 10 AN ORGANIZATION THAT THE SUPPORT CRITERIA OF 509 (A)(2) AS SUPPORTED BY PART III OF SCHEDULE A. MEMORIAL MEDICAL CENTER FOUNDATION PART I LINE 7 IS AN ORGANIZATION THAT NORMALLY RECEIVES A SUBSTANTIAL PART OF ITS SUPPORT FROM A GOVERNMENTAL UNIT OR FROM THE GENERAL PUBLIC DESCRIBED IN SECTION 170(B)(1)(A)(VI). DECATUR MEMORIAL HEALTH FOUNDATION PART I LINE 12A IS 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. PASSAVANT AREA HOSPITAL FOUNDATION PART I LINE 7 IS AN ORGANIZATION THAT NORMALLY RECEIVES A SUBSTANTIAL PART OF ITS SUPPORT FROM A GOVERNMENTAL UNIT OR FROM THE GENERAL PUBLIC DESCRIBED IN SECTION 170(B)(1)(A)(VI). TAYLORVILLE MEMORIAL HOSPITAL FOUNDATION PART I LINE 7 IS AN ORGANIZATION THAT NORMALLY RECEIVES A SUBSTANTIAL PART OF ITS SUPPORT FROM A GOVERNMENTAL UNIT OR FROM THE GENERAL PUBLIC DESCRIBED IN SECTION 170(B)(1)(A)(VI).</p>

990 Schedule A, Supplemental Information

Return Reference	Explanation
PART III, SECTION C, LINE 15 & 16	THE SOFTWARE USED TO PREPARE THE MHS GROUP RETURN DOES NOT ALLOW FOR MULTIPLE PUBLIC CHARITY STATUS. ACCORDINGLY, THE ORGANIZATION HAS SEPARATELY DOCUMENTED THEIR PUBLIC SUPPORT PERCENTAGES AGGREGATED AS FOLLOWS: LINE 15 - PUBLIC SUPPORT PERCENTAGE FOR 2019: 99.2% LINE 16 - PUBLIC SUPPORT PERCENTAGE FOR 2018: 99.3%

990 Schedule A, Supplemental Information

Return Reference	Explanation
PART IV, SECTION A	<p>THE SOFTWARE USED TO PREPARE THE MHS GROUP RETURN DOES NOT ALLOW FOR MULTIPLE PUBLIC CHARITY STATUS. ACCORDINGLY, THE ORGANIZATION HAS SEPARATELY DOCUMENTED THEIR RESPONSES AS FOLLOWS: LINE 1 - NO. DECATUR MEMORIAL HEALTH FOUNDATION SUPPORTED ORGANIZATIONS ARE NOT LISTED BY NAME IN DECATUR MEMORIAL HEALTH FOUNDATION'S GOVERNING DOCUMENTS, HOWEVER THEY ARE DESIGNATED BY PURPOSE AS THE PROGRAMS ALIGN WITH THE ORGANIZATION'S EXEMPT PURPOSE. LINE 2 - NO LINE 3A - NO LINE 4A - NO LINE 5A - YES CHILDREN'S MUSEUM OF ILLINOIS - FEIN: 37-1235904 THE ADDITION OF THE ABOVE WAS TO SUPPORT COMMUNITY ORGANIZATIONS FOR PROGRAMS WHICH ALIGN WITH THE ORGANIZATION'S EXEMPT PURPOSE. AUTHORITY UNDER THE ORGANIZATION'S ORGANIZING DOCUMENT AUTHORIZING SUCH ADDITION: ORGANIZATION'S BYLAWS: TO CONTRACT WITH OTHER ORGANIZATIONS, FOR-PROFIT AND NOT-FOR-PROFIT, WITH INDIVIDUALS, AND WITH GOVERNMENTAL AGENCIES IN FURTHERANCE OF THE ORGANIZATION'S PURPOSES; IN KEEPING WITH THE CHARITABLE MISSION OF DECATUR MEMORIAL HOSPITAL, TO CREATE HEALTHY COMMUNITIES THROUGH INVOLVEMENT IN EDUCATION, FAMILY SYSTEMS, AND ECONOMIC DEVELOPMENT; AND TO PROMOTE WELLNESS AND PREVENTATIVE CARE PROGRAMS WITH DECATUR MEMORIAL HOSPITAL, ITS AFFILIATES AND COMMUNITY GROUPS. THIS WAS EXECUTED UNDER THE EXISTING CORPORATE BYLAWS, AS AUTHORIZED. LINE 5B - NO LINE 6 - NO LINE 7 - NO LINE 8 - NO LINE 9A - NO LINE 9B - NO LINE 9C - NO LINE 10A - NO LINE 11 - NO LINE 11A - NO LINE 11B - NO LINE 11C - NO</p>

990 Schedule A, Supplemental Information

Return Reference	Explanation
PART IV, SECTION B	THE SOFTWARE USED TO PREPARE THE MHS GROUP RETURN DOES NOT ALLOW FOR MULTIPLE PUBLIC CHARITY STATUS. ACCORDINGLY, THE ORGANIZATION HAS SEPARATELY DOCUMENTED THEIR RESPONSES AS FOLLOWS: LINE 1 - YES LINE 2 - YES. PROVIDING BENEFIT TO THE UNRELATED SUPPORTED ORGANIZATION CARRIED OUT THE PURPOSE OF DECATUR MEMORIAL HEALTH FOUNDATION TO CREATE HEALTHY COMMUNITIES THROUGH INVOLVEMENT IN EDUCATION AND FAMILY SYSTEMS.

Additional Data

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

Form 990, Sch A, Part I, Line 12g - Provide the following information about the supported organization(s).

(i)Name of supported organization	(ii)EIN	(iii) Type of organization (described on lines 1- 9 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		
DECATUR MEMORIAL HOSPITAL	370661199	3	Yes		2,455,613	0
CHILDREN'S MUSEUM OF ILLINOIS	371235904	10		No	7,000	0
BABY TALK	371291790	7		No	3,500	0

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

2019

Open to Public Inspection

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

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

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

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

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

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

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

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

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

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

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

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

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

	(a) Name	(b) Address	(c) EIN	(d) Amount paid from filing organization's funds. If none, enter -0-.	(e) Amount of political contributions received and promptly and directly delivered to a separate political organization. If none, enter -0-.
1					
2					
3					
4					
5					
6					

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

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

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

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	
Not over \$500,000	20% of the amount on line 1e.	
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.	
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.	
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.	
Over \$17,000,000	\$1,000,000.	
g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a. If zero or less, enter -0-		
i Subtract line 1f from line 1c. If zero or less, enter -0-		
j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?	<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) 2016	(b) 2017	(c) 2018	(d) 2019	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

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

		(a)		(b)
		Yes	No	Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a	Volunteers?		No	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?		No	
e	Publications, or published or broadcast statements?		No	
f	Grants to other organizations for lobbying purposes?	Yes		180,524
g	Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?		No	
j	Total. Add lines 1c through 1i			180,524
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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

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

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

1 Dues, assessments and similar amounts from members	1	
2 Section 162(e) nondeductible lobbying and political expenditures (do not include amounts of political expenses for which the section 527(f) tax was paid).		
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.

Return Reference	Explanation
PART II-B, LINE 1:	MEMORIAL HEALTH SYSTEM ENGAGES LOBBYISTS TO ASSIST IT IN SECURING FEDERAL GRANTS AND MONITORING STATE REGULATIONS IN SUPPORT OF FURTHERING MEMORIAL HEALTH SYSTEM'S MISSION, WHICH IS "TO IMPROVE THE HEALTH OF THE PEOPLE AND COMMUNITIES WE SERVE". THIS INCLUDES ASSISTING MEMORIAL HEALTH SYSTEM IN DEVELOPING PRESENTATIONS TO THE ILLINOIS CONGRESSIONAL DELEGATION REQUESTING APPROPRIATIONS FOR PRIORITY PROJECTS INVOLVING LOCAL PATIENT SAFETY, QUALITY IMPROVEMENT AND IMPROVED LOCAL ACCESS TO MEDICAL CARE. THE LOBBYISTS ALSO ASSIST MEMORIAL IN COMMUNICATING THE IMPORTANCE OF ADEQUATE MEDICAID FUNDING IN SUPPORT OF THE SUBSTANTIAL SERVICES MEMORIAL'S AFFILIATES PROVIDE TO THOSE IN POVERTY AND IN MONITORING LEGISLATIVE AND REGULATORY DEVELOPMENTS THAT WOULD AFFECT MEMORIAL MEDICAL CENTER'S ABILITY TO CONTINUE DELIVERING ITS ALREADY SUBSTANTIAL COMMUNITY BENEFIT. THE FOLLOWING ORGANIZATIONS PAID FUNDS TO HEALTHCARE ASSOCIATIONS TO AID AND ASSIST HOSPITALS AND HEALTHCARE ENTITIES REGARDING LEGISLATIVE CHANGES. THESE COSTS INCLUDE AMOUNTS PAID DIRECTLY TO LOBBYISTS FROM THE VARIOUS ENTITIES AND ALSO INCLUDE AMOUNTS PAID INDIRECTLY TO LOBBYISTS THROUGH ASSOCIATION DUES. MEMORIAL MEDICAL CENTER: \$60,070 DECATUR MEMORIAL HOSPITAL: \$58,492 PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION: \$24,832 THE ABRAHAM LINCOLN MEMORIAL HOSPITAL: \$17,484 TAYLORVILLE MEMORIAL HOSPITAL: \$16,746 MEMORIAL HOME SERVICES: \$ 2,900

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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

2019

Open to Public Inspection

Name of the organization
MEMORIAL HEALTH SYSTEM GROUP

Employer identification number
90-0756744

Part I

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

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

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

☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit?

☐ Yes ☐ No

Part II

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

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

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

☐ Preservation of an historically important land area

☐ Protection of natural habitat

☐ Preservation of a certified historic structure

☐ Preservation of open space

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

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

3 Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the tax year ►

4 Number of states where property subject to conservation easement is located ►

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds?

☐ Yes ☐ No

6 Staff and volunteer hours devoted to monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ►

7 Amount of expenses incurred in monitoring, inspecting, handling of violations, and enforcing conservation easements during the year ► \$

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)?

☐ Yes ☐ No

9 In Part XIII, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements.

Part III

Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.
Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items.

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

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

(ii) Assets included in Form 990, Part X ► \$

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

a Revenue included on Form 990, Part VIII, line 1 ► \$

b Assets included in Form 990, Part X ► \$

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

Cat. No. 52283D Schedule D (Form 990) 2019

Part III

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

3

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

a☐ Public exhibition

b☐ Scholarly research

c☐ Preservation for future generations

d☐ Loan or exchange programs

e☐ Other

4

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

5

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

☐ Yes

☐ No

Part IV

Escrow and Custodial Arrangements.

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

1a

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

☐ Yes

☐ No

b

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

	Amount
1c	
1d	
1e	
1f	

c

Beginning balance

d

Additions during the year

e

Distributions during the year

f

Ending balance

2a

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

☐ Yes

☐ No

b

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

☐

Part V

Endowment Funds.

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back	
1a	Beginning of year balance	30,362,507	29,433,505	29,386,198	28,384,877	29,069,189
b	Contributions	14,195	831,113	9,674	17,776	14,970
c	Net investment earnings, gains, and losses	2,958,455	803,571	569,769	2,220,438	579,273
d	Grants or scholarships	34,425	121,432	158,361	287,264	906,307
e	Other expenditures for facilities and programs	1,551,780	485,182	284,028	856,778	280,079
f	Administrative expenses	109,642	99,068	89,747	92,851	92,169
g	End of year balance	31,639,310	30,362,507	29,433,505	29,386,198	28,384,877

2

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

a

Board designated or quasi-endowment ▶ 6.910 %

b

Permanent endowment ▶ 79.360 %

c

Temporarily restricted endowment ▶ 13.730 %

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

3a

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

(i) unrelated organizations

(ii) related organizations

b

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

4

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

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

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	66,386,309	21,157,522	87,543,831
b	Buildings	1,127,468	523,691,835	271,867,904
c	Leasehold improvements	235,300	13,420,995	8,466,369
d	Equipment	5,623	308,154,919	228,307,474
e	Other		102,177,432	27,350,417
Total.	Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).) . . . ▶			500,365,239

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) INTEREST IN NET ASSETS OF FOUNDATIONS	151,252,573	C
(B) INVESTMENT IN PARTNERSHIPS	100	C
(C) BENEFICIAL INTEREST IN TRUST	70,460,561	C
(D)		
(E)		
(F)		
(G)		
(H)		
Total. (Column (b) must equal Form 990, Part X, col. (B) line 12.) ▶	221,713,234	

Part VIII

Investments—Program Related.

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

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

Part IX

Other Assets.

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

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

Part X

Other Liabilities.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes See Additional Data Table	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
Total. (Column (b) must equal Form 990, Part X, col.(B) line 25.) ▶	501,962,709

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

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

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

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

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

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

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

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

Additional Data

Software ID:

Software Version:

EIN: 90-0756744

Name: MEMORIAL HEALTH SYSTEM GROUP

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

1. (a) Description of Liability	(b) Book Value
DEFERRED COMPENSATION	10,804,709
ESTIMATED THIRD PARTY PAYOR SETTLEMENTS	58,775,322
RESERVE FOR POST EMPLOYMENT BENEFITS	1,108,364
SWAP LIABILITY	2,720,220
WORKERS' COMPENSATION AND PROFESSIONAL LIABILITY	754,954
ENVIRONMENTAL HAZARDS LIABILITY	862,521
DUE TO AFFILIATES	2,271,578
CHARITABLE GIFT ANNUITY PAYABLE	130,921
OTHER PAYABLES	29,141
INTERCOMPANY DEBT TO MEMORIAL HEALTH SYSTEM (37-1110690)	190,947,237

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

1. (a) Description of Liability	(b) Book Value
LEASE LIABILITY	81,572,259
ADVANCE MEDICARE PAYMENTS	138,751,338
CYCLOTRON DECOMMISSIONING	435,500
UNAMORTIZED BOND DISCOUNTS AND ISSUE COSTS	12,441,334
UNEMPLOYMENT COMPENSATION	257,311
LEADS CONTRIBUTION LIABILITY	100,000

Supplemental Information

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

Supplemental Information

Return Reference	Explanation
PART X, LINE 2:	<p>EACH OF MHS'S SUBSIDIARIES, EXCLUDING THOSE DESCRIBED IN THE FOLLOWING PARAGRAPH, IS A SEPARATELY INCORPORATED NOT-FOR-PROFIT CORPORATION AS DESCRIBED UNDER SECTION 501(C)(3) OF THE CODE AND IS TAX-EXEMPT FROM FEDERAL INCOME TAXES ON RELATED INCOME PURSUANT TO SECTION 501(A) OF THE CODE. THEY DO, HOWEVER, OPERATE CERTAIN PROGRAMS THAT MAY RESULT IN UNRELATED BUSINESS INCOME. UPON REVIEW AS REQUIRED BY ASC 740, INCOME TAX NO TAX PROVISION WAS RECORDED FOR THE YEARS ENDED SEPTEMBER 30, 2020 OR 2019. MEMORIAL HEALTH SYSTEM IS NO LONGER SUBJECT TO INCOME TAX EXAMINATIONS FOR YEARS PRIOR TO 2017. MHS QALICB, LLC (QALICB), MCDEKK, LLC (MCDEKK), AND MEMORIAL HEALTH PARTNERS (MHP) ARE CONSIDERED DISREGARDED ENTITIES FOR TAX PURPOSES AND ARE EXEMPT FROM INCOME TAX. MEMORIAL HOME SERVICES OF CENTRAL ILLINOIS (MHSCI) IS A TAXABLE FOR-PROFIT CORPORATION AND PASSAVANT PHYSICIAN ASSOCIATION (PPA) IS A TAXABLE NOT-FOR-PROFIT CORPORATION. BOTH ARE SUBJECT TO FEDERAL AND STATE INCOME TAXES.</p>

Supplemental Information	
Return Reference	Explanation
SCHEDULE D, PART V	THE PREVIOUS FOUR YEARS HAVE BEEN UPDATED TO REFLECT THE ADDITION OF DECATUR MEMORIAL HOSPITAL AND DECATUR MEMORIAL HEALTH FOUNDATION.

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

		(a) Event #1 FESTIVAL OF TREES (MMCF) (event type)	(b) Event #2 2019 SIGNATURE EVENT (event type)	(c) Other events 4 (total number)	(d) Total events (add col. (a) through col. (c))
Revenue	1 Gross receipts	643,212	38,744	19,193	701,149
	2 Less: Contributions	232,170	28,709	13,063	273,942
	3 Gross income (line 1 minus line 2)	411,042	10,035	6,130	427,207
Direct Expenses	4 Cash prizes				
	5 Noncash prizes	67,642	1,179	214	69,035
	6 Rent/facility costs	16,697	575	460	17,732
	7 Food and beverages	84,487	3,591	6,008	94,086
	8 Entertainment	650	1,100	1,150	2,900
	9 Other direct expenses	72,422	1,760	5,585	79,767
	10 Direct expense summary. Add lines 4 through 9 in column (d) ▶				263,520
	11 Net income summary. Subtract line 10 from line 3, column (d) ▶				163,687

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

		(a) Bingo	(b) Pull tabs/Instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (add col.(a) through col.(c))
Revenue	1 Gross revenue			116,800	116,800
	2 Cash prizes			94,500	94,500
	3 Noncash prizes				
	4 Rent/facility costs				
	5 Other direct expenses			10,604	10,604
Direct Expenses	6 Volunteer labor	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input type="checkbox"/> No	<input type="checkbox"/> Yes _____ % <input checked="" type="checkbox"/> No	
	7 Direct expense summary. Add lines 2 through 5 in column (d) ▶				105,104
	8 Net gaming income summary. Subtract line 7 from line 1, column (d) ▶				11,696

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

a Is the organization licensed to conduct gaming activities in each of these states? ☒ Yes ☐ No

b If "No," explain: _____

10a Were any of the organization's gaming licenses revoked, suspended or terminated during the tax year? ☐ Yes ☒ No

b If "Yes," explain: _____

11 Does the organization conduct gaming activities with nonmembers? ☒ **Yes** ☐ **No**

12 Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming? ☐ **Yes** ☒ **No**

13 Indicate the percentage of gaming activity conducted in:

a The organization's facility	13a	100.000 %
b An outside facility	13b	0 %

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

Name ► KATHRYN J KEIM

Address ► 701 NORTH FIRST STREET SPRINGFIELD, IL 62781

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

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

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

Name ► _____

Address ► _____

16 Gaming manager information:

Name ► MELISSA HANSEN-SCHMADEKE

Gaming manager compensation ► \$ _____

Description of services provided ► OVERSAW THE RAFFLE PROCESS.

☒ Director/officer

☐ Employee

☐ Independent contractor

17 Mandatory distributions:

a Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license? ☐ **Yes** ☒ **No**

b Enter the amount of distributions required under state law distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ► \$ _____

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

Return Reference

Explanation

SCHEDULE H
(Form 990)

Department of the Treasury

Internal Revenue Service

Hospitals

► Complete if the organization answered "Yes" on Form 990, Part IV, question 20.
► Attach to Form 990.
► Go to www.irs.gov/Form990EZ for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
MEMORIAL HEALTH SYSTEM GROUP

Employer identification number
90-0756744

Part I Financial Assistance and Certain Other Community Benefits at Cost

		Yes	No	
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	Yes	
b	If "Yes," was it a written policy?	1b	Yes	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year. a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other 30000.0000000000 % b Did the organization use FPG as a factor in determining eligibility for providing discounted care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other 30100.0000000000 % c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.	3a	Yes	
		3b	Yes	
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	Yes	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	Yes	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	Yes	
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		No
6a	Did the organization prepare a community benefit report during the tax year?	6a	Yes	
b	If "Yes," did the organization make it available to the public?	6b	Yes	
Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.				

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)	104	4,875	13,364,488		13,364,488	1.000 %
b Medicaid (from Worksheet 3, column a)	1	87,168	180,554,470	127,560,799	52,993,671	3.970 %
c Costs of other means-tested government programs (from Worksheet 3, column b)	1	35	55,908	493,786	0	0 %
d Total Financial Assistance and Means-Tested Government Programs	106	92,078	193,974,866	128,054,585	66,358,159	4.970 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4).	403	3,788	2,135,222	209,870	1,925,352	0.140 %
f Health professions education (from Worksheet 5)	96	2,170	14,613,703	3,740,910	10,872,793	0.820 %
g Subsidized health services (from Worksheet 6)	3	159,527	26,557,179		26,557,179	1.990 %
h Research (from Worksheet 7)			232,412		232,412	0.020 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)	154	17,678	55,285,899	107,609	55,178,290	4.140 %
j Total. Other Benefits	656	183,163	98,824,415	4,058,389	94,766,026	7.110 %
k Total. Add lines 7d and 7j	762	275,241	292,799,281	132,112,974	161,124,185	12.080 %

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development	3		65,136		65,136	0 %
3 Community support	3	1	91,090		91,090	0.010 %
4 Environmental improvements						
5 Leadership development and training for community members	2		6,486		6,486	0 %
6 Coalition building	1	107	1,111		1,111	0 %
7 Community health improvement advocacy	2	40	10,114		10,114	0 %
8 Workforce development	2		7,602,978		7,602,978	0.570 %
9 Other						
10 Total	13	148	7,776,915		7,776,915	0.580 %

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

		Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1	Yes	
2 Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	2	33,060,113	
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.	3		
4 Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME)	5	304,872,806	
6 Enter Medicare allowable costs of care relating to payments on line 5	6	329,029,581	
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-24,156,775	
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:			
<input type="checkbox"/> Cost accounting system	<input type="checkbox"/> Cost to charge ratio	<input checked="" type="checkbox"/> Other	

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures

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

Part V Facility Information

Section A. Hospital Facilities

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

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

5

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

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

Part V Facility Information (continued)**Section B. Facility Policies and Practices**(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)
MEMORIAL MEDICAL CENTER**Name of hospital facility or letter of facility reporting group** _____**Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A):** _____**1****Community Health Needs Assessment**

	Yes	No
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C.	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. If "Yes," indicate what the CHNA report describes (check all that apply):	3	Yes
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>17</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	Yes
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply):	7	Yes
a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>WWW.CHOOSEMEMORIAL.ORG/COMMUNITY-HEALTH-NEEDS-ASSESSMENT</u>		
b <input type="checkbox"/> Other website (list url): _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input checked="" type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11.	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>19</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? If "Yes" (list url): <u>WWW.CHOOSEMEMORIAL.ORG/COMMUNITY-HEALTH-NEEDS-ASSESSMENT</u>	10	Yes
a		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

MEMORIAL MEDICAL CENTER			
Name of hospital facility or letter of facility reporting group			
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	13	Yes
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 300.000000000000 % and FPG family income limit for eligibility for discounted care of 301.000000000000 %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input checked="" type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input checked="" type="checkbox"/> Underinsurance discount			
g <input type="checkbox"/> Residency			
h <input type="checkbox"/> Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	15	Yes
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input type="checkbox"/> Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	16	Yes
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): WWW.MEMORIALMEDICAL.COM/FINANCIAL/FINANCIAL-HELP			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): WWW.MEMORIALMEDICAL.COM/FINANCIAL/FINANCIAL-HELP			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): WWW.MEMORIALMEDICAL.COM/FINANCIAL/FINANCIAL-HELP			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j <input type="checkbox"/> Other (describe in Section C)			

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

MEMORIAL MEDICAL CENTER

Name of hospital facility or letter of facility reporting group

	Yes	No
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17 Yes	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C) f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	19	No
If "Yes," check all actions in which the hospital facility or a third party engaged:		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C)		
20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19. (check all that apply):		
a <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (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?	21 Yes	
If "No," indicate why:		
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions b <input type="checkbox"/> The hospital facility's policy was not in writing c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) d <input type="checkbox"/> Other (describe in Section C)		

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

MEMORIAL MEDICAL CENTER

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

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

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

If "Yes," explain in Section C.

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

If "Yes," explain in Section C.

	Yes	No
22		
23		No
24		No

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

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)
 THE ABRAHAM LINCOLN MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group _____

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): _____

2

Community Health Needs Assessment

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

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

THE ABRAHAM LINCOLN MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group

	Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:		
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	13 Yes	
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 300.000000000000 % and FPG family income limit for eligibility for discounted care of 301.000000000000 %		
b <input type="checkbox"/> Income level other than FPG (describe in Section C)		
c <input checked="" type="checkbox"/> Asset level		
d <input checked="" type="checkbox"/> Medical indigency		
e <input checked="" type="checkbox"/> Insurance status		
f <input checked="" type="checkbox"/> Underinsurance discount		
g <input type="checkbox"/> Residency		
h <input type="checkbox"/> Other (describe in Section C)		
14 Explained the basis for calculating amounts charged to patients?	14 Yes	
15 Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	15 Yes	
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e <input type="checkbox"/> Other (describe in Section C)		
16 Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	16 Yes	
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): WWW.ALMH.ORG/FINANCIAL/FINANCIAL-ASSISTANCE		
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): WWW.ALMH.ORG/FINANCIAL/FINANCIAL-ASSISTANCE		
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): WWW.ALMH.ORG/FINANCIAL/FINANCIAL-ASSISTANCE		
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j <input type="checkbox"/> Other (describe in Section C)		

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

THE ABRAHAM LINCOLN MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group

	Yes	No
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17 Yes	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C) f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	19	No
If "Yes," check all actions in which the hospital facility or a third party engaged:		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C)		
20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19. (check all that apply):		
a <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (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?	21 Yes	
If "No," indicate why:		
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions b <input type="checkbox"/> The hospital facility's policy was not in writing c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) d <input type="checkbox"/> Other (describe in Section C)		

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

THE ABRAHAM LINCOLN MEMORIAL HOSPITAL

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

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

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

If "Yes," explain in Section C.

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

If "Yes," explain in Section C.

	Yes	No
22		
23		No
24		No

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

3

Community Health Needs Assessment

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

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

TAYLORVILLE MEMORIAL HOSPITAL			
Name of hospital facility or letter of facility reporting group			
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	13	Yes
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 300.000000000000 % and FPG family income limit for eligibility for discounted care of 301.000000000000 %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input checked="" type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input checked="" type="checkbox"/> Underinsurance discount			
g <input type="checkbox"/> Residency			
h <input type="checkbox"/> Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	15	Yes
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input type="checkbox"/> Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	16	Yes
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): WWW.TAYLORVILLEMEMORIAL.ORG/FINANCIAL/FINANCIAL-ASSISTANCE			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): WWW.TAYLORVILLEMEMORIAL.ORG/FINANCIAL/FINANCIAL-ASSISTANCE			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): WWW.TAYLORVILLEMEMORIAL.ORG/FINANCIAL/FINANCIAL-ASSISTANCE			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j <input type="checkbox"/> Other (describe in Section C)			

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

TAYLORVILLE MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group

	Yes	No
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17 Yes	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C) f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	19	No
If "Yes," check all actions in which the hospital facility or a third party engaged:		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C)		
20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19. (check all that apply):		
a <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (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?	21 Yes	
If "No," indicate why:		
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions b <input type="checkbox"/> The hospital facility's policy was not in writing c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) d <input type="checkbox"/> Other (describe in Section C)		

Part V Facility Information *(continued)*

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

TAYLORVILLE MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group _____

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

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

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

If "Yes," explain in Section C.

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

If "Yes," explain in Section C.

	Yes	No
22		
23		No
24		No

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

(Complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)
 PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIA

Name of hospital facility or letter of facility reporting group _____

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): _____

4

Community Health Needs Assessment

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

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIA			
Name of hospital facility or letter of facility reporting group			
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	13	Yes
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 300.000000000000 % and FPG family income limit for eligibility for discounted care of 301.000000000000 %			
b <input type="checkbox"/> Income level other than FPG (describe in Section C)			
c <input checked="" type="checkbox"/> Asset level			
d <input checked="" type="checkbox"/> Medical indigency			
e <input checked="" type="checkbox"/> Insurance status			
f <input checked="" type="checkbox"/> Underinsurance discount			
g <input type="checkbox"/> Residency			
h <input type="checkbox"/> Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	15	Yes
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d <input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e <input type="checkbox"/> Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	16	Yes
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): WWW.PASSAVANTHOSPITAL.COM/FINANCIAL/FINANCIAL-ASSISTANCE			
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): WWW.PASSAVANTHOSPITAL.COM/FINANCIAL/FINANCIAL-ASSISTANCE			
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): WWW.PASSAVANTHOSPITAL.COM/FINANCIAL/FINANCIAL-ASSISTANCE			
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j <input type="checkbox"/> Other (describe in Section C)			

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

PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIA

Name of hospital facility or letter of facility reporting group

	Yes	No
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17 Yes	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C) f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	19	No
If "Yes," check all actions in which the hospital facility or a third party engaged:		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C)		
20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19. (check all that apply):		
a <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (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?	21 Yes	
If "No," indicate why:		
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions b <input type="checkbox"/> The hospital facility's policy was not in writing c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) d <input type="checkbox"/> Other (describe in Section C)		

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

PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIA

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

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

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

If "Yes," explain in Section C.

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

If "Yes," explain in Section C.

	Yes	No
22		
23		No
24		No

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

5

Community Health Needs Assessment

	Yes	No
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1	No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C.	2	No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. If "Yes," indicate what the CHNA report describes (check all that apply):	3	Yes
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>17</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	No
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	Yes
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply): WWW.DMHCARES.COM/PUBLIC-INFORMATION/QUALITY-DATA/COMMUNITY- a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>HEALTH-NEEDS-ASS</u>	7	Yes
b <input type="checkbox"/> Other website (list url): _____		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11.	8	Yes
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>19</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website? WWW.DMHCARES.COM/PUBLIC-INFORMATION/QUALITY-DATA/COMMUNITY- a If "Yes" (list url): <u>HEALTH-NEEDS-ASS</u>	10	Yes
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b	
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a	No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

DECATUR MEMORIAL HOSPITAL				
Name of hospital facility or letter of facility reporting group			Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:				
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	13	Yes	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 300.000000000000 % and FPG family income limit for eligibility for discounted care of 301.000000000000 %			
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)			
c	<input checked="" type="checkbox"/> Asset level			
d	<input checked="" type="checkbox"/> Medical indigency			
e	<input checked="" type="checkbox"/> Insurance status			
f	<input checked="" type="checkbox"/> Underinsurance discount			
g	<input type="checkbox"/> Residency			
h	<input type="checkbox"/> Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	15	Yes	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application			
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	<input type="checkbox"/> Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	16	Yes	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): WWW.DMHCARES.COM/PATIENT-AND-VISITOR-INFORMATION/FINANCIAL-ASSISTANCE			
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): WWW.DMHCARES.COM/PATIENT-AND-VISITOR-INFORMATION/FINANCIAL-ASSISTANCE			
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): WWW.DMHCARES.COM/PATIENT-AND-VISITOR-INFORMATION/FINANCIAL-ASSISTANCE			
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	<input type="checkbox"/> Other (describe in Section C)			

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

DECATUR MEMORIAL HOSPITAL

Name of hospital facility or letter of facility reporting group

	Yes	No
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17 Yes	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C) f <input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	19	No
If "Yes," check all actions in which the hospital facility or a third party engaged:		
a <input type="checkbox"/> Reporting to credit agency(ies) b <input type="checkbox"/> Selling an individual's debt to another party c <input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP d <input type="checkbox"/> Actions that require a legal or judicial process e <input type="checkbox"/> Other similar actions (describe in Section C)		
20 Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19. (check all that apply):		
a <input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (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?	21 Yes	
If "No," indicate why:		
a <input type="checkbox"/> The hospital facility did not provide care for any emergency medical conditions b <input type="checkbox"/> The hospital facility's policy was not in writing c <input type="checkbox"/> The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C) d <input type="checkbox"/> Other (describe in Section C)		

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

DECATUR MEMORIAL HOSPITAL

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

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

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

If "Yes," explain in Section C.

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

If "Yes," explain in Section C.

	Yes	No
23		No
24		No

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

[illegible]

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

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

How many non-hospital health care facilities did the organization operate during the tax year? **62**

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

Part VI Supplemental Information

Provide the following information.

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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 3C:	OTHER THAN USING THE FPG, MHS HOSPITALS QUALIFY UNINSURED PATIENTS FOR 100% FINANCIAL ASSISTANCE USING THE PRESUMPTIVE ELIGIBILITY CRITERIA AS DEFINED IN THE ILLINOIS FAIR BILLING ACT AND LISTED IN THE FAP. OTHER THAN USING THE FPG, AN UNINSURED PATIENT WITH ANNUAL FAMILY INCOME OVER 300% OF THE FPG WILL QUALIFY ONCE THE SUM OF THE ACCOUNT BALANCES ON ACCOUNTS WITHIN A 12 MONTH PERIOD EXCEED 25% OF THEIR ANNUAL FAMILY INCOME. OTHER THAN THE FPG FOR INSURED PATIENTS, CRITERIA INCLUDES PROOF OF ONE OR MORE OF THE PRESUMPTIVE ELIGIBILITY CATEGORIES LISTED IN THE FAP. IN THE EVENT OF AN ILLNESS WHICH IS CATASTROPHIC AND WHERE PROPER DOCUMENTATION HAS BEEN SUBMITTED, BUT THE PATIENT STILL OWES MONIES THAT CAUSES AN UNDUE HARDSHIP UPON THE HOUSEHOLD, THE VICE PRESIDENT OF REVENUE CYCLE ALONG WITH SENIOR LEADERSHIP MAY REVIEW AND DETERMINE IF AN ADDITIONAL FINANCIAL ASSISTANCE DISCOUNT IS MERITED. THE DEFINITION OF "CATASTROPHIC AND THE AMOUNT OF FINANCIAL ASSISTANCE WILL BE DETERMINED ON A CASE BY CASE BASIS, CONSIDERING ALL FINANCIAL, FAMILY, AND HEALTH CIRCUMSTANCES OF THE PATIENT.
PART I, LINE 6A:	MEMORIAL HEALTH SYSTEM (EIN: 37-1110690) PREPARED A COMMUNITY BENEFIT ANNUAL REPORT FOR THE ENTIRE HEALTH SYSTEM. A LINK TO THE REPORT WHICH IS INCLUDED IN THE MHS ANNUAL REPORT IS AVAILABLE ONLINE FROM ALL FIVE MHS HOSPITAL WEBSITES AS WELL AS THE WEBSITES OF OTHER MHS AFFILIATES: HTTPS://WWW.CHOOSMEMORIAL.ORG/ABOUT/ANNUAL-REPORT . A STAND-ALONE PDF VERSION IS AVAILABLE TO ANYONE UPON REQUEST. THE COMMUNITY BENEFIT ANNUAL REPORT IS ALSO INCLUDED WITHIN MEMORIAL HEALTH SYSTEM'S COMPLETE ANNUAL REPORT, WHICH IS DISTRIBUTED IN PRINT TO MEMBERS OF THE COMMUNITY AT LARGE.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7:	FOR MMC, THE COSTING METHODOLOGY FOR CHARITY CARE, MEDICAID, AND OTHER MEANS TESTED PROGRAMS WAS DERIVED FROM MMC'S COST ACCOUNTING SYSTEM. THIS SYSTEM HAS THE ABILITY TO COMPUTE THE ACTUAL COST OF ALL MEDICAL PROCEDURES AT THE PATIENT-ACCOUNT LEVEL REGARDLESS OF PAYER TYPE OR WHETHER THE PATIENT WAS INPATIENT OR OUTPATIENT. DMH, ALMH, PAH AND TMH UTILIZED MEDICARE COSTING DATA FROM THE FY2020 MEDICARE COST REPORT AS FILED. THE ONLY CATEGORY BY WHICH MMC USED A COST TO CHARGE RATIO FOR SCHEDULE H IS FOR THE DETERMINATION OF BAD DEBT EXPENSE AT COST IN PART III, SECTION A, LINE 2. THE REMAINING LINES ARE BASED ON DIRECT COSTS.
PART I, LINE 7G:	MHS HOSPITALS (MMC, DMH, ALMH, TMH, AND PAH) INCLUDED SUBSIDIZED HEALTH SERVICES FOR MEMORIAL PHYSICIAN SERVICES WHICH HAS PHYSICIAN CLINICS FOR \$23,174,116.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7, COLUMN (F):	THE BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25, COLUMN (A), BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGE IN THIS COLUMN IS \$ 33,060,113.
PART I, LINE 3A	MHS HOSPITALS (ALMH, DMH, MMC, PAH AND TMH) USE AN AMOUNT LESS THAN 300% OF THE FEDERAL POVERTY GUIDELINES (FPG) AS A FACTOR IN DETERMINING ELIGIBILITY FOR PROVIDING FINANCIAL ASSISTANCE TO THE UNINSURED. INSURED PATIENTS MAY QUALIFY FOR FINANCIAL ASSISTANCE IF THE PATIENT HAS INCOME BELOW 300% OF FPG AND MEETS AT LEAST ONE OF THE PRESUMPTIVE ELIGIBILITY CATEGORIES LISTED IN THE FINANCIAL ASSISTANCE POLICY (FAP).

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 3B	MHS HOSPITALS USE AN AMOUNT IN EXCESS OF 300% OF THE FPG AS A FACTOR IN DETERMINING ELIGIBILITY FOR PROVIDING PARTIAL FINANCIAL ASSISTANCE TO THE UNINSURED. THE VALUE OF 301% WAS ENTERED TO SATISFY A MANDATORY FIELD ENTRY REQUIREMENT TO QUALIFY FOR ELECTRONIC FILING.
PART II, COMMUNITY BUILDING ACTIVITIES:	MHS PARTICIPATES IN NUMEROUS COMMUNITY BUILDING ACTIVITIES THAT ARE NOT ACCOUNTED FOR ELSEWHERE ON SCHEDULE H. MHS GROUP SUBORDINATES (MHS GROUP) SUPPORTED ECONOMIC DEVELOPMENT THROUGH SERVICE WITH OUR LOCAL CHAMBERS OF COMMERCE AND COMMUNITY COLLEGES. MHS GROUP PROMOTED HEALTH BY EXPANDING ACCESS TO CARE THROUGH FINANCIAL AND IN-KIND SUPPORT FOR OUR COMMUNITY UNITED WAY ORGANIZATIONS, LOCAL DAYS-OF-SERVICE, AND YMCAS. TWO OF THE MHS GROUP SUBORDINATES, PAH AND ALMH, HAVE CROSS-SECTIONAL COMMUNITY HEALTH COLLABORATIVES TO ADDRESS THE HIGHEST NEEDS OF ITS COMMUNITIES. COMMUNITY HEALTH IMPROVEMENT ADVOCACY IS PROMOTED THROUGH LEADERSHIP INVOLVEMENT WITH THE ILLINOIS HEALTH AND HOSPITAL ASSOCIATION, THE AMERICAN HOSPITAL ASSOCIATION, AND SIU SCHOOL OF MEDICINE, AS WELL AS FUNDING TO THE FAITH COALITION FOR THE COMMON GOOD. AS ONE OF THE LARGEST LOCAL EMPLOYERS OUTSIDE OF STATE GOVERNMENT, MHS IS AN IMPORTANT ECONOMIC LINK THAT PROVIDES EMPLOYMENT AND BENEFITS FOR THOUSANDS OF FAMILIES. MHS ALSO COLLABORATES WITH OTHER ORGANIZATIONS TO EXPAND OPPORTUNITIES TO TRAIN AND RECRUIT HEALTHCARE PROFESSIONALS TO INCREASE ACCESS TO CARE IN RURAL AREAS.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 2:	MEMORIAL HEALTH SYSTEM'S ACCOUNTING POLICY FOR BAD DEBT EXPENSE IS DESCRIBED ON PAGE 17 OF THE NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS IN THE MEMORIAL HEALTH SYSTEM'S CONSOLIDATED FINANCIAL STATEMENTS.
PART III, LINE 3:	MEMORIAL HEALTH SYSTEM DOES NOT BELIEVE ANY AMOUNT OF BAD DEBT EXPENSES WOULD BE ATTRIBUTABLE TO PATIENTS ELIGIBLE UNDER THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY. ANY EXPENSES RELATED TO A PATIENT WHO IS ELIGIBLE UNDER THE FAP WOULD BE RECORDED AS CHARITY CARE RATHER THAN BAD DEBT.

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 4:	MEMORIAL HEALTH SYSTEM'S ACCOUNTING POLICY FOR BAD DEBT EXPENSE IS DESCRIBED ON PAGE 17 OF THE NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS IN THE MEMORIAL HEALTH SYSTEM'S CONSOLIDATED FINANCIAL STATEMENTS.
PART III, LINE 8:	<p>THE COSTING METHODOLOGY UTILIZED FOR THE DETERMINATION OF MEMORIAL HEALTH SYSTEM HOSPITALS' MEDICARE ALLOWABLE COST (SCHEDULE H, PART III, LINE 6) WAS CALCULATED AS FOLLOWS: MMC, DMH, ALMH, TMH, AND PAH UTILIZED MEDICARE COSTING DATA FROM THE FY2020 MEDICARE COST REPORT AS FILED. MMC WAS ABLE TO CAPTURE THE MEDICARE COSTING FOR INPATIENT MEDICAL SURGICAL, INPATIENT PSYCHIATRIC, INPATIENT REHABILITATION AND OUTPATIENT MEDICAL SURGICAL SERVICES DURING FY2019. THIS COSTING DATA EXCLUDED THE DIRECT MEDICAL EDUCATION COST FOR THE RESIDENCY PROGRAM ASSOCIATED WITH THE SOUTHERN ILLINOIS UNIVERSITY SCHOOL OF MEDICINE. THIS COST WAS INCLUDED IN THE HEALTH PROFESSIONAL EDUCATION SECTION OF PART I, LINE 7 (F) OF SCHEDULE H. OTHER SECTIONS OF MEDICARE COSTS THAT WOULD NORMALLY BE EXCLUDED FROM THE MEDICARE COST REPORT BUT SHOULD BE INCLUDED FOR PURPOSES OF THIS SCHEDULE ARE THE FOLLOWING: 1. MMC'S ESRD PROGRAM-THIS PROGRAM IS RELATED TO THE END-STAGE RENAL DIALYSIS PROGRAM. THE PROGRAM IS REFLECTED ON THE W/S I OF THE COST REPORT BUT DOES NOT HAVE A SETTLEMENT. 2. MMC'S OUTPATIENT CLINICAL LAB CHARGES-THESE MEDICARE OUTPATIENT CHARGES ARE PAID ON A FEE-FOR-SERVICE BASIS AND ARE NOT REFLECTED ON THE AS FILED MEDICARE COST REPORT. 3. MMC'S OUTPATIENT THERAPY SERVICES-THESE MEDICARE OUTPATIENT CHARGES RELATED TO THERAPEUTIC SERVICES, SUCH AS PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH THERAPY SERVICES, ARE SUBJECT TO A FEE-FOR-SERVICE PAYMENT METHOD AND NOT FILED ON THE MEDICARE COST REPORT. 4. PART B PROFESSIONAL FEES-MMC HAS ITS PART B MEDICARE PROFESSIONAL FEES BILLED THROUGH A SEPARATE CORPORATION OF MEMORIAL HEALTH SYSTEM. THE BILLING SERVICE IS CALLED PHYSICIAN BILLING SERVICE. IT BILLS FOR THE PROFESSIONAL FEES ON BEHALF OF MMC AND SWEEPS THE MEDICARE PAYMENTS BACK TO IT. SOME OF THE PROFESSIONAL FEES BILLED BY PHYSICIAN BILLING SERVICE ARE CRNA, HEARING CENTER, SPINE WORKS CLINIC, HEART FAILURE CLINIC, CLINICAL PSYCHOLOGISTS, DIETARY CONSULTING, BARIATRIC SURGERY, EXPRESS CARE LAB AND RADIOLOGY SERVICES, AND EKG INTERPRETATIONS. THESE SERVICES ARE TYPICALLY EXCLUDED FROM THE MEDICARE COST REPORT BUT SHOULD BE INCLUDED FOR PURPOSE OF SCHEDULE H. THE MEDICARE CHARGES ASSOCIATED WITH BULLET POINTS 1 THROUGH 4 ABOVE WERE APPLIED TO THE CALCULATED COST TO CHARGE RATIOS FROM THE MEDICARE COST REPORT TO DETERMINE ITS COST. THIS COST DATA, ALONG WITH THE COST DATA ALREADY COMPILED FROM THE AS FILED MEDICARE COST REPORT WAS THE BASIS FOR ALLOWABLE MEDICARE COST OF \$329,029,581. THE TOTAL SHORTFALL REPORTED ON SCHEDULE H, PART III, LINE 7 WAS \$24,156,775. THE ENTIRE SHORTFALL SHOULD BE CONSIDERED A COMMUNITY BENEFIT FOR MMC, DMH, ALMH, TMH, AND PAH. THIS SHORTFALL REFLECTS THE EXCESS COSTS INCURRED BY THE FOUR MHS HOSPITALS THAT CURRENT FEE-FOR-SERVICE PAYMENTS PRESENTLY DO NOT COVER. THESE ARE VITAL SERVICES TO THE COMMUNITY THESE HOSPITALS SERVE THAT CURRENT MEDICARE PAYMENTS DO NOT COVER. MEDICARE IS AN IMPORTANT PAYER TO THE COMMUNITIES OF SPRINGFIELD, DECATUR, LINCOLN, JACKSONVILLE, AND TAYLORVILLE. ACCORDINGLY, ALL MHS HOSPITALS ACCEPT MEDICARE PATIENTS REGARDLESS OF WHETHER THEIR TREATMENT WILL RESULT IN A PAYMENT OR NOT. BY PROVIDING THESE SERVICES TO MEDICARE PATIENTS, THE MHS HOSPITALS PROMOTE ACCESS TO HEALTH CARE THAT MIGHT NOT BE PROVIDED OTHERWISE. ELDERLY ARE OFTEN CONSIDERED AN UNDERSERVED POPULATION WHO EXPERIENCE ISSUES WITH ACCESS TO HEALTHCARE SERVICES, BOTH AT THE URBAN AND RURAL COMMUNITY LEVEL. WITHOUT TAX EXEMPT HOSPITALS, CMS AND THE U.S. GOVERNMENT WOULD HAVE TO BEAR THE BURDEN OF DIRECTLY PROVIDING SERVICES TO THE ELDERLY.</p>

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Form and Line Reference	Explanation
PART III, LINE 9B:	<p>PER THE FINANCIAL ASSISTANCE POLICY, MMC, DMH, ALMH, TMH, AND PAH WILL NOT PURSUE COLLECTION ACTION IN COURT AGAINST A PATIENT WHO QUALIFIES FOR FINANCIAL ASSISTANCE IF THE PATIENT HAS CLEARLY DEMONSTRATED THAT HE OR SHE DOES NOT HAVE SUFFICIENT INCOME OR ASSETS TO MEET ANY PART OF THEIR FINANCIAL OBLIGATION TO THE APPLICABLE HOSPITAL. PER THE FINANCIAL ASSISTANCE POLICY, IF AN UNINSURED PATIENT HAS REQUESTED FINANCIAL ASSISTANCE AND/OR APPLIED FOR OTHER COVERAGE AND IS COOPERATING WITH THE APPLICABLE MHS HOSPITAL, MHS WILL NOT PURSUE COLLECTION ACTION UNTIL A DECISION HAS BEEN MADE THAT THERE IS NO LONGER A REASONABLE BASIS TO BELIEVE THE PATIENT MAY QUALIFY FOR FINANCIAL ASSISTANCE OR OTHER COVERAGE. PER THE FINANCIAL ASSISTANCE POLICY, IF AN UNINSURED PATIENT COMPLIES WITH A PAYMENT PLAN THAT HAS BEEN AGREED UPON BY THE APPLICABLE MHS HOSPITAL, MHS WILL NOT PURSUE COLLECTION ACTION. PER THE FINANCIAL ASSISTANCE POLICY, IF MHS HAS GIVEN THE PATIENT THE OPPORTUNITY TO ASSESS THE ACCURACY OF THE BILL AND HAS SUFFICIENT REASON TO BELIEVE THAT THE PATIENT DOES NOT QUALIFY FOR ADDITIONAL FINANCIAL ASSISTANCE UNDER ALL TERMS OF THIS POLICY REGARDING HIS OR HER PARTIAL OBLIGATION, AND THE PATIENT CONTINUES WITH NON-PAYMENT, COLLECTION ACTION MAY BE TAKEN BY MHS TO ENFORCE THE TERMS OF ANY PAYMENT PLAN. ONCE FINANCIAL ASSISTANCE STATUS IS DETERMINED, IT WILL BE APPLIED TO ALL OPEN ACCOUNTS AND WILL BE VALID FOR A PERIOD OF 6 MONTHS FROM DATE OF DETERMINATION AND 6 MONTHS RETROACTIVELY.</p>
PART VI, LINE 2:	<p>MHS REVIEWS A VARIETY OF INFORMATION TO IDENTIFY COMMUNITY NEEDS. THESE INCLUDE HOSPITAL ADMISSIONS AND DISCHARGES, LEADING CAUSES OF MORTALITY AND MORBIDITY IN EACH COUNTY, AS REPORTED BY THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH AND THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTHY PEOPLE 2020. ADDITIONAL INFORMATION IS GLEANED FROM CONSUMER SURVEYS, PATIENT SURVEYS, MEDICAL STAFF SURVEYS, EVALUATIONS FROM COMMUNITY EDUCATION EVENTS, SUPPORT GROUP FEEDBACK, WEBMASTER AND SOCIAL MEDIA QUESTIONS AND FEEDBACK, VOLUNTEER BOARD MEMBER AND COMMUNITY BENEFIT COMMITTEE FEEDBACK, REQUESTS FROM THE COMMUNITY AND GRANT APPLICATIONS TO THE ORGANIZATION'S FOUNDATIONS. INFORMATION FROM THESE SOURCES HELPS PRIORITIZE MHS'S COMMUNITY BENEFIT INVESTMENTS AND HELPS ENSURE THOSE INITIATIVES ARE ALIGNED WITH OUR MISSION, VALUES, STRATEGIC PLAN AND BUDGET. PRIORITIES ARE ESTABLISHED BASED ON OVERALL NEED, LEADING CAUSES OF DEATH, IMPACT ON HEALTH STATUS, ORGANIZATIONAL CORE COMPETENCIES, AND RESOURCES TO MEANINGFULLY ADDRESS THE NEEDS. EACH MHS AFFILIATE HAS THE FLEXIBILITY TO DEVELOP SPECIFIC COMMUNITY BENEFIT INITIATIVES THAT ARE DESIGNED TO RESPOND TO THE NEEDS OF ITS PARTICULAR COMMUNITY. MHS UNDERSTANDS COLLABORATION WITH OTHER COMMUNITY ORGANIZATIONS IS AN IMPORTANT COMPONENT OF COMMUNITY HEALTH IMPROVEMENT EFFORTS AND RESPONDS TO DIRECT COMMUNITY REQUESTS AS APPROPRIATE.</p>

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Form and Line Reference	Explanation
PART VI, LINE 3:	<p>MMC, DMH, ALMH, TMH, AND PAH PROACTIVELY INFORM PATIENTS ABOUT THEIR FINANCIAL ASSISTANCE POLICY AND THE ELIGIBILITY CRITERIA. A FINANCIAL ASSISTANCE LINK ON EACH MHS HOSPITAL'S WEBSITE GOES TO THE FINANCIAL ASSISTANCE POLICY AND APPLICATION. THE POLICY AND APPLICATION FORM ARE AVAILABLE IN ENGLISH AND SPANISH. FOREIGN LANGUAGE TRANSLATION ASSISTANCE IS AVAILABLE UPON REQUEST. INFORMATION ON THE AVAILABILITY OF FINANCIAL ASSISTANCE IS POSTED AT PRIMARY REGISTRATION SITES, INCLUDING THE EMERGENCY DEPARTMENT. THE "PEACE OF MIND REGARDING PAYMENT" BROCHURE IS AVAILABLE TO EVERY PATIENT AT EVERY VISIT AND IS AVAILABLE IN BOTH ENGLISH AND SPANISH.MHS COLLEAGUES IN PATIENT REGISTRATION, PATIENT FINANCIAL SERVICES AND SOCIAL SERVICES ARE TRAINED TO UNDERSTAND THE FINANCIAL ASSISTANCE POLICY AND KNOW HOW TO DIRECT QUESTIONS TO THE APPROPRIATE MHS HOSPITAL REPRESENTATIVE WHO CAN ANSWER SPECIFIC QUESTIONS ABOUT THE FINANCIAL ASSISTANCE POLICY. THEY ALSO REFER PATIENTS TO MEDICAID COORDINATORS WHO CAN EXPLAIN THE AVAILABILITY OF VARIOUS GOVERNMENT PROGRAMS, SUCH AS MEDICAID OR OTHER STATE PROGRAMS AND ASSIST THE PATIENT WITH QUALIFICATION FOR SUCH PROGRAMS.MMC AND PAH CONTRACT WITH FULL-TIME MEDICAID COORDINATORS. THEIR GOAL IS TO VISIT ALL INPATIENTS WHO ARE IDENTIFIED AS SELF-PAY WITHIN ONE DAY OF ADMISSION. IF AN INPATIENT IS IDENTIFIED AS BEING POTENTIALLY ELIGIBLE FOR MEDICAID OR OTHER GOVERNMENT BENEFITS, THE APPLICATION PROCESS IS STARTED IMMEDIATELY. THE MEDICAID COORDINATORS WILL CONTINUE TO WORK WITH A PATIENT POST-DISCHARGE TO WALK THEM THROUGH THE ENTIRE APPLICATION PROCESS. THEY ALSO CONTACT A SELF-PAY OUTPATIENT WITH OVER \$1,000 IN CHARGES AND OFFER TO HELP THEM WITH THE MEDICAID APPLICATION PROCESS. IF THE MEDICAID COORDINATORS DETERMINE THAT THE PATIENT IS OVER INCOME FOR MEDICAID THEY CONTACT THE FINANCIAL ASSISTANCE REPRESENTATIVE SO THAT A FINANCIAL ASSISTANCE APPLICATION CAN BE SENT TO THE PATIENT.MHS HOSPITAL BILLING STATEMENT INCLUDES FINANCIAL ASSISTANCE INFORMATION WITH A PHONE NUMBER TO CALL FOR INFORMATION. PATIENTS ARE ENCOURAGED TO INQUIRE ABOUT FINANCIAL ASSISTANCE AT ANY STAGE OF THE BILLING PROCESS.</p>
PART VI, LINE 4:	<p>MEMORIAL HEALTH SYSTEM INCLUDES FIVE HOSPITALS IN SANGAMON, LOGAN, CHRISTIAN, MACON AND MORGAN COUNTIES, SERVING A WIDE REGION OF CENTRAL AND SOUTHERN ILLINOIS, WHICH IS LARGELY RURAL AND AGRICULTURAL. IN SANGAMON COUNTY, PATIENTS COME FROM MORE THAN 40 OTHER COUNTIES AND ALSO FROM OUT OF STATE, MAKING MMC A SIGNIFICANT RESOURCE FOR HEALTHCARE SERVICES. SANGAMON COUNTY (POPULATION 195,348) COMPRISES 868 SQUARE MILES IN CENTRAL ILLINOIS. IT IS PRIMARILY A RURAL AREA THAT INCLUDES THE CITY OF SPRINGFIELD (POPULATION 117,000), WHICH IS THE COUNTY'S LARGEST CITY AS WELL AS THE STATE CAPITOL OF ILLINOIS AND THE COUNTY SEAT. SANGAMON COUNTY HAS EIGHT FEDERALLY DESIGNATED MEDICALLY UNDERSERVED AREAS (MUAS). THE OTHER HOSPITAL SERVING SANGAMON COUNTY IS ST. JOHN'S HOSPITAL, A 430-BED NONPROFIT HOSPITAL AFFILIATED WITH HOSPITAL SISTERS HEALTH SYSTEM. THE POPULATION OF SANGAMON COUNTY IS 82.2% WHITE, 13% BLACK, 2.1% ASIAN, AND 2.4% HISPANIC. PERSONS AGE 65 AND OLDER MAKE UP 17.9% OF SANGAMON COUNTY'S POPULATION, WHICH IS HIGHER THAN THE STATE AVERAGE OF 15.6%. THE MEDIAN HOUSEHOLD INCOME IS \$60,446. A TOTAL OF 15.2% OF ALL COUNTY RESIDENTS LIVE BELOW THE FEDERAL POVERTY LEVEL, INCLUDING 24.4% OF CHILDREN UNDER THE AGE OF 6. IN TY2019/FY2020, 0.9% OF THE PATIENTS SERVED AT MMC RECEIVED PATIENT FINANCIAL ASSISTANCE (UNINSURED); 17% WERE ON MEDICAID, AND 32.6% RECEIVED MEDICARE. IN LOGAN COUNTY, ALMH IS THE ONLY HOSPITAL IN THE PRIMARY SERVICE AREA OF LOGAN COUNTY (POP. 28,925). THE CITY OF LINCOLN (POPULATION 13,685), WHERE ALMH IS LOCATED, IS THE COUNTY SEAT. LINCOLN CONTAINS ALMOST HALF OF THE COUNTY'S POPULATION. RACE/ETHNIC MAKEUP IS 89% WHITE, 8.3% BLACK AND 3.5% HISPANIC. THE MEDIAN HOUSEHOLD INCOME IS \$57,899. PERSONS AGE 65 AND OLDER MAKE UP 18.3% OF LOGAN COUNTY'S POPULATION. 8.5% OF ALL RESIDENTS LIVE BELOW THE FEDERAL POVERTY LEVEL. HIGH SCHOOL GRADUATES MAKE UP 88.9% OF RESIDENTS. ONLY 20.4 PERCENT OF RESIDENTS HAVE EARNED A BACHELOR'S DEGREE OR HIGHER, IN COMPARISON TO THE STATE AVERAGE OF 34.1%. IN TY2019/FY2020, 2.1% OF PATIENTS SERVED AT ALMH RECEIVED PATIENT FINANCIAL ASSISTANCE (UNINSURED); 21.1% WERE ON MEDICAID, AND 49.6% RECEIVED MEDICARE. TMH IS ONE OF TWO HOSPITALS IN THE PRIMARY SERVICE AREA OF CHRISTIAN COUNTY (POP. 32,661). TMH IS LOCATED IN TAYLORVILLE, WHILE THE OTHER, PANA COMMUNITY HOSPITAL, IS A CRITICAL ACCESS FACILITY IN THE SOUTHEAST CORNER OF THE COUNTY. THE MAJORITY OF THE PATIENTS SERVED BY TMH COME FROM CHRISTIAN COUNTY. CHRISTIAN COUNTY'S RACE/ETHNICITY INCLUDES 96.3% WHITE, 1.6% BLACK, AND 1.7% HISPANIC. THE MEDIAN HOUSEHOLD INCOME IS \$52,415. THE COUNTY HAS AN AGING POPULATION: PERSONS AGE 65 AND OLDER MAKE UP 19.9% OF THE POPULATION, VS. 15.6 % FOR THE STATE OF ILLINOIS. 13% OF ALL PEOPLE LIVE BELOW THE FEDERAL POVERTY LEVEL, INCLUDING 16.5% OF CHILDREN. CHRISTIAN COUNTY HAS NINE MEDICALLY UNDERSERVED AREAS. IN TY2019/FY2020, 2.1% OF PATIENTS SERVED AT TMH RECEIVED PATIENT FINANCIAL ASSISTANCE (UNINSURED); 20.6% WERE ON MEDICAID AND 52.3% RECEIVED MEDICARE. PASSAVANT AREA HOSPITAL IS LOCATED IN JACKSONVILLE, THE COUNTY SEAT OF MORGAN COUNTY. JACKSONVILLE IS HOME TO THE ILLINOIS SCHOOL FOR THE DEAF AND THE ILLINOIS SCHOOL FOR THE VISUALLY IMPAIRED, AS WELL AS TWO PRIVATE LIBERAL ARTS COLLEGES, A COMMUNITY COLLEGE AND SEVERAL INDUSTRIAL FACTORIES. IN 2016, THE ESTIMATED POPULATION OF MORGAN COUNTY WAS 33,976. RACE AND ETHNIC BREAKOUTS ARE 89.9% WHITE, 7% BLACK, 2.5% LATINO OR HISPANIC. IN MORGAN COUNTY, 2.9 PERCENT OF THE POPULATION SPEAKS A LANGUAGE OTHER THAN ENGLISH AT HOME. PEOPLE OVER THE AGE OF 65 MAKE UP 20 PERCENT OF THE POPULATION. HIGH SCHOOL GRADUATES MAKE UP 91.7% OF THE POPULATION (2.8 PERCENT HIGHER THAN THE ILLINOIS AVERAGE. THE MEDIAN HOUSEHOLD INCOME IN MORGAN COUNTY IS \$48,508. 14.6% OF PEOPLE LIVE BELOW THE POVERTY LINE (1.5% HIGHER THAN THE ILLINOIS AVERAGE OF 14%), INCLUDING 22.7%. IN TY2019/FY2020, 0.8% OF PATIENTS SERVED AT PAH RECEIVED PATIENT FINANCIAL ASSISTANCE (UNINSURED); 23.6% OF PATIENTS WERE ON MEDICAID; AND 37.93% RECEIVED MEDICARE. DECATUR MEMORIAL HOSPITAL IS LOCATED IN DECATUR, THE COUNTY SEAT OF MACON COUNTY. DECATUR IS CONSIDERED A METROPOLITAN STATISTICAL AREA AND IS HOME OF A PRIVATE UNIVERSITY AND PUBLIC COMMUNITY COLLEGE, AS WELL AS SEVERAL INDUSTRIAL FACTORIES SUCH AS ADM AND CATERPILLAR. DECATUR IS LISTED AS NUMBER 3 IN "THE FASTEST DECLINING LARGE CITIES" WHICH SHOWED A 7.1% POPULATION LOSS FROM 2010 TO 2019 BY THE UNITED STATES CENSUS BUREAU. THE POPULATION OF MACON COUNTY IS ESTIMATED AROUND 110,000 PEOPLE. RACE AND ETHNIC BREAKOUTS ARE 79.3% WHITE, 16.3% BLACK, AND 1% ASIAN. PEOPLE OVER THE AGE OF 65 MAKE UP 18.8% OF THE POPULATION. HIGH SCHOOL GRADUATES MAKE UP 94.3% OF THE POPULATION (6.3% HIGHER THAN THE ILLINOIS AVERAGE). THE MEDIAN HOUSEHOLD INCOME IN MACON COUNTY IS \$67,188.</p>

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Form and Line Reference	Explanation
PART VI, LINE 5:	<p>EACH MHS HOSPITAL HAS A BOARD OF DIRECTORS MADE UP OF MEDICAL, BUSINESS, AND COMMUNITY LEADERS WHO RESIDE IN THAT HOSPITAL'S PRIMARY SERVICE AREA. VOLUNTEER BOARD MEMBERS ARE NEITHER EMPLOYEES NOR INDEPENDENT CONTRACTORS NOR FAMILY MEMBERS THEREOF. THEY DONATE NUMEROUS HOURS OF SERVICE IN THEIR OVERSIGHT ROLE, INCLUDING DURING THE CHNA PROCESS. ALL MHS HOSPITALS HAVE OPEN MEDICAL STAFF THAT ALLOW MEMBERSHIP TO ANYONE WHO MEETS THE CREDENTIALING REQUIREMENTS. ALL MHS HOSPITALS PROVIDE 24/7 EMERGENCY DEPARTMENTS THAT SERVE AS SAFETY NET PROVIDERS FOR THE UNINSURED AND UNDERINSURED WHO DO NOT HAVE PRIMARY CARE PHYSICIANS. WE PROVIDE CARE TO ALL PEOPLE REGARDLESS OF THEIR ABILITY TO PAY. IN ADDITION TO OUR STANDARD COMMUNITY BENEFIT PLANS, MEMORIAL HEALTH SYSTEM UTILIZES SURPLUS FUNDS TO IMPROVE PATIENT CARE, MEDICAL EDUCATION, RESEARCH, AND ACCESS TO HEALTH CARE, AS WELL AS UPGRADING HOSPITAL INFRASTRUCTURES. MMC SERVES AS THE REGIONAL BURN CENTER FOR CENTRAL AND SOUTHERN ILLINOIS AND IS THE REGIONAL REHABILITATION PROVIDER FOR COMPREHENSIVE INPATIENT AND OUTPATIENT REHAB. MMC'S REGIONAL CANCER CENTER APPLIES ITS RESOURCES AND RESEARCH TO OFFER THE LATEST IN CANCER EDUCATION AND TREATMENT. MMC'S TRANSPLANT SERVICES HAS COMPLETED HUNDREDS OF KIDNEY OR PANCREAS TRANSPLANTS AND OUR EMERGENCY DEPARTMENT IS A LEVEL 1 TRAUMA CENTER. MMC SUPPORTS PATIENTS FROM TWO FQHCs IN SANGAMON COUNTY. MHS COLLABORATES WITH COMMUNITY PARTNERS IN SANGAMON AND MORGAN COUNTIES TO PLACE COMMUNITY HEALTH WORKERS IN AT-RISK NEIGHBORHOODS TO ADDRESS THE SOCIAL DETERMINANTS OF HEALTH. MMC PROVIDES SIGNIFICANT FINANCIAL SUPPORT FOR THE SIU SCHOOL OF MEDICINE, WHO DOES NOT RECEIVE SUFFICIENT OPERATING SUPPORT FROM THE STATE OF ILLINOIS. MMC SERVES AS A MAJOR TEACHING HOSPITAL FOR SIU SOM AND COLLABORATES WITH LOCAL COLLEGES TO OFFER NURSING PROGRAMS TO HELP FILL THE GAP OF NURSING SHORTAGES. ALMH, DMH AND PAH PROVIDE REGULAR HEALTH SCREENINGS, SUPPORT GROUPS, AND COMMUNITY PROGRAMS, IN ADDITION TO THEIR GENERAL SERVICE LINES (INCLUDING GENERAL ACUTE INPATIENT CARE, ORTHOPEDICS, SURGERY, OUTPATIENT REHABILITATION, AND MORE). TMH IS WELL INTO A MULTI-YEAR FACILITY RENOVATION PROJECT TO REPLACE OUTDATED INPATIENT AND OUTPATIENT FACILITIES. AN INVESTMENT OF \$57.7 MILLION WILL MODERNIZE THE AGING TMH STRUCTURE, WHICH WAS BUILT IN 1954/56, WITH SEVERAL ADDITIONS IN 1956, 1993 AND 2010. THE ORIGINAL 1954/1956 PORTION OF THE BUILDING BEING REPLACED IS A NEW MODERNIZED SECTION THAT WILL SUPPORT MAXIMUM EFFICIENCY AND OPERATIONAL IMPROVEMENTS NEEDED TO PROVIDE THE BEST PATIENT CARE AND EXPERIENCE FOR PATIENTS AND THEIR FAMILIES. MEMORIAL HEALTH SYSTEM, INCLUDING EACH OF OUR MHS HOSPITALS, HAS PROVIDED OUR COMMUNITIES A COORDINATED RESPONSE TO THE COVID-19 PANDEMIC. FROM COMMUNITY EDUCATION, COLLABORATION WITH LOCAL HEALTH DEPARTMENTS, EXPANDING TELEHEALTH AND PROVIDING RESPIRATORY CLINICS - WE HAVE BEEN A KEY PILLAR OF CENTRAL ILLINOIS' PANDEMIC RESPONSE. OUR COMMUNITY BENEFIT PROGRAMS PROVIDED SUPPLIES TO AID IN SOCIAL DISTANCING AND DONATED OVER 80,000 MASKS TO APPROXIMATELY 70 PARTNER ORGANIZATIONS FOR DISTRIBUTION THROUGHOUT OUR COMMUNITIES.</p>
PART VI, LINE 6:	<p>MEMORIAL HEALTH SYSTEM (MHS), A 501C3 CORPORATION, IS THE SOLE CORPORATE MEMBER OF THE ABRAHAM LINCOLN MEMORIAL HOSPITAL (ALMH), TAYLORVILLE MEMORIAL HOSPITAL (TMH), PASSAVANT MEMORIAL AREA HOSPITAL (PAH), DECATUR MEMORIAL HOSPITAL (DMH), AND MEMORIAL MEDICAL CENTER (MMC). OTHER AFFILIATES INCLUDE: MEMORIAL PHYSICIAN SERVICES, A PRIMARY CARE PHYSICIAN NETWORK THAT INCLUDES SEVERAL CLINICS LOCATED IN MEDICALLY UNDERSERVED OR HEALTH MANPOWER SHORTAGE AREAS; MEMORIAL BEHAVIORAL HEALTH, A MULTI-COUNTY OUTPATIENT MENTAL HEALTH NETWORK THAT PROVIDES SERVICE BASED ON A SLIDING-SCALE FEE SCHEDULE AND FREE CARE TO A WIDE RANGE OF PATIENTS WITH PSYCHIATRIC DISORDERS; MEMORIAL HOME SERVICES, A MULTI-COUNTY HOME CARE AND HOSPICE PROGRAM; A CHILD CARE CENTER; AND FIVE HOSPITAL FOUNDATIONS, ALL OF WHICH ARE 501C3 ENTITIES. MHS AFFILIATES ENGAGE IN A WIDE RANGE OF PROGRAMS THAT PROMOTE COMMUNITY HEALTH, INCLUDING INTEGRATING SERVICES TO PROVIDE IMPROVED ACCESS AND STREAMLINING TRANSACTIONS BETWEEN DOCTOR'S OFFICES, HOSPITALS, HOME HEALTH AGENCIES, AND MENTAL HEALTH CLINICS. IN ADDITION TO HOSPITAL COMMUNITY BENEFIT ACTIVITIES, OTHER MHS AFFILIATES' COMMUNITY BENEFIT CONTRIBUTIONS TOTAL MORE THAN \$9.2 MILLION. MEMORIAL PHYSICIAN SERVICES (MPS) OFFERS FIVE WALK-IN EXPRESSCARE LOCATIONS AND TELEHEALTH, IN ORDER TO IMPROVE PATIENT ACCESS. COMPRISED OF MORE THAN 165 PHYSICIANS, ADVANCED PRACTICE REGISTERED NURSES, DOCTOR OF NURSING PRACTICE AND PHYSICIAN ASSISTANTS, MPS PROVIDES 350,000+ PATIENTS VISITS EACH YEAR. PHYSICIAN OFFICES AND CLINICS ARE LOCATED IN SPRINGFIELD, JACKSONVILLE, BEARDSTOWN, LINCOLN, DECATUR, PETERSBURG AND CHATHAM. MPS PROVIDES COMMUNITY BENEFITS BY MENTORING AND PROVIDING HEALTH PROFESSION EDUCATIONAL OPPORTUNITIES FOR MEDICAL STUDENTS, ADVANCED PRACTICE REGISTERED NURSES, DOCTOR OF NURSING PRACTICE, PHYSICIAN ASSISTANTS AND CERTIFIED MEDICAL ASSISTANTS. MEMORIAL BEHAVIORAL HEALTH (MBH) CARES FOR CHILDREN AND ADULTS AT ITS MULTIPLE SITES OF CARE IN SPRINGFIELD, LINCOLN, AND JACKSONVILLE. SERVICES INCLUDE CRISIS INTERVENTION, PSYCHIATRIC SERVICES, SCREENING AND ASSESSMENT, OUTPATIENT THERAPY, CASE MANAGEMENT, SUPPORT GROUPS, EMPLOYMENT SERVICES, AND RESIDENTIAL CARE, AS WELL AS LEVEL 1 SUBSTANCE USE SERVICES TO ADULTS IN SPRINGFIELD. THE PSYCHIATRIC RESPONSE TEAM WORKS WITH FOUR AREA HOSPITAL EMERGENCY DEPARTMENTS. MBH ALSO PROVIDES COMMUNITY-BASED CRISIS INTERVENTION SERVICES AT LOCAL SCHOOLS, HOMELESS SHELTERS, AND WITH LOCAL LAW ENFORCEMENT. MBH IS A MEMBER OF THE NATIONAL SUICIDE PREVENTION LIFELINE. IT STAFFS A HOTLINE ANSWERING CALLS FROM INDIVIDUALS IN CRISIS 24/7, 365 DAYS A YEAR. MBH ALSO SPONSORS PROFESSIONAL CONFERENCE ATTENDED BY PROVIDERS THROUGHOUT THE STATE. MHS FOUNDATIONS PROVIDE GRANTS FOR PATIENT CARE, EDUCATION, AND CLINICAL RESEARCH. THESE ADDITIONAL FOUNDATION COMMUNITY BENEFITS TOTALED MORE THAN \$1.6 MILLION. SUPPORT WAS GRANTED TO SIU SCHOOL OF MEDICINE, THE UNIVERSITY OF ILLINOIS AT CHICAGO, EMERGENCY MEDICAL SERVICES, PATIENT ASSISTANCE FUNDS, THE ALMH COMMUNITY HEALTH COLLABORATIVE, SCHOLARSHIPS, STOP THE BLEED PROGRAMS, AND MANY OTHER GROUPS AND PROGRAMS THROUGHOUT CENTRAL ILLINOIS.</p>

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Form and Line Reference	Explanation
PART VI, LINE 7, REPORTS FILED WITH STATES	IL
PART VI, LINE 4 CONTINUED	IN TY2019/FY2020, 2.5% OF PATIENTS SERVED AT DMH RECEIVED PATIENT FINANCIAL ASSISTANCE OR AN UNINSURED DISCOUNT; 15.9% OF PATIENTS WERE ON MEDICAID; AND 44.9% OF PATIENTS WERE ON MEDICARE.

Additional Data

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

Form 990 Schedule H, Part V Section A. Hospital Facilities

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 5		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER—24 hours	ER—other	Other (Describe)	Facility reporting group
1	MEMORIAL MEDICAL CENTER 701 NORTH FIRST STREET SPRINGFIELD, IL 62781 HTTPS://WWW.MEMORIALMEDICAL.COM/ 0001487	X	X		X		X	X			
2	THE ABRAHAM LINCOLN MEMORIAL HOSPITAL 200 STAHLHUT DRIVE LINCOLN, IL 62656 HTTP://WWW.ALMH.ORG/ 0005728	X	X			X		X			
3	TAYLORVILLE MEMORIAL HOSPITAL 201 E PLEASANT TAYLORVILLE, IL 62568 HTTPS://WWW.TAYLORVILLEMEMORIAL.ORG/ 0005447	X	X			X		X			
4	PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION 1600 W WALNUT ST JACKSONVILLE, IL 62650 HTTPS://WWW.PASSAVANTHOSPITAL.COM/ 0001792	X	X					X			
5	DECATUR MEMORIAL HOSPITAL 2300 NORTH EDWARD STREET DECATUR, IL 62526 HTTPS://WWW.DMHCARES.COM/ 0000471	X	X					X		ACUTE CARE & LONG TERM CARE	

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

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

Form and Line Reference	Explanation
MEMORIAL MEDICAL CENTER	<p>PART V, SECTION B, LINE 5: MEMORIAL MEDICAL CENTER (MMC) COLLABORATED WITH HSHS ST. JOHN'S HOSPITAL AND THE SANGAMON COUNTY DEPARTMENT OF PUBLIC HEALTH TO COMPLETE A CHNA IN TY2017/FY2018. MMC DID NOT RECEIVE ANY DIRECT WRITTEN COMMENTS ON THE 2015 CHNA OR IMPLEMENTATION STRATEGIES. FOR THE 2018 CHNA, COMMUNITY HEALTH NEEDS WERE PRIORITIZED BASED ON REVIEWS OF MULTIPLE SOURCES OF SECONDARY DATA, AS WELL AS PRIMARY DATA GATHERED A COMMUNITY ADVISORY COMMITTEE (CAC) COMPRISED OF 13 REPRESENTATIVES FROM COMMUNITY ORGANIZATIONS. THESE INCLUDED TWO FEDERALLY QUALIFIED HEALTH CENTERS (SIU CENTER FOR FAMILY MEDICINE AND CENTRAL COUNTIES HEALTH CENTERS); SANGAMON COUNTY DEPARTMENT OF COMMUNITY RESOURCES (COMMUNITY ACTION); MEMORIAL BEHAVIORAL HEALTH; CATHOLIC CHARITIES; LINCOLN LAND COMMUNITY COLLEGE'S OPEN DOOR MENTORSHIP PROGRAM; SIU SCHOOL OF MEDICINE'S DEPARTMENT OF EQUITY, DIVERSITY AND INCLUSION; SPRINGFIELD POLICE DEPARTMENT; SPRINGFIELD SCHOOL DISTRICT 186; SANGAMON COUNTY FARM BUREAU; GREATER SPRINGFIELD CHAMBER OF COMMERCE; SPRINGFIELD URBAN LEAGUE; AND UNITED WAY OF CENTRAL ILLINOIS. THE CAC MET ON OCTOBER 24, 2017, TO REVIEW OUTCOMES OF THE 2015 CHNA IMPLEMENTATION STRATEGIES, DISCUSS SOCIAL DETERMINANTS OF HEALTH, AND AN OVERVIEW OF SECONDARY DATA CONSULTED FOR THE 2018 CHNA. THE CAC HAD OPPORTUNITY TO PROVIDE INPUT ON KEY COMMUNITY ISSUES THEY WERE ADDRESSING. AT THE SECOND MEETING ON NOVEMBER 17, 2017, THE CAC REVIEWED DATA ON 18 IDENTIFIED PRIORITY NEEDS, INCLUDING SANGAMON COUNTY INCIDENCE RATES, EMERGENCY DEPARTMENT AND HOSPITALIZATION DATA, TRENDS OVER TIME AND DISPARITIES. THE CAC SHARED SPECIFIC INFORMATION ON HOW THESE ISSUES IMPACTED THEIR CLIENTS AND THE COMMUNITY, AND THEN COMPLETED A FORCED RANKING TO SELECT THE NINE ISSUES THAT WOULD BE INCLUDED ON A COMMUNITY SURVEY. THE UNIVERSITY OF ILLINOIS' SURVEY RESEARCH DEPARTMENT CONDUCTED A COMMUNITY SURVEY ON THESE NINE ISSUES FROM JANUARY 12-FEBRUARY 12, 2018, AND PROVIDED A REPORT BACK TO THE HOSPITAL; 1,079 INDIVIDUALS COMPLETED THE SURVEY. THE CAC MET A FINAL TIME ON MARCH 20, 2018. MEMBERS RECEIVED A DETAILED REVIEW OF THE COMMUNITY SURVEY OUTCOMES. THE CAC ALSO COMPLETED AN ASSET AND GAPS ANALYSIS AND DISCUSSED POPULATIONS DISPROPORTIONATELY AFFECTED. USING THE PREDEFINED CRITERIA OF MAGNITUDE, SERIOUSNESS, FEASIBILITY AND TRIPLE AIM, THE CAC RECOMMENDED FOUR FINAL ISSUES AS THE TOP PRIORITIES FOR THE HOSPITALS TO ADDRESS IN SANGAMON COUNTY: ACCESS TO CARE, MENTAL HEALTH, SUBSTANCE ABUSE AND MOTHER/INFANT HEALTH. MMC ACCEPTED THIS RECOMMENDATION. A COMPLETE DESCRIPTION OF THE CHNA PROCESS IS PROVIDED IN MMC'S CHNA REPORT AT WWW.CHOOSEMEMORIAL.ORG/HEALTHYCOMMUNITIES.</p>

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

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

Form and Line Reference	Explanation
THE ABRAHAM LINCOLN MEMORIAL HOSPITAL	<p>PART V, SECTION B, LINE 5: THE ABRAHAM LINCOLN MEMORIAL HOSPITAL (ALMH) COLLABORATED WITH THE LOGAN COUNTY DEPARTMENT OF PUBLIC HEALTH TO COMPLETE A CHNA IN TY2017/FY2018. ALMH DID NOT RECEIVE ANY DIRECT WRITTEN COMMENTS ON THE 2015 CHNA OR IMPLEMENTATION STRATEGIES. COMMUNITY AND INTERNAL ADVISORY COMMITTEES WERE USED TO ANALYZE HEALTH DATA AND SELECT THE PRIORITIES. THE COMMUNITY ADVISORY COMMITTEE (CAC) CONSISTED OF OVER 20 MEMBERS FROM THE ALMH COMMUNITY HEALTH COLLABORATIVE NETWORK INCLUDING A FEDERALLY QUALIFIED HEALTH CENTER (SIU FAMILY HEALTH CENTER), COMMUNITY ACTION PARTNERSHIP OF CENTRAL ILLINOIS, GATEWAY FOUNDATION, MOMS WHO CARE, HEARTLAND COMMUNITY COLLEGE, LINCOLN COLLEGE, LINCOLN PARK DISTRICT, MEMORIAL BEHAVIORAL HEALTH, LOGAN COUNTY DEPARTMENT OF PUBLIC HEALTH, SIU SCHOOL OF MEDICINE, LOGAN COUNTY PROBATION, CHESTNUT HEALTH SYSTEM AND THE SIU OFFICE OF POPULATION SCIENCE AND POLICY. THE INTERNAL ADVISORY COMMITTEE (IAC) INCLUDED A VARIETY OF STAKEHOLDERS INCLUDING REPRESENTATIVES FROM THE ALMH FOUNDATION, COMMUNITY ACTION PARTNERSHIP OF CENTRAL ILLINOIS, LINCOLN SCHOOL DISTRICT 27, PRIVATE BUSINESSES, LINCOLN AREA YMCA, LINCOLN POLICE DEPARTMENT, LINCOLN PARK DISTRICT, LOGAN COUNTY PARKS AND TRAILS FOUNDATION, LOGAN COUNTY REGIONAL PLANNING COMMISSION, LOGAN COUNTY DEPARTMENT OF PUBLIC HEALTH AND MEMORIAL BEHAVIORAL HEALTH. IN THE FALL AND WINTER OF 2017, THE CAC REVIEWED OUTCOMES OF THE 2015 CHNA IMPLEMENTATION STRATEGIES, DISCUSSED SOCIAL DETERMINANTS OF HEALTH, AND REVIEWED AN OVERVIEW OF SECONDARY DATA TO HELP DETERMINE PRIORITIES FOR THE 2018 CHNA. THE CAC HAD AN OPPORTUNITY TO PROVIDE INPUT ON KEY COMMUNITY ISSUES. THE DOT METHOD/DOTMOCRACY WAS THE METHOD CHOSEN TO NARROW THE LIST OF 25 POTENTIAL PRIORITIES. 10 AREAS OF NEED FOR LOGAN COUNTY WERE IDENTIFIED BASED ON THE PREDEFINED CRITERIA OF MAGNITUDE, SERIOUSNESS, FEASIBILITY AND TRIPLE AIM, ALONG WITH IDENTIFIED INCREASES IN OCCURRENCE AND TIMELINE TRENDING IDENTIFIED IN THE SECONDARY DATA. IN FEBRUARY/MARCH 2018, UNIVERSITY OF ILLINOIS AT SPRINGFIELD'S SURVEY RESEARCH PROGRAM CONDUCTED A COMMUNITY SURVEY. PARTICIPANTS WERE ASKED TO RANK THE 10 PRIORITIES AND WERE ENCOURAGED TO IDENTIFY ADDITIONAL CONCERNS. A TOTAL OF 565 INDIVIDUALS COMPLETED THE SURVEY. THE SURVEY SHOWED SIMILAR RESULTS FOR THE TOP 10 AREAS OF COMMUNITY CONCERN. THESE 10 PRIORITIES WERE PRESENTED TO THE IAC FOR REVIEW. ONCE AGAIN MAGNITUDE, SERIOUSNESS, FEASIBILITY AND TRIPLE AIM WERE TAKEN INTO CONSIDERATION. THE IAC RECEIVED A DETAILED REVIEW OF THE COMMUNITY SURVEY OUTCOMES, COMPLETED AN ASSET AND GAPS ANALYSIS AND DISCUSSED POPULATIONS DISPROPORTIONATELY AFFECTED. THE IAC RECOMMENDED FOUR FINAL ISSUES AS THE TOP PRIORITIES FOR THE HOSPITAL TO ADDRESS IN LOGAN COUNTY: MENTAL HEALTH, SUBSTANCE ABUSE, CANCER AND OBESITY. A COMPLETE DESCRIPTION OF THE CHNA PROCESS IS PROVIDED IN ALMH'S CHNA REPORT AT WWW.CHOOSEMEMORIAL.ORG/HEALTHYCOMMUNITIES.</p>

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

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

Form and Line Reference	Explanation
TAYLORVILLE MEMORIAL HOSPITAL	<p>PART V, SECTION B, LINE 5: TAYLORVILLE MEMORIAL HOSPITAL (TMH) COLLABORATED WITH THE CHRISTIAN COUNTY DEPARTMENT OF PUBLIC HEALTH TO COMPLETE A CHNA IN TY2017/FY2018. TMH DID NOT RECEIVE ANY DIRECT WRITTEN COMMENTS ON THE 2015 CHNA OR IMPLEMENTATION STRATEGIES. FOR THE 2018 CHNA, COMMUNITY HEALTH NEEDS WERE PRIORITIZED BASED ON REVIEWS OF SECONDARY DATA, AS WELL AS PRIMARY DATA GATHERED FROM THE COMMUNITY ADVISORY COMMITTEE (CAC) COMPRISED OF TWELVE REPRESENTATIVES FROM COMMUNITY ORGANIZATIONS. THE CAC IS MADE UP OF REPRESENTATIVES FROM ORGANIZATIONS THAT SERVE LOW-INCOME, MINORITY AND AT-RISK POPULATIONS IN CHRISTIAN COUNTY. TWELVE ORGANIZATIONS PARTICIPATED ON THE CAC. THESE INCLUDED: CENTRAL COUNTIES HEALTH CENTER (A FEDERALLY QUALIFIED HEALTH CENTER), GREATER TAYLORVILLE CHAMBER OF COMMERCE, CHRISTIAN COUNTY MENTAL HEALTH ASSOCIATION, SPRINGFIELD CLINIC, TAYLORVILLE MINISTERIAL ALLIANCE, CHRISTIAN COUNTY YMCA, TAYLORVILLE COMMUNITY UNIT SCHOOL DISTRICT #3, CHRISTIAN COUNTY PREVENTION COALITION, TAYLORVILLE POLICE DEPARTMENT, UNITED WAY OF CHRISTIAN COUNTY, SENIOR CITIZENS OF CHRISTIAN COUNTY, AND GATEWAY FOUNDATION. THE SECONDARY DATA SOURCES INCLUDED, COUNTY HEALTH RANKINGS AND ROADMAPS, CHRISTIAN COUNTY 2016 COMMUNITY HEALTH ASSESSMENT SURVEY, CENTRAL COUNTIES FEDERALLY QUALIFIED HEALTH CLINIC (REPORT MADE TO HRSA), IDPH STATISTICS ON INCIDENCES OF STDs, IDPH "CANCER IN ILLINOIS" REPORT 2017, IDPH ILLINOIS STATE CANCER REGISTRY DATA, AND THE ILLINOIS YOUTH SURVEY 2016. THE MOST SIGNIFICANT SOURCE OF SECONDARY DATA WAS COLLECTED AND ANALYZED THROUGH CONDUENT'S HEALTHY COMMUNITIES INSTITUTE DATA PLATFORM. THE CAC MET ON DECEMBER 12, 2017 WHERE TAYLORVILLE MEMORIAL HOSPITAL AND CHRISTIAN COUNTY DEPARTMENT OF PUBLIC HEALTH PROVIDED AN OVERVIEW OF OUTCOMES OF THE 2015 CHNA AND IMPLEMENTATION STRATEGIES FOR THE HOSPITAL AND THE HEALTH DEPARTMENT'S IPLAN. TAYLORVILLE MEMORIAL HOSPITAL CONTRACTED WITH THE UNIVERSITY OF ILLINOIS AT SPRINGFIELD SURVEY RESEARCH DEPARTMENT TO CONDUCT THE CHRISTIAN COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT SURVEY FROM JANUARY 12 TO FEBRUARY 12, 2018. THE SURVEY TOOK PLACE ONLINE. BECAUSE EVERYONE DOES NOT HAVE COMPUTER ACCESS, PAPER COPIES OF THE SURVEY WERE ALSO AVAILABLE. A TOTAL OF 702 INDIVIDUALS COMPLETED THE SURVEY. THE CAC CONVENED FOR ITS FINAL MEETING ON MARCH 29, 2018. THE CAC MEMBERS IDENTIFIED THE TOP PRIORITIES AS: MENTAL HEALTH AND SUBSTANCE ABUSE. A COMPLETE DESCRIPTION OF THE CHNA PROCESS IS PROVIDED IN TMH'S CHNA REPORT AT WWW.CHOOSEMEMORIAL.ORG/HEALTHYCOMMUNITIES.</p>

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

Form and Line Reference	Explanation
PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION	<p>PART V, SECTION B, LINE 5: PASSAVANT AREA HOSPITAL (PAH) COLLABORATED WITH THE MORGAN COUNTY HEALTH DEPARTMENT (MCHD) TO COMPLETE ITS CHNA IN TY2017/FY2018. NO DIRECT WRITTEN FEEDBACK WAS RECEIVED, OTHER THAN SEVERAL ARTICLES IN THE NEWSPAPER COMMENDING THE COLLABORATION. COMMUNITY HEALTH NEEDS WERE PRIORITIZED BASED ON REVIEWS OF SECONDARY COMMUNITY DATA, AS WELL AS PRIMARY DATA GATHERED BY A COMMUNITY ADVISORY COMMITTEE (CAC) COMPRISED OF 15 REPRESENTATIVES FROM THE FOLLOWING COMMUNITY ORGANIZATIONS: JACKSONVILLE SCHOOL DISTRICT117/ EARLY YEARS PROGRAM, SERVES CHILDREN AGES 3-18; PRAIRIE COUNCIL ON AGING; SIU CENTER FOR FAMILY MEDICINE (FQHC); MEMORIAL BEHAVIORAL HEALTH; CENTRAL COUNTIES HEALTH CENTER (FQHC); JACKSONVILLE POLICE DEPARTMENT; MORGAN COUNTY SHERIFF; MORGAN COUNTY PROBATION; MORGAN COUNTY EMERGENCY SERVICES; SALVATION ARMY; ILLINOIS DEPARTMENT OF HUMAN SERVICES; MIDWEST YOUTH SERVICES; ELM CITY CENTER; LOCUST STREET RESOURCE CENTER; AND HOME INSTEAD SENIOR CARE. NOVEMBER 2017-TWO CAC MEETINGS WERE HELD. THE FORMAT OF THE MEETINGS INCLUDED A SHORT INTRODUCTION OF THE CHNA, A SUMMARY OF THE OUTCOMES FROM THE 2015 CHNA AND AN EXPLANATION OF THE 2018 PROCESS. THIS WAS FOLLOWED BY AN ENGAGING SESSION IN WHICH ATTENDEES WERE ASKED TO IDENTIFY THREE OF THE COUNTY'S HIGHEST UNMET NEEDS. THE EXERCISE GAVE US A COMPREHENSIVE SNAPSHOT OF THE NEEDS IN OUR COMMUNITY ACCORDING TO OUR SERVICE PROVIDERS. THESE RESULTS WERE COMBINED AND CATEGORIZED ACCORDING TO THE COUNTY HEALTH RANKING MODEL INTO FOUR CATEGORIES: HEALTH BEHAVIORS, CLINICAL CARE, SOCIAL AND ECONOMIC FACTORS AND PHYSICAL ENVIRONMENT. THE CAC WAS RECONVENED TO REVIEW HEALTH FACTORS AND START TO PRIORITIZE THEM BASED ON THEIR COLLECTIVE OPINIONS OF THE GREATEST NEED. THE GROUP WAS ASKED TO IDENTIFY A TOP-DOWN LIST OF THE FIVE HIGHEST-NEED PRIORITIES. THEY IDENTIFIED YOUTH SERVICES, MENTAL HEALTH, DRUG/ALCOHOL TREATMENT, STDs/EARLY SEXUAL HEALTH AND OBESITY. COMMON THEMES WERE ACCESS TO CARE, INFORMATION AND AFFORDABILITY. A SURVEY WAS CONDUCTED FOR MORGAN COUNTY BY THE UNIVERSITY OF ILLINOIS' SURVEY RESEARCH DEPARTMENT FROM JANUARY 12-FEBRUARY 12, 2018. 797 INDIVIDUALS COMPLETED THE SURVEY. THE CACS CONVENED FOR ITS FINAL MEETING ON MARCH 22, 2018. THE CAC RECEIVED A DETAILED REVIEW OF THE OUTCOMES OF THE COMMUNITY SURVEY. CAC MEMBERS REVIEWED THE SURVEY RESULTS AND ENGAGED IN AN EXERCISE TO BEGIN MAPPING AVAILABLE COMMUNITY RESOURCES IN THE AREAS OF UNMET NEED. NEXT, THE CAC REVISITED THE COUNTY HEALTH RANKING MODEL. WE USED THIS MODEL TO APPLY OUR RESEARCH AND EXPLORE HOW HEALTH FACTORS UNIQUE TO MORGAN COUNTY COULD BE ADDRESSED IN OUR IMPLEMENTATION STRATEGY. THE PRIORITIES, ALONG WITH HEALTH FACTORS IDENTIFIED BY COMMUNITY MEMBERS WHO TOOK THE SURVEY, WERE CHARTED IN THE MODEL. AGENCY LEADERS WERE ASKED TO EVALUATE EACH FACTOR ON WHETHER THEIR ORGANIZATION HAS EXISTING PROACTIVE OR REACTIVE PROGRAMS. THIS EXERCISE CREATED A SNAPSHOT OF EXISTING RESOURCES AS THEY APPLY TO OUR HEALTH</p>

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

Form and Line Reference	Explanation
PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION	NEEDS, AND ALSO IDENTIFIED GAPS THAT EXIST IN SERVICES. UPON FINAL REVIEW OF THE RESEARCH AND FEEDBACK PROVIDED BY COMMUNITY RESOURCES, PAHS IDENTIFIED THREE PRIORITIES TO BE ADDRESSED: ACCESS TO CARE, SUBSTANCE ABUSE AND MENTAL HEALTH. A COMPLETE DESCRIPTION OF THE CHN A PROCESS IS PROVIDED IN PAH'S CHNA REPORT AT WWW.CHOOSEMEMORIAL.ORG/HEALTHYCOMMUNITIES .

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

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

Form and Line Reference	Explanation
DECATUR MEMORIAL HOSPITAL	PART V, SECTION B, LINE 5: DECATUR MEMORIAL HOSPITAL (DMH) COLLABORATED WITH THE MACON COUNTY HEALTH DEPARTMENT (MCHD) TO COMPLETE ITS CHNA IN TY2017/FY2018. NO DIRECT WRITTEN FEEDBACK WAS RECEIVED ON THIS PROCESS. COMMUNITY HEALTH NEEDS WERE PRIORITIZED BASED ON REVIEWS OF SECONDARY COMMUNITY DATA, AS WELL AS PRIMARY DATA GATHERED BY AN INTERNAL ADVISORY COMMITTEE (IAC) COMPRISED OF 6 REPRESENTATIVES FROM THROUGHOUT THE HOSPITAL. THE FOLLOWING COMMUNITY ORGANIZATIONS ALSO CONSULTED ON THIS PROCESS: DEVELOPMENT REVITALIZATION FOR THE CITY OF DECATUR, DECATUR ILLINOIS ECONOMIC DEVELOPMENT CORPORATION, AND HSHS ST. MARY'S HOSPITAL. A COMMUNITY SURVEY WAS CONDUCTED, WHICH IDENTIFIED MANY NEEDS THROUGHOUT THE COMMUNITY, MANY OF WHICH REGARDED ACCESS-ISSUES. 993 INDIVIDUALS COMPLETED THE SURVEY. IN SEPTEMBER 2018, A FOCUS GROUP OF 6 PARTICIPANTS MET TO FOCUS ON ACCESS NEEDS. UPON FINAL REVIEW OF THE RESEARCH AND FEEDBACK PROVIDED, DMH IDENTIFIED THREE PRIORITIES TO BE ADDRESSED: ACCESS TO CARE, SUBSTANCE ABUSE AND MENTAL HEALTH. A COMPLETE DESCRIPTION OF THE CHNA PROCESS IS PROVIDED IN DMH'S CHNA REPORT AT HTTPS://WWW.DMHCARES.COM/PUBLIC-INFORMATION/QUALITY-DATA/COMMUNITY-HEALTH-NEEDS-ASSESSMENT/ .

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
MEMORIAL MEDICAL CENTER	PART V, SECTION B, LINE 6A: MEMORIAL MEDICAL CENTER (MMC) CONDUCTED THE 2018 SANGAMON COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT IN COLLABORATION WITH HSHS ST. JOHN'S HOSPITAL.

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
MEMORIAL MEDICAL CENTER	PART V, SECTION B, LINE 6B: MMC COLLABORATED WITH THE SANGAMON COUNTY DEPARTMENT OF PUBLIC HEALTH ON THE CHNA, ASSISTING THE HEALTH DEPARTMENT IN COMPLETING ITS IPLAN FOR THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH. MMC AND COUNTY HEALTH DEPARTMENT PRODUCED SEPARATE REPORTS AND IMPLEMENTATION STRATEGIES.

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
THE ABRAHAM LINCOLN MEMORIAL HOSPITAL	PART V, SECTION B, LINE 6B: ALMH COLLABORATED WITH THE LOGAN COUNTY DEPARTMENT OF PUBLIC HEALTH ON THE CHNA, ASSISTING THE HEALTH DEPARTMENT IN COMPLETING ITS IPLAN FOR THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH. ALMH AND COUNTY HEALTH DEPARTMENT PRODUCED SEPARATE REPORTS AND IMPLEMENTATION STRATEGIES.

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

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

Form and Line Reference	Explanation
TAYLORVILLE MEMORIAL HOSPITAL	PART V, SECTION B, LINE 6B: TMH COLLABORATED WITH THE CHRISTIAN COUNTY HEALTH DEPARTMENT ON THE CHNA, ASSISTING THE HEALTH DEPARTMENT IN COMPLETING ITS IPLAN FOR THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH. TMH AND COUNTY HEALTH DEPARTMENT PRODUCED SEPARATE REPORTS AND IMPLEMENTATION STRATEGIES.

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION	PART V, SECTION B, LINE 6B: PAH COLLABORATED WITH THE MORGAN COUNTY HEALTH DEPARTMENT ON THE NEEDS ASSESSMENT, ASSISTING THE HEALTH DEPARTMENT IN COMPLETING ITS IPLAN FOR THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH. PAH AND COUNTY HEALTH DEPARTMENT PRODUCED SEPARATE REPORTS AND IMPLEMENTATION STRATEGIES.

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

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

Form and Line Reference	Explanation
DECATUR MEMORIAL HOSPITAL	PART V, SECTION B, LINE 6B: DMH COLLABORATED WITH THE MACON COUNTY HEALTH DEPARTMENT ON THE NEEDS ASSESSMENT, ASSISTING THE HEALTH DEPARTMENT IN COMPLETING ITS IPLAN FOR THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH. DMH AND COUNTY HEALTH DEPARTMENT PRODUCED SEPARATE REPORTS AND IMPLEMENTATION STRATEGIES.

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

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

Form and Line Reference	Explanation
MEMORIAL MEDICAL CENTER	PART V, SECTION B, LINE 7D: THE MEMORIAL HEALTH SYSTEM (MHS) COMMUNICATIONS TEAM ISSUED PRESS RELEASES TO COMMUNICATE CHNA OUTCOMES TO LOCAL MEDIA OUTLETS, WITH RESULTING COVERAGE BY THE LOCAL PAPER. MMC ALSO PROVIDED A PRESENTATION TO THE SPRINGFIELD CITIZENS CLUB ON DECEMBER 20, 2019. ALSO, THE MHS 2020 ANNUAL REPORT CONTAINS THE WEB ADDRESS TO DIRECT READERS TO THE CHNA REPORT. A PAPER COPY WILL BE PROVIDED TO ANYONE IN THE COMMUNITY UPON REQUEST.

Form 990 Part V Section C Supplemental Information for Part V, Section B.	
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 1j, 3, 4, 5d, 6i, 7, 10, 11, 12i, 14g, 16e, 17e, 18e, 19c, 19d, 20d, 21, and 22. If applicable, provide separate descriptions for each facility in a facility reporting group, designated by "Facility A," "Facility B," etc.	
Form and Line Reference	Explanation
THE ABRAHAM LINCOLN MEMORIAL HOSPITAL	PART V, SECTION B, LINE 7D: THE MHS COMMUNICATIONS TEAM ISSUED PRESS RELEASES TO COMMUNICATE CHNA OUTCOMES TO LOCAL MEDIA OUTLETS, WITH RESULTING COVERAGE BY THE LOCAL PAPER AND RADIO STATION. THE MHS 2020 ANNUAL REPORT CONTAINS THE WEB ADDRESS TO DIRECT READERS TO THE CHNA REPORT. A PAPER COPY WILL BE PROVIDED TO ANYONE IN THE COMMUNITY UPON REQUEST.

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

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

Form and Line Reference	Explanation
TAYLORVILLE MEMORIAL HOSPITAL	PART V, SECTION B, LINE 7D: THE MHS COMMUNICATIONS TEAM ISSUED PRESS RELEASES TO LOCAL MEDIA OUTLETS, WITH RESULTING COVERAGE BY THE LOCAL PAPER, THE BREEZE-COURIER, AND RADIO STATION WTIM-AM, TO ANNOUNCE THE COMPLETION OF THE COMMUNITY NEEDS ASSESSMENT IN DECEMBER 2018. TMH ALSO DISTRIBUTED NEWS RELEASES TO MORE THAN A DOZEN MEDIA CONTACTS IN THE TAYLORVILLE AREA. ALSO, THE MHS ANNUAL REPORT AND TMH COMMUNITY BENEFIT ANNUAL REPORT CONTAIN THE WEB ADDRESS TO DIRECT READERS TO THE CHNA REPORT. A PAPER COPY WILL BE PROVIDED TO ANYONE IN THE COMMUNITY UPON REQUEST.

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

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

Form and Line Reference	Explanation
PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION	PART V, SECTION B, LINE 7D: THE MHS COMMUNICATIONS TEAM ISSUED PRESS RELEASES TO COMMUNICATE CHNA OUTCOMES TO LOCAL MEDIA OUTLETS, WITH RESULTING COVERAGE BY THE JACKSONVILLE JOURNAL COURIER. PAH ALSO PROVIDED A PRESENTATION TO THE COMMUNITY OUTREACH COMMITTEE ON OCTOBER 28, 2018. ALSO, THE MHS 2020 ANNUAL REPORT CONTAINS THE WEB ADDRESS TO DIRECT READERS TO THE CHNA REPORT. A PAPER COPY WILL BE PROVIDED TO ANYONE IN THE COMMUNITY UPON REQUEST.

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

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

Form and Line Reference	Explanation
MEMORIAL MEDICAL CENTER	<p>PART V, SECTION B, LINE 11: MEMORIAL MEDICAL CENTER'S (MMC) SANGAMON COUNTY CHNA IDENTIFIED NINE FINAL PRIORITIES THAT WERE RECOMMENDED BY ITS COMMUNITY ADVISORY COMMITTEE (CAC) TO BE INCLUDED ON THE COMMUNITY SURVEY. FOLLOWING THE SURVEY, THE CAC RECOMMENDED FOUR TOP PRIORITIES, WHICH MMC SELECTED AS ITS FINAL PRIORITIES TO ADDRESS IN 2019-2021 IMPLEMENTATION STRATEGY. FIRST, ACCESS TO CARE WILL BE ADDRESSED THROUGH A COMMUNITY HEALTH WORKER PROGRAM IN TWO AT-RISK NEIGHBORHOODS; BY PROVIDING SUPPORT TO SIU SCHOOL OF MEDICINE TO CONTINUE EDUCATING THE NEXT GENERATION OF PHYSICIANS; AND SUPPORT FOR BUILDING A NEW YMCA IN DOWNTOWN SPRINGFIELD. SECOND, MENTAL HEALTH WILL BE ADDRESSED BY CONTINUING TO OFFER MENTAL HEALTH FIRST AID TRAINING TO THE COMMUNITY; SUPPORT FOR THE CHILDREN'S MOSAIC MENTAL HEALTH PROGRAMS IN SCHOOLS; SUPPORT FOR GIRLS ON THE RUN; AND PROVIDING FUNDING FOR MEMORIAL BEHAVIORAL HEALTH TO COLLABORATE IN A NEW COMMUNITY OUTREACH AND ENGAGEMENT TEAM TO RESPOND TO CRISIS CALLS WITH THE SPRINGFIELD POLICE DEPARTMENT THAT DEAL WITH MENTAL ILLNESS, HOMELESSNESS AND SUBSTANCE ABUSE. THIRD, MMC WILL ADDRESS SUBSTANCE ABUSE THROUGH SYSTEM-WIDE WORK WITH MHS AFFILIATES TO COMBAT OPIOID ABUSE, AND WILL COORDINATE THE WORK WITH OTHER HOSPITALS AND MEDICAL GROUPS. ALSO, MHS IS DEVELOPING A SYSTEM-WIDE INITIATIVE TO EXPAND ACCESS TO SUBSTANCE USE SERVICES. THE FINAL PRIORITY, MOTHER/INFANT HEALTH, WILL BE ADDRESSED THROUGH SUPPORT OF THE NURSE FAMILY PARTNERSHIP IN COLLABORATION WITH OTHER COMMUNITY PROVIDERS AND, WITH HSHS ST. JOHN'S HOSPITAL AND THE SANGAMON COUNTY DEPARTMENT OF PUBLIC HEALTH, ADDRESS INFANT MORTALITY, PARTICULARLY ACCIDENTAL ASPHYXIATION THROUGH MARCH 2020. THERE WERE FIVE NON-PRIORITIZED SIGNIFICANT HEALTH NEEDS THAT MMC DID NOT INCLUDE IN ITS IMPLEMENTATION STRATEGY. (1) HOUSING IS NOT A CORE COMPETENCY OF MMC, AND THERE ARE A NUMBER OF OTHER ORGANIZATIONS ALREADY ADDRESSING THIS ISSUE IN THE COMMUNITY. THE CAC DID NOT RECOMMEND THAT THE MMC SELECT THIS A FINAL PRIORITY. (2) VIOLENT CRIME - MMC DOES NOT HAVE THE EXPERTISE TO ADDRESS THIS ISSUE DIRECTLY OR THE RESOURCES TO LEAD AN INITIATIVE, ALTHOUGH IT DOES WORK WITH BOTH INDIVIDUALS AND ORGANIZATIONS ON ISSUES OF INDIVIDUAL AND PUBLIC SAFETY. (3) EDUCATION - THE CAC RECOMMENDED THAT THE MMC FOCUS ON OTHER INITIATIVES WHICH ARE A HIGHER PRIORITY. (4) FOOD ACCESS - THE ASSETS/GAPS PROCESS SHOWED THAT THIS ISSUE IS BEING ADDRESSED THROUGH NUMEROUS OTHER AGENCIES AND COMMUNITY RESOURCES. (5) CHILD ABUSE - ISSUES OF CHILD ABUSE ARE DEALT WITH ON AN INDIVIDUAL BASIS IN THE MMC EMERGENCY DEPARTMENT, MEMORIAL PHYSICIAN SERVICES AND MEMORIAL BEHAVIORAL HEALTH. HOWEVER, THE MMC DOES NOT HAVE THE EXPERTISE TO ADDRESS THIS ISSUE ON A COMMUNITY-WIDE BASIS. (6) ASTHMA - THIS ISSUE WAS NOT A HIGH PRIORITY IN THE COMMUNITY SURVEY OR FOR THE CAC. MMC CHOSE TO ADDRESS OTHER, HIGHER-PRIORITY ISSUES.</p>

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

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

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

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

Form and Line Reference	Explanation
TAYLORVILLE MEMORIAL HOSPITAL	<p>PART V, SECTION B, LINE 11: TAYLORVILLE MEMORIAL HOSPITAL (TMH) REVIEWED DATA, OFFERED ADD ITIONAL INSIGHTS ON ISSUES AFFECTING THE COMMUNITY AND RANKED THE PRIORITIES USING THE DEF INED CRITERIA. THE CAC IDENTIFIED SIX PRIORITY HEALTH NEEDS: CANCER, DIABETES, OBESITY, ME NTAL HEALTH, SUBSTANCE ABUSE, AND SEXUALLY TRANSMITTED DISEASES THAT WERE RECOMMENDED TO B E INCLUDED ON THE COMMUNITY SURVEY. FOLLOWING THE SURVEY, THE EXTERNAL ADVISORY GROUP, INC LUDING REPRESENTATIVES FROM PUBLIC HEALTH, SOCIAL SERVICES ORGANIZATIONS AND THOSE OFFERIN G CARE UNDERSERVED POPULATIONS, AS WELL AS RECOMMENDATIONS FROM THE MEMORIAL HEALTH SYSTEM INTERNAL ADVISORY TEAM, REVIEWED THE SURVEY RESULTS AND DATA AND RECOMMENDED TWO TOP PRIO RITIES TO ADDRESS IN 2019-2021 IMPLEMENTATION STRATEGY. THE TWO FINAL PRIORITIES WERE SELE CTED: MENTAL HEALTH AND SUBSTANCE ABUSE (DRUGS, ALCOHOL AND TOBACCO). THESE WERE APPROVED BY THE TAYLORVILLE MEMORIAL HOSPITAL BOARD ON JULY 10, 2018. MENTAL HEALTH WILL BE ADDRESS ED BY CONTINUING TO OFFER MENTAL HEALTH FIRST AID TRAINING TO THE COMMUNITY, EXPANDING YOU TH-FOCUSED MENTAL HEALTH FIRST AID, SUPPORT FOR GIRLS ON THE RUN, CONTINUING TO OFFER SENI OR LIFE SOLUTIONS, AND DEVELOPING A "STEP-DOWN" PROGRAM FOR ON-GOING SUPPORT OF SENIOR LIF E SOLUTIONS GRADUATES. TMH WILL ADDRESS SUBSTANCE ABUSE THROUGH SYSTEM-WIDE WORK WITH MHS AFFILIATES TO COMBAT OPIOID ABUSE, AND WILL COORDINATE WORK WITH OTHER HOSPITALS AND MEDIC AL GROUPS. ALSO, MHS IS DEVELOPING A SYSTEM-WIDE INITIATIVE TO EXPAND ACCESS TO SUBSTANCE ABUSE TREATMENT. TMH WILL ALSO CONTINUE DONATION OF NARCAN TO LOCAL LAW ENFORCEMENT IN CHR ISTIAN COUNTY, FUND AN DRUG ABUSE PREVENTION PROGRAM FOR YOUTH IN TAYLORVILLE SCHOOLS BY T HE GROUP OVERDOSE LIFELINE, DEVELOP RESOURCES FOR TOBACCO CESSATION FOR THE COMMUNITY IN C OLLABORATION WITH THE AMERICAN LUNG ASSOCIATION, AND CONTINUE TO PROVIDE LEADERSHIP AND SU PPORT FOR THE INITIATIVES OF THE CHRISTIAN COUNTY PREVENTION COALITION AND FAMILIES ANONYM OUS PROGRAM. THERE WERE FOUR NON-PRIORITIZED SIGNIFICANT HEALTH NEEDS THAT TMH DID NOT INC LUDE IN ITS IMPLEMENTATION STRATEGY. (1) CANCER WAS NOT SELECTED BECAUSE IT WAS NOT RANKED BY THE CAC AS HAVING A HIGH PRIORITY AND THERE WAS OPPORTUNITY TO ADDRESS LUNG CANCER INC IDENCE WITH EFFORTS TO ADDRESS TOBACCO ABUSE. EXISTING ASSETS IN THE COMMUNITY WITH CANCER DIAGNOSIS AND TREATMENT WERE CONSIDERED TO BE WELL UTILIZED AND APPROPRIATE. THE CAC DID NOT RECOMMEND THAT THE HOSPITAL SELECT THIS AS A FINAL PRIORITY. (2 AND 3) OBESITY AND DIA BETES WERE ELIMINATED FROM FURTHER CONSIDERATION BECAUSE THE ADVISORY GROUP MEMBERS BELIEV ED THAT EFFORTS TO IMPROVE TREATMENT AND PREVENTION OF OBESITY WOULD ALSO POSITIVELY IMPAC T INCIDENCE OF DIABETES. TMH ALREADY DEVOTES SIGNIFICANT RESOURCES TO ADDRESSING DIABETES EDUCATION AND SUPPORT. TMH IS PARTNERING WITH THE LOCAL YMCA'S DIABETES PREVENTION PROGRAM . THE DECISION WAS MADE TO APPLY ADDITIONAL RESOURCES TO OTHER SELECTED PRIORITIES. (4) SE XUALLY TRANSMITTED DISEASES WA</p>

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

Form and Line Reference	Explanation
TAYLORVILLE MEMORIAL HOSPITAL	S NOT SELECTED BECAUSE IT WAS CONSISTENTLY RANKED LOW ON THE LIST OF PRIORITIES WITH BOTH THE COMMUNITY AND THE CAC. THE DECISION WAS MADE TO APPLY ADDITIONAL RESOURCES TO THE OTHE R SELECTED PRIORITIES.

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

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

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

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

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

Form and Line Reference	Explanation
DECATUR MEMORIAL HOSPITAL	PART V, SECTION B, LINE 11: DECATUR MEMORIAL HOSPITAL (DMH) REVIEWED SECONDARY DATA, CONDUCTED A COMMUNITY SURVEY AND FOCUS GROUPS AND RANKED THE PRIORITIES USING FEEDBACK FROM THESE PRIMARY SOURCES. SURVEY RESPONDENTS WERE ASKED ABOUT THE THREE MOST IMPORTANT FACTORS FOR A HEALTHY COMMUNITY, THREE MOST IMPORTANT HEALTH PROBLEMS, THREE MOST DANGEROUS RISKY BEHAVIORS, AND THE TOP THREE UNMET NEEDS FOR MACON COUNTY. THE IAC REVIEWED THE SURVEY RESULTS AND DATA AND RECOMMENDED THREE TOP PRIORITIES TO ADDRESS IN THE 2019-2021 IMPLEMENTATION STRATEGY. THERE WERE MANY NEEDS IDENTIFIED THROUGH THE ASSESSMENT PROCESS THAT DMH WILL NOT BE DIRECTLY ADDRESSING, SUCH AS ACCESS TO SAFE NEIGHBORHOODS, DUE TO SCOPE OF NEED AND ABILITY TO MAKE AN IMPACT. THE FINAL PRIORITIES SELECTED WERE: MENTAL HEALTH, ACCESS TO CARE, AND SUBSTANCE USE. SINCE THE AFFILIATION OF DMH WITH MHS, MENTAL HEALTH IS BEING ADDRESSED BY CONTINUING TO OFFER FINANCIAL ASSISTANCE TO THE BABYTALK PROGRAM AND OFFERING VARIOUS SUPPORT GROUPS TO MACON COUNTY RESIDENTS. ACCESS TO CARE IS BEING SUPPORTED THROUGH CONTINUED FINANCIAL AND IN-KIND SUPPORT OF SIU SCHOOL OF MEDICINE, PROVIDING TOKENS FOR TRANSPORTATION TO INDIGENT PATIENTS/VISITORS, AND PROVIDING MEMORIAL WEIGHT LOSS AND WELLNESS SERVICES IN MACON COUNTY. SUBSTANCE USE IS BEING ADDRESSED THROUGH OUR PARTICIPATION ON THE MACON COUNTY SUBSTANCE USE TASK-FORCE, AS WELL AS HEALTH-SYSTEM WIDE STRATEGIES TO COMBAT THE USE OF OPIOIDS THROUGH PRESCRIPTION STEWARDSHIP.

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

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

Form and Line Reference	Explanation
LINE 13A	MHS USES AN AMOUNT IN EXCESS OF 300% OF THE FPG AS A FACTOR IN DETERMINING ELIGIBILITY FOR PROVIDING PARTIAL FINANCIAL ASSISTANCE TO THE UNINSURED. THE VALUE OF 301% WAS ENTERED TO SATISFY A MANDATORY FIELD ENTRY REQUIREMENT TO QUALIFY FOR ELECTRONIC FILING.

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

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

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

Name and address	Type of Facility (describe)
1 1 - DMH ENDOSCOPY CENTER 2 MEMORIAL DR PHYS PLZ WEST STE 102 DECATUR, IL 62526	AMBULATORY ENDOSCOPY CENTER
1 2 - FORSYTH IMAGING CENTER 389 WEST WEAVER ROAD FORSYTH, IL 62535	DIAGNOSTIC CENTER
2 3 - SOUTH SHORES IMAGING CENTER 1689 S FRANKLIN ST DECATUR, IL 62521	DIAGNOSTIC CENTER
3 4 - SPORTS PERFORMANCE ENHANCEMENT CENTER 2122 NORTH 27TH ST DECATUR, IL 62526	PHYSICAL THERAPY
4 5 - MEMORIAL PHYSICIAN SERVICES-KOKE MILL 3132 OLD JACKSONVILLE RD SPRINGFIELD, IL 62704	MPS PHYSICIAN
5 6 - DMH SURGERY CENTER 304 W HAY SUITE 114 DECATUR, IL 62526	AMBULATORY SURGERY CENTER
6 7 - MEMORIAL PHYS SVCS-JACKSONVILLE 15 FOUNDERS LANE SUITE 100 JACKSONVILLE, IL 62650	MPS PHYSICIAN
7 8 - MEMORIAL PHYSICIAN SERVICES-LINCOLN 515 NORTH COLLEGE STREET LINCOLN, IL 62526	MPS PHYSICIAN
8 9 - MEMORIAL PHYS SVCS-WOMEN'S HEALTHCARE 747 NORTH RUTLEDGE SPRINGFIELD, IL 62701	MPS PHYSICIAN
9 10 - DMH HOME HEALTH CARE 2870 NORTH MAIN ST DECATUR, IL 62526	HOME HEALTH AGENCY
10 11 - MEMORIAL PHYSICIAN SERVICES-CHATHAM 101 EAST PLUMMER CHATHAM, IL 62629	MPS PHYSICIAN
11 12 - MEMORIAL EXPRESSCARE AT NORTH DIRKSEN 3220 ATLANTA STREET SPRINGFIELD, IL 62702	ANCILLARY SERVICES
12 13 - DECATUR MEMORIAL EXPRESS CARES 2300 NORTH EDWARD ST DECATUR, IL 62526	ANCILLARY SERVICES
13 14 - MEMORIAL EXPRESSCARE AT SOUTH SIXTH 2950 SOUTH SIXTH STREET SPRINGFIELD, IL 62703	ANCILLARY SERVICES
14 15 - MEMORIAL PHYSICIAN SVCS-VINE STREET 3225 HEDLEY RD SPRINGFIELD, IL 62711	MPS PHYSICIAN

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

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

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

Name and address	Type of Facility (describe)
16 16 - DECATUR MEDICAL GROUP CARDIOLOGY 2300 NORTH EDWARD ST DECATUR, IL 62526	OUTPATIENT SERVICES
1 17 - MEMORIAL EXPRESSCARE AT KOKE MILL 3132 OLD JACKSONVILLE RD SPRINGFIELD, IL 62704	ANCILLARY SERVICES
2 18 - DECATUR MEDICAL GROUP ENTA 101 W MCKINLEY COURT DECATUR, IL 62526	OUTPATIENT SERVICES
3 19 - DECATUR MEDICAL GROUP GENERAL SURGERY 302 W HAY STREET SUITE 205 DECATUR, IL 62526	OUTPATIENT SERVICES
4 20 - DECATUR MEDICAL GROUP NEPHROLOGY 241 W WEAVER STREET SUITE 210 FORSYTH, IL 62535	OUTPATIENT SERVICES
5 21 - MEMORIAL EXPRESSCARE AT CHATHAM 101 EAST PLUMMER CHATHAM, IL 62629	ANCILLARY SERVICES
6 22 - SPORTSCARE AT YMCA 4550 WEST ILES SPRINGFIELD, IL 62711	OUTPATIENT SERVICES
7 23 - DECATUR MEDICAL GROUP VASCULAR 302 W HAY STREET SUITE 205 DECATUR, IL 62526	OUTPATIENT SERVICES
8 24 - MEMORIAL PHYSICIAN SVCS-PETERSBURG 1 CENTRE DRIVE PETERSBURG, IL 62675	MPS PHYSICIAN
9 25 - MEMORIAL INDUSTRIAL REHAB 775 ENGINEERING DRIVE SPRINGFIELD, IL 62703	OUTPATIENT SERVICES
10 26 - DECATUR MEDICAL GROUP ORTHO 304 W HAY STREET SUITE 111 DECATUR, IL 62526	OUTPATIENT SERVICES
11 27 - DECATUR MEDICAL GROUP NEUROLOGY 2 MEMORIAL DRIVE SUITE 207 DECATUR, IL 62526	OUTPATIENT SERVICES
12 28 - DMH HOSPICE 2870 NORTH MAIN ST DECATUR, IL 62526	HOSPICE AGENCY
13 29 - MEMORIAL PHYSICIAN SVCS-NORTH DIRKSEN 3220 ATLANTA STREET SPRINGFIELD, IL 62707	MPS PHYSICIAN
14 30 - WOUND HEALING CENTER 901 NORTH FIRST STREET SPRINGFIELD, IL 62702	OUTPATIENT SERVICES

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

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

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

Name and address	Type of Facility (describe)
31 31 - SPINWORKS PAIN CENTER 501 NORTH FIRST STREET SPRINGFIELD, IL 62702	OUTPATIENT SERVICES
1 32 - DECATUR MEDICAL GROUP PULMONOLOGY 2300 NORTH EDWARD ST DECATUR, IL 62526	OUTPATIENT SERVICES
2 33 - DECATUR MEDICAL GROUP FORSYTH 241 WEAVER ROAD SUITE 145-C FORSYTH, IL 62535	DMG PHYSICIAN
3 34 - DECATUR MEDICAL GRP GASTROENTEROLOGY 2 MEMORIAL DR PHYS PLZ WEST STE 101 DECATUR, IL 62526	OUTPATIENT SERVICES
4 35 - DMH OCC HEALTH & WELLNESS PARTNERS 2122 NORTH 27TH ST DECATUR, IL 62526	OUTPATIENT SERVICES
5 36 - DECATUR MED GRP INTERNAL MEDICINE ASSOCI 304 W HAY STREET SUITE 312 DECATUR, IL 62526	OUTPATIENT SERVICES
6 37 - DECATUR MEDICAL GROUP PODIATRY 2 MEMORIAL DRIVE SUITE 305 DECATUR, IL 62526	OUTPATIENT SERVICES
7 38 - DECATUR MED GRP INFECTIOUS DISEASE 304 W HAY STREET SUITE 212 DECATUR, IL 62526	OUTPATIENT SERVICES
8 39 - DECATUR MEDICAL GROUP YOUNGERMAN ONE MEMORIAL DRIVE SUITE 110 DECATUR, IL 62526	DMG PHYSICIAN
9 40 - DECATUR MEDICAL GROUP MT ZION 4775 E MARYLAND AVENUE DECATUR, IL 62526	DMG PHYSICIAN
10 41 - DECATUR MEDICAL GROUP UROLOGY 302 W HAY STREET SUITE 200 DECATUR, IL 62526	OUTPATIENT SERVICES
11 42 - MEMORIAL PHYSICIAN SVCS-SOUTH SIXTH 2950 SOUTH SIXTH STREET SPRINGFIELD, IL 62703	MPS PHYSICIAN
12 43 - MEMORIAL PHYSICIAN SVCS-MACARTHUR 2115 SOUTH MACARTHUR BLVD SPRINGFIELD, IL 62704	MPS PHYSICIAN
13 44 - DECATUR MEDICAL GROUP ROCK SPRINGS 330 N WYCKLES ROAD DECATUR, IL 62526	DMG PHYSICIAN
14 45 - DECATUR MEDICAL GROUP MCCORMACK 241 WEAVER ROAD SUITE 240 FORSYTH, IL 62535	DMG PHYSICIAN

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

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

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

Name and address	Type of Facility (describe)
46 46 - DECATUR MEDICAL GROUP WEST HAY 304 W HAY STREET SUITE 218 DECATUR, IL 62526	DMG PHYSICIAN
1 47 - DECATUR MEDICAL GRP INTERNAL MEDICINE 2975 N WATER STREET DECATUR, IL 62526	OUTPATIENT SERVICES
2 48 - DECATUR MEDICAL GROUP SOUTH SHORES 550 SOUTHLAND DRIVE SUITE 1 DECATUR, IL 62526	DMG PHYSICIAN
3 49 - DECATUR MEDICAL GROUP SULLIVAN 1220 W JACKSON STREET SULLIVAN, IL 61951	DMG PHYSICIAN
4 50 - JBS BEARDSTOWN 8460 ST LUKES DRIVE BEARDSTOWN, IL 62618	OUTPATIENT SERVICES
5 51 - CONCORDIA VILLAGE 4101 WEST ILES AVENUE SPRINGFIELD, IL 62711	OUTPATIENT SERVICES
6 52 - DECATUR MEDICAL GROUP SHELBYVILLE 415 N CEDAR STREET SHELBYVILLE, IL 62565	DMG PHYSICIAN
7 53 - DECATUR MEDICAL GROUP ARTHUR 650 W COLUMBIA STREET ARTHUR, IL 61911	DMG PHYSICIAN
8 54 - DMH HEALTH AND WELLNESS CENTER 2122 NORTH 27TH ST DECATUR, IL 62526	WELLNESS CENTER
9 55 - TLEHEALTH 701 NORTH FIRST STREET SPRINGFIELD, IL 62781	VIRTUAL CARE
10 56 - DECATUR MEDICAL GROUP MILLIKIN 150 S FAIRVIEW AVENUE DECATUR, IL 62522	DMG PHYSICIAN
11 57 - DECATUR MEDICAL GROUP MONTICELLO 777 BRIDGE STREET MONTICELLO, IL 61856	DMG PHYSICIAN
12 58 - DECATUR MEDICAL GRP SIGNATURE HEALTH 389 W WEAVER STREET SUITE 100 FORSYTH, IL 62535	OUTPATIENT SERVICES
13 59 - MEMORIAL EXPRESSCARE AT NORTH WATER 3131 N WATER ST DECATUR, IL 62526	ANCILLARY SERVICES
14 60 - DECATUR MEDICAL GROUP GERIATRIC PSYCH 102 W KENWOOD COURT SUITE 120 DECATUR, IL 62526	OUTPATIENT SERVICES

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

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

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

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

Name and address	Type of Facility (describe)
61 61 - DECATUR MEDICAL GROUP SNAP MD 2300 NORTH EDWARD ST DECATUR, IL 62526	OUTPATIENT SERVICES
1 62 - DECATUR MEDICAL GROUP GOWDAR 741 W PERSHING ROAD DECATUR, IL 62526	DMG PHYSICIAN

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

Schedule I
(Form 990)

Grants and Other Assistance to Organizations,
Governments and Individuals in the United States
Complete if the organization answered "Yes," on Form 990, Part IV, line 21 or 22.
▶ Attach to Form 990.
▶ Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2019

Open to Public
Inspection

Department of the
Treasury
Internal Revenue Service

Name of the organization
MEMORIAL HEALTH SYSTEM GROUP

Employer identification number
90-0756744

Part I General Information on Grants and Assistance

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

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

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

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table ▶ 20

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

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

Part III can be duplicated if additional space is needed.

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

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

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

Additional Data

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

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
ILLINOIS HOSPITAL RESEARCH AND EDUCATION FOUNDATION 1151 EAST WARRENVILLE ROAD NAPERVILLE, IL 60566	23-7421930	501(C)(3)	53,496				SEE PART IV CONTRIBUTION TO THE ILLINOIS HEALTH RESEARCH EDUCATIONAL FUND TO DONATE TO GRANT PROGRAM FOR HOSPITALS TO COVER A PORTION OF THE NET LOSS SUSTAINED FROM THE ILLINOIS PROVIDER ASSESSMENT PROGRAM.
KUMLER OUTREACH MINISTRIES 303 NORTH GRAND AVE EAST SPRINGFIELD, IL 62702	37-0695489	501(C)(3)	8,900				SEE PART IV PHARMACEUTICAL ASSISTANCE

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MEMORIAL HOME SERVICES 701 NORTH FIRST STREET SPRINGFIELD, IL 62781	37-0714225	501(C)(3)	15,014				SEE PART IV PROVIDE GENERAL SUPPORT.
MEMORIAL MEDICAL CENTER 701 NORTH FIRST STREET SPRINGFIELD, IL 62781	37-0661220	501(C)(3)	303,089				SEE PART IV PROVIDE SUPPORT FOR MCLI AND GENERAL SUPPORT.

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MENTAL HEALTH CENTERS OF CENTRAL ILLINOIS 701 NORTH FIRST STREET SPRINGFIELD, IL 62781	37-0646367	501(C)(3)	251,423				SEE PART IV PROVIDE GENERAL SUPPORT, MOSAIC PROGRAM TO PROVIDE CHILDREN'S MENTAL HEALTH SERVICES BY INCREASING THE NUMBER OF BEHAVIORAL HEALTH CLINICIANS SERVING SPRINGFIELD 186 SCHOOLS, AND COMMUNITY OUTREACH AND ENGAGEMENT TEAM (COET) TO RESPOND TO CRISIS CALLS WITH SIU MEDICINE AND THE SPRINGFIELD POLICE DEPARTMENT.
PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION 701 NORTH FIRST STREET SPRINGFIELD, IL 62781	37-0661230	501(C)(3)	344,004	10,449	OTHER	SUPPLIES AND FOOD	SEE PART IV PROVIDE GENERAL SUPPORT, EQUIPMENT AND SUPPLIES, COMMUNITY HEALTH IMPROVEMENT, AND COMMUNITY HEALTH SUPPORT.

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
SIU PHYSICIANS & SURGEONS INC DBA SIU HEALTHCARE PO BOX 19639 SPRINGFIELD, IL 62794	36-4143823	501(C)(3)	2,567,356				SEE PART IV MEMORIAL MEDICAL CENTER ENTERED INTO AN ELECTRONIC HEALTH RECORD DONATION AGREEMENT WITH SIU HEALTHCARE TO PROVIDE FUNDING TO ASSIST SIU HEALTHCARE WITH THE IMPLEMENTATION OF THE ALLSCRIPTS TOUCHWORKS ELECTRONIC HEALTH RECORD. SIU HEALTHCARE ELECTED TO TRANSITION TO THE ALLSCRIPTS ELECTRONIC HEALTH RECORD IN COLLABORATION WITH MEMORIAL PHYSICIAN SERVICES, AN AFFILIATE OF MEMORIAL HEALTH SYSTEM, AND THE SPRINGFIELD CLINIC, LLP. THIS COLLABORATION AMONG THE MAJOR PHYSICIAN GROUPS IN THE COMMUNITY WILL IMPROVE THE COORDINATION OF CARE FOR ALL PATIENTS THROUGHOUT THE REGION. MMC HAS ALSO ENTERED INTO AN AGREEMENT WITH SIU HEALTHCARE TO CONTRIBUTE FROM MMC'S FUNDING FOR THE ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES ASSESSMENT PROGRAM TO SIU'S ALZHEIMERS DISEASE AND RELATED DISORDERS PROGRAM. MMC HAS ALSO CONTRIBUTED TOWARDS THE ACCESS TO CARE COLLABORATIVE, A PROGRAM THAT IS ADDRESSING ACCESS TO CARE.
SIU SCHOOL OF MEDICINE 801 NORTH RUTLEDGE SPRINGFIELD, IL 62702	37-6005961	501(C)(3)	3,799,876				SEE PART IV PROVIDE GENERAL SUPPORT.

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
TAYLORVILLE MEMORIAL HOSPITAL 701 NORTH FIRST STREET SPRINGFIELD, IL 62781	37-0661250	501(C)(3)	169,227	11,338	FMV	GENERAL AND COVID SUPPLIES AND FOOD	SEE PART IV ASSIST WITH CAPITAL PROJECT, MEDICAL TECHNOLOGIES AND PATIENT SERVICES, GENERAL AND COVID SUPPLIES AND FOOD.
YMCA 701 SOUTH FOURTH STREET SPRINGFIELD, IL 62703	37-0661263	501(C)(3)	5,200,000				SEE PART IV TO CONNECT PEOPLE OF ALL AGES AND BACKGROUNDS TO BRIDGE THE GAP IN COMMUNITY NEEDS SO THAT EVERYONE HAS THE OPPORTUNITY TO LEARN, GROW AND THRIVE.

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
UNIVERISTY OF ILLINOIS FOUNDATION 1305 W GREEN ST URBANA, IL 61801	37-6006007	501(C)(3)	1,500,000				SEE PART IV TO BUILD NURSING PROGRAMS IN PARTNERSHIP WITH UIS AND UIC NURSING FOR THE BENEFIT OF CENTRAL ILLINOIS.
JACKSONVILLE PUBLIC SCHOOL DISTRICT #117 211 W STATE JACKSONVILLE, IL 62650	37-6004176	501(C)(3)	21,000				SEE PART IV COMMUNITY HEALTH IMPROVEMENT.

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
LINCOLN LAND COMMUNITY COLLEGE FOUNDATION 5250 SHEPERD RD SPRINGFIELD, IL 62794	37-1360597	501(C)(3)	6,082,978				SEE PART IV EXPANDED NURSING EDUCATION PARTNERSHIP TO INCREASE ENROLLMENT CAPACITY FOR NURSING STUDENTS AND THE REGIONAL NURSING WORKFORCE TO BETTER SERVE PATIENTS THROUGHOUT CENTRAL AND SOUTHERN ILLINOIS.
SPRINGFIELD AND CENTRAL ILLINOIS AFRICAN AMERICAN HISTORY MUSEUM 1440 MONUMENT AVE SPRINGFIELD, IL 62702	02-0775028	501(C)(3)	7,500				SEE PART IV PROVIDED SUPPORT TO CONTINUE THE MUSEUMS MISSION OF IDENTIFYING, COLLECTING, MAINTAINING AND EXHIBITING THE HISTORIES OF AFRICAN AMERICANS WITH A FOCUS ON CENTRAL ILLINOIS.

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
KIDZEUM 412 E ADAMS ST SPRINGFIELD, IL 62701	37-1320003	501(C)(3)	50,000				SEE PART IV PROVIDE SUPPORT FOR THE KIDZEUM HEALTH AND SCIENCE MUSEUM WHICH HAS A VERY STRONG HEALTH EDUCATION COMPONENT FOR CHILDREN.
GIRLS ON THE RUN SPRINGFIELD 907 CLOCKTOWER DR SPRINGFIELD, IL 62704	27-1822009	501(C)(3)	7,500				SEE PART IV PROVIDE SUPPORT FOR POSITIVE YOUTH DEVELOPMENT FOR GIRLS, 3RD-8TH GRADE. LIFE SKILLS ARE TAUGHT THROUGH DYNAMIC INTERACTIVE LESSONS AND RUNNING GAMES. THE GOAL OF THE PROGRAM IS TO UNLEASH CONFIDENCE THROUGH ACCOMPLISHMENT WHILE ESTABLISHING A LIFETIME APPRECIATION OF HEALTH AND FITNESS.

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
LINCOLN ECONOMIC ADVANCEMENT & DEVELOPMENT 1 BURWELL DR LINCOLN, IL 626563086	84-3635858	501(C)(3)	150,000				SEE PART IV TO HELP THE ECONOMIC ADVANCEMENT AND DEVELOPMENT IN LINCOLN, IL.
LOGAN COUNTY PO BOX 400 LINCOLN, IL 62656	37-6001284			33,601	BOOK	DONATION OF OLD AMBULANCE GARAGE AND LAND	SEE PART IV DONATION OF OLD AMBULANCE GARAGE AND LAND.

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MEMORIAL HEALTH SYSTEM 701 NORTH FIRST STREET SPRINGFIELD, IL 62781	37-1110690	501(C)(3)		34,000	FMV	FOOD DONATIONS TO HOSPITAL DURING COVID.	SEE PART IV FOOD DONATIONS TO HOSPITAL DURING COVID.
DECATUR MEMORIAL HOSPITAL 701 NORTH FIRST STREET SPRINGFIELD, IL 62781	37-0661199	501(C)(3)	175,055				SEE PART IV PROVIDE GENERAL SUPPORT.

Form 990, Schedule I, Part II, Grants and Other Assistance to Domestic Organizations and Domestic Governments.							
(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CHILDREN'S MUSEUM OF ILLINOIS 55 SOUTH COUNTRY CLUB RD DECATUR, IL 62521	37-1235904	501(C)(3)	7,000				SEE PART IV 2020 MUSEUM SUMMER CAMP SPONSORSHIP.
WEST CENTRAL MASS TRANSIT 1120 W WALNUT JACKSONVILLE, IL 62650	87-0709277		30,000				SEE PART IV COMMUNITY HEALTH SUPPORT.

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

EDUCATIONAL ASSISTANCE PAYMENTS	228	870,732			
EDUCATIONAL ASSISTANCE PAYMENTS	228	870,732			
PRESCRIPTION DRUGS FOR PATIENTS	56	7,844			
SHELTER AND UTILITY ASSISTANCE FOR PATIENTS	89	56,333			
DIRECT CASH ASSISTANCE TO PATIENTS	92	33,789			
TRANSPORTATION ASSISTANCE FOR PATIENTS	145	34,679			

Form 990, Schedule I, Part III, Grants and Other Assistance to Domestic Individuals.					
EMPLOYEE ASSISTANCE	144	65,680			
EMPLOYEE ASSISTANCE	144	65,680			
TAYLORVILLE CUPS ASSISTANCE	18	3,916			
PEDIATRIC DENTISTRY	4	6,252			
COMMUNITY HEALTH OUTREACH	24	2,000			
MEALS AND GROCERIES FOR PATIENTS	54	21,020			

Schedule J (Form 990)	Compensation Information	OMB No. 1545-0047
		2019
		Open to Public Inspection
Department of the Treasury Internal Revenue Service	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.	
Name of the organization MEMORIAL HEALTH SYSTEM GROUP		Employer identification number 90-0756744

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

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

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

[illegible]

Part III Supplemental Information

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

Return Reference	Explanation
PART I, LINE 1A	CHARTER TRAVEL IS OCCASIONALLY PROVIDED FOR EXECUTIVES/KEY EMPLOYEES ATTENDING OFF-SITE BUSINESS RELATED MEETINGS, SO AS TO MINIMIZE TRAVEL TIME AND ENABLE THEM TO WORK EFFICIENTLY AND SECURELY ON CONFIDENTIAL ORGANIZATION BUSINESS MATTERS. CHARTER TRAVEL IS NOT TAXABLE INCOME TO THE INDIVIDUAL BECAUSE IT IS STRICTLY RELATED TO BUSINESS TRAVEL.
PART I, LINE 3	THE REPORTED COMPENSATION AND BENEFITS RECEIVED BY EDGAR CURTIS, PRESIDENT AND CEO OF MEMORIAL HEALTH SYSTEM, FOR CALENDAR YEAR 2019 (BEFORE THE COVID-19 PANDEMIC), WAS COMPRISED OF THE FOLLOWING COMPONENTS: BASE COMPENSATION, INCENTIVE COMPENSATION, OTHER COMPENSATION, RETIREMENT/DEFERRED COMPENSATION AND OTHER NONTAXABLE BENEFITS. MEMORIAL HEALTH SYSTEM, A RELATED ORGANIZATION OF MEMORIAL HEALTH SYSTEM GROUP, USES THE FOLLOWING TO ESTABLISH THE COMPENSATION OF THE ORGANIZATION'S CEO/EXECUTIVE DIRECTOR: 1) COMPENSATION COMMITTEE; 2) INDEPENDENT COMPENSATION CONSULTANT; 3) COMPENSATION SURVEY OR STUDY; AND 4) APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE. BASE COMPENSATION LEVELS WERE SET BY THE LEADERSHIP COMPENSATION COMMITTEE, WHICH IS A COMMITTEE OF THE MHS BOARD CONSISTING ENTIRELY OF MHS BOARD MEMBERS WHO ARE INDEPENDENT AND WHO ARE FREE OF ANY CONFLICTS OF INTEREST. BASE COMPENSATION IS SET AT OR AROUND THE MIDDLE OF THE MARKET BASE SALARY DATA FOR HEALTHCARE ORGANIZATIONS SIMILAR TO MHS, AS MEASURED AND PRESENTED TO THE COMMITTEE BY AN INDEPENDENT COMPENSATION CONSULTANT. INCENTIVE COMPENSATION WAS CONDITIONED ON ACHIEVEMENT OF SPECIFIC, RIGOROUS PERFORMANCE MEASURES ACROSS ALL OF MHS, AND THOSE PERFORMANCE MEASURES WERE REVIEWED AND APPROVED IN ADVANCE BY THE LEADERSHIP COMPENSATION COMMITTEE. RETIREMENT BENEFITS IN COLUMN (B)(III) IS COMPRISED PRIMARILY OF THE DISTRIBUTION OF VESTED AMOUNTS OF \$216,334 THAT WERE PREVIOUSLY DEPOSITED IN A DEFERRED COMPENSATION PLAN, BUT ARE NOW DISTRIBUTED DIRECTLY BECAUSE MR. CURTIS IS FULLY VESTED.
PART I, LINES 4A-B	THE FOLLOWING LISTED INDIVIDUALS RECEIVED THE FOLLOWING AMOUNTS IN THE FORM OF SEVERANCE BENEFITS, IN CONNECTION WITH A QUALIFYING TERMINATION OF EMPLOYMENT DURING OR PRIOR TO THE YEAR BEING REPORTED: LARRY HEGLAND \$87,650, LINDA FAHEY \$66,146, GREG PAGLIUZZA \$79,471, AND TIMOTHY STONE JR. \$121,238. ALL SEVERANCE PAY AMOUNTS WERE PROVIDED UNDER PREVIOUSLY APPROVED SEVERANCE PAY AGREEMENTS, AND ARE TRIGGERED ONLY BY CERTAIN TYPES OF EMPLOYMENT TERMINATION. CERTAIN LISTED INDIVIDUALS PARTICIPATE IN NONQUALIFIED DEFERRED COMPENSATION PLANS OF MEMORIAL HEALTH SYSTEM (MHS), A RELATED ORGANIZATION AND CENTRAL ORGANIZATION OF THE GROUP EXEMPTION. MHS CREDITS ANNUAL CONTRIBUTION AMOUNTS TO THESE PLANS, AND THESE AMOUNTS SERVE TO PROVIDE SUPPLEMENTAL RETIREMENT INCOME TO THESE INDIVIDUALS. ALL CREDITED AMOUNTS ARE REVIEWED AND APPROVED BY A COMMITTEE OF THE MHS BOARD AS PART OF REASONABLE TOTAL COMPENSATION. ALL AMOUNTS CREDITED ARE UNVESTED WHILE THE EXECUTIVE IS REQUIRED TO PROVIDE SUBSTANTIAL FUTURE SERVICES, AND THEN ARE TAXED IN FULL WHEN THE SERVICE PERIOD IS COMPLETED AND THE AMOUNTS BECOME VESTED. ALL AMOUNTS CREDITED TO THESE EXECUTIVES UNDER THESE PLANS ARE INCLUDED IN COLUMN (C) AS UNVESTED, NONTAXABLE DEFERRED COMPENSATION WHEN FIRST CREDITED, AND THEN ARE AGAIN INCLUDED IN COLUMN (B)(III) WHEN THE AMOUNTS BECOME VESTED AND ARE SUBJECT TO TAX. THE AMOUNTS INCLUDED IN COLUMN (F) FOR CERTAIN INDIVIDUALS REPRESENT AMOUNTS THAT WERE REPORTED ON PRIOR FORM 990S FOR PRIOR YEARS, AND SHOULD BE SUBTRACTED FROM THE TOTAL COMPENSATION IN COLUMN (E) TO RESULT IN A MORE ACCURATE TOTAL COMPENSATION FOR CALENDAR YEAR 2019. THE FOLLOWING CURRENT OR FORMER OFFICERS, KEY EMPLOYEES, AND HIGHEST COMPENSATED EMPLOYEES RECEIVED DEFERRED COMPENSATION PAYOUTS IN THE CALENDAR YEAR FROM MHS OR A RELATED ORGANIZATION: DAVID BAUMBERGER, M.D. \$46,825, JIM BLACKWELL \$4,674, JAMES BOHAN, M.D. \$343,318, KIMBERLY BOURNE \$2,230, DEBORAH BRAGG \$24,857, RANDALL BRYANT \$3,699, MARK BURMESTER \$11,041, CHARLES CALLAHAN, PH.D. \$49,491, EDGAR CURTIS \$216,334, AIMEE DAILY, PH.D. \$28,299, DOLAN DALPOAS \$29,972, VIRGINIA DOLAN, M.D. \$28,378, J. TRAVIS DOWELL \$24,769, MIKE EDWARDS \$5,817, ANNA EVANS, J.D. \$39,220, LINDA FAHEY \$82,377, NICOLE FLORENCE, M.D. \$55,280, ANTHONY GRIFFIN, M.D. \$14,176, DAVID GRAHAM, M.D. \$58,332, MARK HANSEN, M.D. \$76,423, LARRY HEGLAND, M.D. \$22,045, KEVIN HORATH \$23,812, LINDA JONES, D.N.S. \$29,207, ROBERT KAY \$54,234, SHARON NORRIS \$5,335, GREG PAGLIUZZA \$46,424, MARSHA PRATER, PH.D. \$47,491, DOUGLAS RAHN, D.B.A. \$1,263,270, CHRISTOPHER RIVERA, M.D. \$20,003, JOHN RIDLEY \$27,619, MITCHELL ROGERS \$14,050, DAVID SAMPLES \$16,998, ROBERT SCOTT \$26,432, TIMOTHY STONE, JR. \$96,026, AND AMIR WAHAB, M.D. \$112,294. TO BECOME ENTITLED TO THE BENEFITS PROVIDED, EACH COVERED EMPLOYEE MUST MEET SUBSTANTIAL REQUIREMENTS RELATING TO FURTHER EMPLOYMENT. UNTIL THOSE REQUIREMENTS ARE SATISFIED, IF EVER, THE EMPLOYEE IS NOT ENTITLED TO THESE AMOUNTS. IF THE EMPLOYEE WERE TO HAVE TERMINATED EMPLOYMENT VOLUNTARILY IN THE YEAR TO WHICH THIS RETURN APPLIES AND NOT MET THESE SUBSTANTIAL REQUIREMENTS, THESE SUPPLEMENTAL RETIREMENT BENEFITS WOULD HAVE BEEN FORFEITED. THESE SUPPLEMENTAL RETIREMENT BENEFITS ARE PART OF A RETIREMENT PROGRAM THAT PROVIDES RETIREMENT INCOME FOR ALL YEARS OF SERVICE THAT THE EMPLOYEE PROVIDES TO THE ORGANIZATION. ACCORDINGLY, ANY RETIREMENT BENEFITS SHOULD BE VIEWED AS APPLYING TO THE ENTIRE LENGTH OF THE EMPLOYEE'S SERVICE. THE LEADERSHIP COMPENSATION COMMITTEE OF THE MHS BOARD APPROVES ALL RETIREMENT BENEFITS, TOGETHER WITH ALL OTHER FORMS OF COMPENSATION AND BENEFITS FOR THESE AND OTHER SENIOR LEADERS, IN A MANNER INTENDED TO QUALIFY FOR THE "REBUTTABLE PRESUMPTION OF REASONABLENESS" UNDER FEDERAL INCOME TAX LAW.
PART II	THE FOLLOWING INDIVIDUALS HAVE LISTED COMPENSATION, BUT THEY ARE NOT PAID FOR THEIR SERVICE AS BOARD MEMBERS (WHICH IS WHY THEY ARE LISTED). THEY INSTEAD ARE COMPENSATED FOR SUBSTANTIAL SERVICES THEY PROVIDE AS AN EMPLOYEE OF THE ORGANIZATION OR OF A RELATED ORGANIZATION. THE INDIVIDUALS FALLING INTO THIS CATEGORY ARE THE FOLLOWING: AMIR WAHAB, M.D., TRACY MIZEUR, M.D., ANTHONY GRIFFIN, M.D., CHRISTOPHER RIVERA, M.D., MARK HANSEN, M.D., J. TRAVIS DOWELL, D. JANE DAVIS, RAEDENA RYAN, VIRGINIA DOLAN, M.D., NICOLE FLORENCE, M.D., JAMESON ROSZHART, TAMAR KUTZ, HARRY SCHMIDT, W SCOTT BOSTON, M.D., DOLAN DALPOAS, KIMBERLY BOURNE, EVAN DAVIS, KATHRYN KEIM, EDGAR CURTIS, KEVIN ENGLAND, CHARLES CALLAHAN, JOHN RIDLEY AND JANICE GAMBACH.
PART VII QUESTION 5	DECATUR MEMORIAL HOSPITAL (DMH) BECAME AFFILIATED WITH MEMORIAL HEALTH SYSTEM ON 10/1/2019. PRIOR TO AFFILIATION, ILLINOIS HEALTH AND SCIENCE (IHS) WAS THE RELATED PARENT ORGANIZATION TO DMH. TIMOTHY STONE, JR., FORMER DMH PRESIDENT & CEO AND KATHERINE ANDERSON, ESQ., FORMER DMH VP LEGAL AFFAIRS & CORPORATE COMPLIANCE WERE BOTH PAID OUT OF THIS ORGANIZATION WHILE DOING WORK FOR DMH. TIMOTHY STONE, JR. RECEIVED \$501,100, AND KATHERINE ANDERSON RECEIVED \$256,784, IN COMPENSATION FROM IHS, WHICH IN EACH CASE IS INCLUDED IN THE COMPENSATION NUMBERS REPORTED IN THIS FORM 990.

Additional Data

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1EDGAR CURTIS PRESIDENT&CEO MHS; BRDMBR MPS	(i)	0	0	0	0	0	0	0
	(ii)	952,518	431,182	264,068	27,650	21,711	1,697,129	0
1DOUGLAS RAHN DBA FORMER PRESIDENT&CEO PAH	(i)	0	0	0	0	0	0	0
	(ii)	0	0	1,263,270	0	0	1,263,270	1,047,921
2STEVEN SOBOL MD PHYSICIAN DMH	(i)	1,001,794	90,591	4,269	4,200	26,076	1,126,930	0
	(ii)	0	0	0	0	0	0	0
3CHARLES CALLAHAN PHD MHSOSPPRES;PRESMMC/MMCF/MHSVC;CHRMH	(i)	514,252	194,411	120,870	188,840	32,590	1,050,963	43,418
	(ii)	0	0	0	0	0	0	0
4RAYCHAUDHURI RATUL MD PHYSICIAN DMH	(i)	941,713	25,000	360	0	25,214	992,287	0
	(ii)	0	0	0	0	0	0	0
5JOHN WATERS MD PHYSICIAN DMH	(i)	898,554	0	3,696	4,200	18,096	924,546	0
	(ii)	0	0	0	0	0	0	0
6DAVID GRAHAM MD MHS SVP&CHIEF QLTY&INNOVATION OFF.	(i)	0	0	0	0	0	0	0
	(ii)	446,208	162,444	70,263	170,378	18,829	868,122	51,095
7JAMES BOHAN MD PHYSICIAN MPS	(i)	347,901	38,850	402,507	27,650	67,931	884,839	19,555
	(ii)	0	0	0	0	0	0	0
8TURGUT TANSEL MD PHYSICIAN DMH	(i)	841,594	0	1,104	4,200	33,267	880,165	0
	(ii)	0	0	0	0	0	0	0
9TIMOTHY STONE JR FORMER DMH PRESIDENT & CEO	(i)	425,812	87,621	219,640	66,365	11,007	810,445	0
	(ii)	0	0	0	0	0	0	0
10AMIR JOHN WAHAB MD BRDMEM ALMH(THRUJAN20)/MPS PHYSICIAN	(i)	394,770	44,484	180,206	27,650	112,832	759,942	41,372
	(ii)	0	0	0	0	0	0	0
11ANNA EVANS JD MHS SVP & GENERAL COUNSEL	(i)	0	0	0	0	0	0	0
	(ii)	384,820	141,913	45,811	128,754	32,353	733,651	31,394
12ROBERT KAY FORMER MHS SVP & CFO	(i)	0	0	0	0	0	0	0
	(ii)	399,870	184,283	102,871	24,900	18,109	730,033	0
13RAJESH GOVINDAIAH MD MHS SVP & CMO	(i)	0	0	0	0	0	0	0
	(ii)	477,234	119,972	34,866	87,299	6,601	725,972	0
14KATHRYN KEIM MHS SVP&CFO; SEC&TREAS MHV/MHSVC/MPS	(i)	0	0	0	0	0	0	0
	(ii)	443,391	162,807	10,707	74,674	31,935	723,514	0
15KEVIN ENGLAND MHS SVP&CAO; VCH&PRESMHV; VCHMHSVC	(i)	0	0	0	0	0	0	0
	(ii)	313,249	152,475	22,666	176,300	34,294	698,984	0
16AIMEE DAILY PHD MHS SVP & CHIEF TRANSFORM. OFF.	(i)	337,310	134,536	58,971	65,319	20,415	616,551	24,887
	(ii)	0	0	0	0	0	0	0
17VIRGINIA DOLAN MD BOARD MEMBER SRS	(i)	416,723	13,745	85,074	27,312	60,595	603,449	28,245
	(ii)	0	0	0	0	0	0	0
18DAVID BAUMBERGER MD FORMER DMH CHIEF MEDICAL OFFICER	(i)	391,604	104,427	50,566	51,083	26,238	623,918	0
	(ii)	0	0	0	0	0	0	0
19ROBERT SCOTT MHS SVP & CHRO	(i)	0	0	0	0	0	0	0
	(ii)	331,450	120,614	56,945	58,468	27,141	594,618	22,519

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees								
(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
21NICOLE FLORENCE MD BOARD MEMBER SRS	(i)	348,474	32,666	121,641	24,900	80,638	608,319	0
	(ii)	0	0	0	0	0	0	0
1MARK HANSEN MD CHAIR MPS/MPS PHYSICIAN	(i)	315,116	30,918	107,217	27,650	99,113	580,014	0
	(ii)	0	0	0	0	0	0	0
2DREW EARLY PRESIDENT&CEO DMH	(i)	238,248	0	29,737	46,161	24,830	338,976	0
	(ii)	87,107	99,480	16,369	9,273	7,449	219,678	0
3MARSHA PRATER PHD MHS/MMC SVP & CNO	(i)	334,354	121,199	64,873	25,710	10,657	556,793	0
	(ii)	0	0	0	0	0	0	0
4JAMESON ROSZHART MHS PRESAMBGRP; BM MHV/MPS/CHR MHSVC	(i)	0	0	0	0	0	0	0
	(ii)	320,570	129,155	10,353	60,107	30,395	550,580	0
5J TRAVIS DOWELL PRESIDENT MPS & VP MPS	(i)	0	0	0	0	0	0	0
	(ii)	247,557	65,512	96,108	56,009	41,897	507,083	22,354
6DOLAN DALPOAS PRESIDENT&CEO ALMH; BRDMBR MHSVC	(i)	0	0	0	0	0	0	0
	(ii)	289,946	74,302	55,481	58,264	419	478,412	22,995
7ANTHONY GRIFFIN MD BOARD MEMBER MPS/MPS PHYSICIAN	(i)	344,914	27,808	38,508	16,811	39,120	467,161	13,936
	(ii)	0	0	0	0	0	0	0
8GREG PAGLIUZZA FORMER DMH SVP & CFO	(i)	261,999	6,228	130,548	36,967	21,679	457,421	0
	(ii)	0	0	0	0	0	0	0
9LARRY HEGLAND MD FORMER DMH CHIEF MEDICAL OFFICER	(i)	293,510	17,363	112,072	15,965	11,555	450,465	0
	(ii)	0	0	0	0	0	0	0
10LINDA JONES DNS MMC VP OF ANCILLARY OPS	(i)	280,118	72,454	60,303	24,167	9,921	446,963	0
	(ii)	0	0	0	0	0	0	0
11KIMBERLY BOURNE PRESIDENT&CEO TMH&TMHF; BRDMBR MHSVC	(i)	0	0	0	0	0	0	0
	(ii)	263,657	68,747	23,277	55,333	26,953	437,967	1,706
12PATRICK OCONNOR FORMER DMH VP REVENUE CYCLE	(i)	0	0	431,473	0	0	431,473	0
	(ii)	0	0	0	0	0	0	0
13LINDA FAHEY FORMER DMH SVP & COO	(i)	224,875	108	152,949	35,601	1,639	415,172	0
	(ii)	0	0	0	0	0	0	0
14CHRISTOPHER RIVERA MD BOARD MEMBER MPS/MPS PHYSICIAN	(i)	253,484	22,812	38,152	19,321	36,130	369,899	19,904
	(ii)	0	0	0	0	0	0	0
15MARK BURMESTER FRMRDMH OFF; MHSSYSADSTRAT (TRJAN20)	(i)	233,528	0	13,931	32,584	18,893	298,936	0
	(ii)	67,090	0	239	1,505	2,806	71,640	0
16EVAN DAVIS VP CLIN OPS MMC/BOARD MEMBER MHV	(i)	227,068	66,628	4,951	34,247	28,377	361,271	0
	(ii)	0	0	0	0	0	0	0
17MITCHELL ROGERS FORMER KE MMC SYSADMIN CARDIO SVCS	(i)	231,462	59,981	23,450	41,661	2,939	359,493	0
	(ii)	0	0	0	0	0	0	0
18JOHN RIDLEY BRDMMEMMHVC/SYSADMINAMBULATORY	(i)	202,530	0	32,767	32,847	28,632	296,776	0
	(ii)	55,966	0	140	948	4,258	61,312	0
19W SCOTT BOSTON MD PRESIDENT&CEO PAH/CRNA; BRDMBR MHSVC	(i)	0	0	0	0	0	0	0
	(ii)	196,817	96,098	8,528	31,150	16,306	348,899	0

Form 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees								
(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
41JENNIFER BOND MMC VP OF NURSING	(i)	207,309	66,628	6,826	30,220	27,010	337,993	0
	(ii)	0	0	0	0	0	0	0
1KATHERINE ANDERSON ESQ FRMR DMH OFF; MHSSRGENCOUNS (TRMAY20)	(i)	252,822	22,095	880	28,421	8,511	312,729	0
	(ii)	0	0	0	0	0	0	0
2RANDALL BRYANT VP, DECATUR MEDICAL GROUP	(i)	182,571	12,416	6,208	12,405	20,677	234,277	0
	(ii)	50,470	0	10,681	855	2,697	64,703	0
3TRACY MIZEUR MD BOARD MEMBER ALMH/MPS PHYSICIAN	(i)	206,089	21,081	31,987	19,041	10,220	288,418	0
	(ii)	0	0	0	0	0	0	0
4SHARON NORRIS FORMER DMH OFFICER	(i)	226,340	0	9,498	20,061	29,913	285,812	0
	(ii)	0	0	0	0	0	0	0
5DEBORAH BRAGG FORMER DMH OFFICER	(i)	223,247	0	27,538	28,303	4,842	283,930	0
	(ii)	0	0	0	0	0	0	0
6KEVIN HORATH FORMER DMH OFFICER	(i)	220,729	0	26,996	28,779	3,521	280,025	0
	(ii)	0	0	0	0	0	0	0
7HARRY SCHMIDT FRMR PRES/CEO PAH/CRNA; BM MHSVC	(i)	0	0	0	0	0	0	0
	(ii)	175,686	0	65,158	37,407	1,093	279,344	0
8DAVID KING MHS VP SUPPORT OPERATIONS	(i)	170,540	48,689	5,958	29,881	10,243	265,311	0
	(ii)	0	0	0	0	0	0	0
9JENNIFER HARRIS FORMER KE MMC SYSADM,PERIOP SVCS	(i)	211,975	27,160	186	16,136	751	256,208	0
	(ii)	0	0	0	0	0	0	0
10JANICE GAMBACH PRES SRS (TRDEC19);ADMIN MBH (TRJAN20)	(i)	0	0	0	0	0	0	0
	(ii)	190,741	24,927	6,567	16,364	11,074	249,673	0
11TAMAR KUTZ BOARD MEMBER MHSVC; VP QUAL&OPS	(i)	0	0	0	0	0	0	0
	(ii)	191,725	23,293	3,946	20,662	2,185	241,811	0
12DAVID SAMPLES FORMER DMH OFFICER; MHS SYSDIRCAP	(i)	172,749	0	19,608	19,841	29,079	241,277	0
	(ii)	0	0	0	0	0	0	0
13JIM BLACKWELL FORMER DMH OFFICER	(i)	158,649	0	5,679	16,906	18,758	199,992	0
	(ii)	0	0	0	0	0	0	0
14MELISSA HANSEN-SCHMADEKE MMCF EXECUTIVE DIRECTOR	(i)	140,152	12,996	164	9,378	12,004	174,694	0
	(ii)	0	0	0	0	0	0	0
15MIKE EDWARDS FORMER DMH VP REVENUE CYCLE	(i)	113,635	17,500	6,598	20,115	5,943	163,791	0
	(ii)	0	0	0	0	0	0	0

Schedule L
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions with Interested Persons

▶ Complete if the organization answered "Yes" on Form 990, Part IV, lines 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.
▶ Attach to Form 990 or Form 990-EZ.
▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
MEMORIAL HEALTH SYSTEM GROUP

Employer identification number
90-0756744

Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 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

Part IV Business Transactions Involving Interested Persons.

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

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

Part V Supplemental Information

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

Return Reference	Explanation
SCH L, PART IV, BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS:	(A) NAME OF PERSON: BRITTANY LIBKA(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: EMPLOYEE; DAUGHTER OF BOARD MEMBER.(C) AMOUNT OF TRANSACTION \$22,372.(D) MEMORIAL MEDICAL CENTER PAID COMPENSATION AND BENEFITS OF \$22,445 TO BRITTANY LIBKA RELATED TO EMPLOYMENT SERVICES FOR THE FISCAL YEAR ENDED 9/30/2020. BRITTANY LIBKA IS THE DAUGHTER OF GEOFFREY ISRINGHAUSEN, MMC BOARD MEMBER. THE COMPENSATION PAID WAS NEGOTIATED AT ARM'S LENGTH AND REPRESENTS FAIR MARKET VALUE FOR THE SERVICES PROVIDED.(E) SHARING OF ORGANIZATION REVENUES? = NO
(A) NAME OF PERSON: MADELINE CALLAHAN	(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: EMPLOYEE; DAUGHTER OF CEO AND PRESIDENT OF THE HOSPITAL GROUP.(C) AMOUNT OF TRANSACTION \$56,085.(D) MEMORIAL MEDICAL CENTER PAID COMPENSATION AND BENEFITS OF \$56,085 TO MADELINE CALLAHAN RELATED TO EMPLOYMENT SERVICES FOR THE FISCAL YEAR ENDED 9/30/2020. MADELINE IS THE DAUGHTER OF CHARLES CALLAHAN. THE COMPENSATION PAID WAS NEGOTIATED AT ARM'S LENGTH AND REPRESENTS FAIR MARKET VALUE FOR THE SERVICES PROVIDED.(E) SHARING OF ORGANIZATION REVENUES? = NO
(A) NAME OF PERSON: COURTNEY PUTMAN	(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: EMPLOYEE; DAUGHTER OF MMC BOARD MEMBER(C) AMOUNT OF TRANSACTION \$43,628.(D) MEMORIAL MEDICAL CENTER PAID COMPENSATION AND BENEFITS OF \$43,628 TO COURTNEY PUTMAN RELATED TO EMPLOYMENT SERVICES FOR THE FISCAL YEAR ENDED 9/30/2020. COURTNEY PUTMAN IS THE DAUGHTER OF WILLIAM PUTMAN, MMC BOARD MEMBER. THE COMPENSATION PAID WAS NEGOTIATED AT ARM'S LENGTH AND REPRESENTS FAIR MARKET VALUE FOR THE SERVICES PROVIDED.(E) SHARING OF ORGANIZATION REVENUES? = NO
(A) NAME OF PERSON: CARRIE WALDEN	(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: EMPLOYEE; DAUGHTER OF MMC BOARD MEMBER(C) AMOUNT OF TRANSACTION \$55,236.(D) MEMORIAL MEDICAL CENTER PAID COMPENSATION AND BENEFITS OF \$55,236 TO CARRIE WALDEN RELATED TO EMPLOYMENT SERVICES FOR THE FISCAL YEAR ENDED 9/30/2020. CARRIE WALDEN IS THE DAUGHTER OF RANDALL S. GERMEAAD, MMC BOARD MEMBER. THE COMPENSATION PAID WAS NEGOTIATED AT ARM'S LENGTH AND REPRESENTS FAIR MARKET VALUE FOR THE SERVICES PROVIDED.(E) SHARING OF ORGANIZATION REVENUES? = NO
(A) NAME OF PERSON: KATHLEEN FAHEY	(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: EMPLOYEE; DAUGHTER OF FORMER DMH BOARD MEMBER(C) AMOUNT OF TRANSACTION \$12,861.(D) DECATUR MEMORIAL HOSPITAL PAID COMPENSATION AND BENEFITS OF \$12,861 TO KATHLEEN FAHEY RELATED TO EMPLOYMENT SERVICES FOR THE FISCAL YEAR ENDED 9/30/2020. KATHLEEN FAHEY IS THE DAUGHTER OF LINDA FAHEY, FORMER DMH BOARD MEMBER. THE COMPENSATION PAID WAS NEGOTIATED AT ARM'S LENGTH AND REPRESENTS FAIR MARKET VALUE FOR THE SERVICES PROVIDED.(E) SHARING OF ORGANIZATION REVENUES? = NO
(A) NAME OF PERSON: RYAN BRAGG	(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: EMPLOYEE; SON OF FORMER DMH OFFICER(C) AMOUNT OF TRANSACTION \$45,134.(D) DECATUR MEMORIAL HOSPITAL PAID COMPENSATION AND BENEFITS OF \$45,134 TO RYAN BRAGG RELATED TO EMPLOYMENT SERVICES FOR THE FISCAL YEAR ENDED 9/30/2020. RYAN BRAGG IS THE SON OF DEBORAH BRAGG, FORMER DMH OFFICER. THE COMPENSATION PAID WAS NEGOTIATED AT ARM'S LENGTH AND REPRESENTS FAIR MARKET VALUE FOR THE SERVICES PROVIDED.(E) SHARING OF ORGANIZATION REVENUES? = NO
(A) NAME OF PERSON: SHERYL ROBERTS	(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: EMPLOYEE; DAUGHTER OF PAH BOARD MEMBER(C) AMOUNT OF TRANSACTION \$129,572.(D) PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION PAID COMPENSATION AND BENEFITS OF \$129,572 TO SHERYL ROBERTS RELATED TO EMPLOYMENT SERVICES FOR THE FISCAL YEAR ENDED 9/30/20. SHERYL ROBERTS IS THE DAUGHTER OF NANCY SPANGENBERG, PAH BOARD MEMBER. THE COMPENSATION PAID WAS NEGOTIATED AT ARM'S LENGTH AND REPRESENTS FAIR MARKET VALUE FOR THE SERVICES PROVIDED.(E) SHARING OF ORGANIZATION REVENUES? = NO
(A) NAME OF PERSON: LISA MOSES	(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION: EMPLOYEE; SISTER-IN-LAW OF TMH BOARD MEMBER(C) AMOUNT OF TRANSACTION \$93,950.(D) TAYLORVILLE MEMORIAL HOSPITAL PAID COMPENSATION AND BENEFITS OF \$93,950 TO LISA MOSES RELATED TO EMPLOYMENT SERVICES FOR THE YEAR ENDED 9/30/20. LISA MOSES IS THE SISTER-IN-LAW OF N. TERESA FRANCE, TMH BOARD MEMBER. THE COMPENSATION PAID WAS NEGOTIATED AT ARM'S LENGTH AND REPRESENTS FAIR MARKET VALUE FOR THE SERVICES PROVIDED.(E) SHARING OF ORGANIZATION REVENUES? = NO

Additional Data

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

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) BRITTANY LIBKA	SEE PART V	22,372	SEE PART V		No
(1) MADELINE CALLAHAN	SEE PART V	56,085	SEE PART V		No

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(3) COURTNEY PUTMAN	SEE PART V	43,628	SEE PART V		No
(1) CARRIE WALDEN	SEE PART V	55,236	SEE PART V		No

Form 990, Schedule L, Part IV - Business Transactions Involving Interested Persons					
(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(5) KATHLEEN FAHEY	SEE PART V	12,861	SEE PART V		No
(1) RYAN BRAGG	SEE PART V	45,134	SEE PART V		No

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(7) SHERYL ROBERTS	SEE PART V	129,572	SEE PART V		No
(1) LISA MOSES	SEE PART V	93,950	SEE PART V		No

efile GRAPHIC print - DO NOT PROCESS		As Filed Data -	DLN: 93493228032421
SCHEDULE M (Form 990)		Noncash Contributions	
Department of the Treasury Internal Revenue Service		OMB No. 1545-0047	
Name of the organization MEMORIAL HEALTH SYSTEM GROUP		Employer identification number 90-0756744	
▶Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.		2019	
▶Attach to Form 990.		Open to Public Inspection	
▶Go to www.irs.gov/Form990 for the latest information.			

Part I Types of Property		(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art—Works of art					
2 Art—Historical treasures					
3 Art—Fractional interests					
4 Books and publications					
5 Clothing and household goods		X		2,629	COST/SALE OF COMPARABLE
6 Cars and other vehicles					
7 Boats and planes					
8 Intellectual property					
9 Securities—Publicly traded		X	10	169,042	AVG OF HIGH & LOW PRICE
10 Securities—Closely held stock					
11 Securities—Partnership, LLC, or trust interests					
12 Securities—Miscellaneous					
13 Qualified conservation contribution—Historic structures					
14 Qualified conservation contribution—Other					
15 Real estate—Residential					
16 Real estate—Commercial					
17 Real estate—Other		X	1	4,691,717	FARMLAND APPRAISAL
18 Collectibles					
19 Food inventory					
20 Drugs and medical supplies		X	129	202,768	COVID PPE
21 Taxidermy					
22 Historical artifacts					
23 Scientific specimens					
24 Archeological artifacts					
FOOD DONATIONS TO HOSPITAL DURING COVID 19		X	200	64,686	FMV ESTIMATE
25 Other ▶ (PANDEMIC)					
26 Other ▶ (LAMINATOR)		X	1	8,700	INVOICE
27 Other ▶ (DECORATING)		X	3	1,068	FMV ESTIMATE
28 Other ▶ (EVENT)					
28 Other ▶ (ATHLETIC)		X	1	100	FMV ESTIMATE
28 Other ▶ (PASS)					
29 Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement				29	0
30a During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least three years from the date of the initial contribution, and which isn't required to be used for exempt purposes for the entire holding period?				Yes	No
b If "Yes," describe the arrangement in Part II.					
31 Does the organization have a gift acceptance policy that requires the review of any nonstandard contributions?				Yes	
32a Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions?				Yes	
b If "Yes," describe in Part II.					
33 If the organization didn't report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II.					

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

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

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury

Internal Revenue Service

Name of the organization
MEMORIAL HEALTH SYSTEM GROUP

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2019

Open to Public Inspection

Employer identification number

90-0756744

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART I	ALL PRIOR YEAR BALANCES HAVE BEEN UPDATED TO REFLECT THE ADDITION OF DECATUR MEMORIAL HOSPITAL AND DECATUR MEMORIAL HEALTH FOUNDATION TO THE GROUP RETURN.

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 4	DMH AND DMHF BYLAWS WERE AMENDED AND RESTATED FOR AFFILIATION WITH MEMORIAL HEALTH SYSTEM. ARTICLES OF INCORPORATION WERE AMENDED FOR AFFILIATION WITH MEMORIAL HEALTH SYSTEM.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 6	<p>MEMORIAL HEALTH SYSTEM IS THE SOLE CORPORATE MEMBER OF THE FOLLOWING SUBORDINATES INCLUDED IN THIS GROUP RETURN: MEMORIAL MEDICAL CENTER, DECATUR MEMORIAL HOSPITAL, PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION, THE ABRAHAM LINCOLN MEMORIAL HOSPITAL, TAYLORVILLE MEMORIAL HOSPITAL, MEMORIAL PHYSICIAN SERVICES, MEMORIAL HOME SERVICES AND MEMORIAL HEALTH VENTURES. MEMORIAL HEALTH SYSTEM CORPORATION CONTAINS 104 INDIVIDUAL MEMBERS WHO ELECT THE BOARD OF DIRECTORS. OTHER SUBORDINATES INCLUDED IN THIS GROUP RETURN INCLUDE: SPRINGFIELD RESIDENTIAL SERVICES, WHICH HAS A SELF-PERPETUATING BOARD OF DIRECTORS WHOSE MEMBERSHIP SHALL BE APPROVED BY OR BE MEMBERS OF THE BOARD OF DIRECTORS FOR MENTAL HEALTH CENTERS OF CENTRAL ILLINOIS. JACKSONVILLE CRNA'S AND PASSAVANT AREA HOSPITAL FOUNDATION'S SOLE CORPORATE MEMBER IS PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION. DECATUR MEMORIAL HEALTH FOUNDATION'S SOLE CORPORATE MEMBER IS DECATUR MEMORIAL HOSPITAL. TAYLORVILLE MEMORIAL HOSPITAL FOUNDATION'S SOLE CORPORATE MEMBER IS TAYLORVILLE MEMORIAL HOSPITAL. MEMORIAL MEDICAL CENTER FOUNDATION'S BOARD OF DIRECTORS COMPRISE ITS MEMBERSHIP.</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A	<p>MEMORIAL HEALTH SYSTEM, THE SOLE CORPORATE MEMBER OF MEMORIAL MEDICAL CENTER, DECATUR MEMORIAL HOSPITAL, PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION, THE ABRAHAM LINCOLN MEMORIAL HOSPITAL, TAYLORVILLE MEMORIAL HOSPITAL, MEMORIAL PHYSICIAN SERVICES, MEMORIAL HOME SERVICES AND MEMORIAL HEALTH VENTURES, ELECTS THE BOARD OF DIRECTS OF EACH OF THOSE SUBORDINATE ORGANIZATIONS INCLUDED IN THIS GROUP RETURN. OTHER SUBORDINATES INCLUDED IN THIS GROUP RETURN HAVE THEIR BOARD OF DIRECTORS SELECTED FROM THE BOARDS OF ITS RESPECTIVE SOLE CORPORATE MEMBER AS FOLLOWS: SPRINGFIELD RESIDENTIAL SERVICES (SOLE CORPORATE MEMBER: MENTAL HEALTH CENTERS OF CENTRAL ILLINOIS), JACKSONVILLE CRNA'S AND PASSAVANT AREA HOSPITAL FOUNDATION (SOLE CORPORATE MEMBER: PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION), DECATUR MEMORIAL HEALTH FOUNDATION (SOLE CORPORATE MEMBER: DECATUR MEMORIAL HOSPITAL), TAYLORVILLE MEMORIAL HOSPITAL FOUNDATION (SOLE CORPORATE MEMBER: TAYLORVILLE MEMORIAL HOSPITAL). MEMORIAL MEDICAL CENTER FOUNDATION BOARD OF DIRECTORS ELECTS ITS BOARD MEMBERS BASED ON SPECIFIED CRITERIA WITHIN ITS BYLAWS AS REPRESENTATIVES OF THE COMMUNITY OR A RELATIONSHIP (FORMAL OR INFORMAL) WITH MEMORIAL HEALTH SYSTEM OR MEMORIAL MEDICAL CENTER.</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B	THE RESPECTIVE BYLAWS OF MEMORIAL MEDICAL CENTER, DECATUR MEMORIAL HOSPITAL, PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION, THE ABRAHAM LINCOLN MEMORIAL HOSPITAL, TAYLORVILLE MEMORIAL HOSPITAL, MEMORIAL PHYSICIAN SERVICES, MEMORIAL HOME SERVICES AND MEMORIAL HEALTH VENTURES IMPOSE RESERVE POWERS OVER EACH SUBORDINATE BY THE SOLE CORPORATE MEMBER (MEMORIAL HEALTH SYSTEM) TO AMEND BYLAWS OR GOVERNING DOCUMENTS, APPROVAL OF BUDGETS, MATERIAL FINANCIAL TRANSACTIONS OVER SPECIFIED DOLLAR AMOUNTS AND OTHER SIGNIFICANT BUSINESS TRANSACTIONS.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	A DRAFT COPY OF THE MHS GROUP FORM 990 AND ALL ATTACHMENTS IS PROVIDED TO ALL OF THE MEMORIAL HEALTH SYSTEM BOARD OF DIRECTORS AND A BOARD COMMITTEE PRIOR TO FILING. ALL QUESTIONS AND COMMENTS ARISING FROM THESE REVIEWS ARE ADDRESSED PRIOR TO SUBMISSION OF THE RETURN TO THE APPROPRIATE TAXING AUTHORITIES.

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

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

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VII, SECTION B	FEES LISTED FOR CONSTRUCTION AND COMPUTER SOFTWARE/SUPPORT MAY INCLUDE REIMBURSEMENT OF EXPENSES IN ADDITION TO PAYMENT FOR SERVICES.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART IX, LINE 11G	PHYSICIAN SERVICES: PROGRAM SERVICE EXPENSES 122,020,764. MANAGEMENT AND GENERAL EXPENSES 1,415,653. FUNDRAISING EXPENSES 0. TOTAL EXPENSES 123,436,417. PURCHASED SERVICES: PROGRAM SERVICE EXPENSES 44,486,824. MANAGEMENT AND GENERAL EXPENSES 21,143,092. FUNDRAISING EXPENSES 0. TOTAL EXPENSES 65,629,916. CONTRACT LABOR: PROGRAM SERVICE EXPENSES 5,911,244. MANAGEMENT AND GENERAL EXPENSES 2,087. FUNDRAISING EXPENSES 0. TOTAL EXPENSES 5,913,331. PROFESSIONAL FEES: PROGRAM SERVICE EXPENSES 700,288. MANAGEMENT AND GENERAL EXPENSES 3,352,358. FUNDRAISING EXPENSES 0. TOTAL EXPENSES 4,052,646.

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9:	CHANGE IN MINIMUM PENSION LIABILITY 144,481,803. TRANSFERS TO RELATED ORGANIZATIONS -139,436,727. BOOK/TAX DIFFERENCE 108,602. OTHER 33,529. NONOPERATING NET PERIOD BENEFIT COST -2,240,282. CHANGE IN FAIR VALUE OF INTEREST RATE SWAP -775,814. CHANGE IN INTEREST IN NET ASSETS OF FOUNDATIONS 10,095,270.

SCHEDULE R
(Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

► Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
► Attach to Form 990.
► Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
MEMORIAL HEALTH SYSTEM GROUP

Employer identification number
90-0756744

Part I Identification of Disregarded Entities. Complete if the organization answered "Yes" on Form 990, Part IV, line 33.

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity

Part II Identification of Related Tax-Exempt Organizations. Complete if the organization answered "Yes" on Form 990, Part IV, line 34 because it had one or more related tax-exempt organizations during the tax year.

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1)ABRAHAM LINCOLN HEALTHCARE FOUNDATION 200 STAHLHUT DR LINCOLN, IL 62656 36-3492268	GRANTS TO OTHER CHARITABLE ORGANIZATIONS AND HOSPITALS	IL	501(C)(3)	LINE 7	MEMORIAL HEALTH SYSTEM		No
(2)MENTAL HEALTH CENTERS OF CENTRAL ILLINOIS 710 NORTH EIGHTH ST SPRINGFIELD, IL 62702 37-0646367	TRAINING, PSYCHIATRIC, AND RESIDENT SERVICES FOR MENTALLY ILL AND DISABLED	IL	501(C)(3)	LINE 7	MEMORIAL HEALTH SYSTEM		No
(3)HEARTLAND RISK MANAGEMENT 2300 NORTH EDWARD ST DECATUR, IL 62526 45-4256254	SUPPORTING THE HOSPITAL	IL	501(C)(3)	LINE 12A, I	DECATUR MEMORIAL HOSPITAL	Yes	
(4)MEMORIAL HEALTH SYSTEM 701 NORTH FIRST ST SPRINGFIELD, IL 62781 37-1110690	PARENT	IL	501(C)(3)	LINE 12C, III-FI	N/A		No

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of- year assets	(h) Percentage ownership	(i) Section 512 (b)(13) controlled entity?	
								Yes	No
(1) MEMORIAL HOME SERVICES OF CENTRAL ILLINOIS INC 701 NORTH FIRST STREET SPRINGFIELD, IL 62781 37-1190216	PROVIDE DURABLE MEDICAL EQUIPMENT AND SUPPLIES TO PATIENTS	IL	MEMORIAL HOME SERVICES	C	10,516,949	8,791,567	100.000 %	Yes	
(2) PASSAVANT PHYSICIAN ASSOCIATION 1600 WEST WALNUT STREET JACKSONVILLE, IL 62650 26-1200566	PHYSICIAN SERVICES	IL	PASSAVANT MEMORIAL AREA HOSPITAL ASSOCIATION	C	369,405	25,835	100.000 %	Yes	

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

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

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)MEMORIAL HOME SERVICES OF CENTRAL ILLINOIS INC	O	126,426	COST BASIS
(2)MEMORIAL HOME SERVICES OF CENTRAL ILLINOIS INC	K	102,057	COST - RENTAL EQUIPMENT
(3)MEMORIAL HOME SERVICES OF CENTRAL ILLINOIS INC	H	124,360	COST BASIS
(4)MEMORIAL HOME SERVICES OF CENTRAL ILLINOIS INC	S	2,180,232	COST BASIS
(5)HEARTLAND RISK MANAGEMENT	M	681,085	CASH PAYMENT
(6)PASSAVANT PHYSICIAN ASSOCIATION	R	786,943	FMV

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

[illegible]

Part VII **Supplemental Information**

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

Return Reference	Explanation

Additional Data

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

Form 990, Schedule R, Part V - Transactions With Related Organizations

(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
MEMORIAL HOME SERVICES OF CENTRAL ILLINOIS INC	O	126,426	COST BASIS
MEMORIAL HOME SERVICES OF CENTRAL ILLINOIS INC	K	102,057	COST - RENTAL EQUIPMENT
MEMORIAL HOME SERVICES OF CENTRAL ILLINOIS INC	H	124,360	COST BASIS
MEMORIAL HOME SERVICES OF CENTRAL ILLINOIS INC	S	2,180,232	COST BASIS
HEARTLAND RISK MANAGEMENT	M	681,085	CASH PAYMENT
PASSAVANT PHYSICIAN ASSOCIATION	R	786,943	FMV