

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

▶ Do not enter Social Security numbers on this form as it may be made public.
▶ Information about Form 990 and its instructions is at www.irs.gov/form990.

OMB No. 1545-0047

2017

Open to Public
Inspection

A For the 2017 calendar year, or tax year beginning , 2017, and ending , 20

B Check if applicable: <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization MEMORIAL HOSPITAL OF SOUTH BEND, INC		D Employer identification number 35-0868132
	Doing Business As		E Telephone number (574) 647-3549
	Number and street (or P.O. box if mail is not delivered to street address)	Room/suite	G Gross receipts \$ 545,623,357.
	615 N. MICHIGAN STREET City or town, state or province, country, and ZIP or foreign postal code SOUTH BEND, IN 46601		
F Name and address of principal officer: LARRY TRACY 615 N. MICHIGAN STREET SOUTH BEND, IN 46601			H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions)
I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527			
J Website: ▶ WWW.QUALITYOFLIFE.ORG			
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶			L Year of formation: 1923
M State of legal domicile: IN			

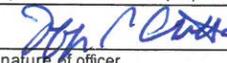
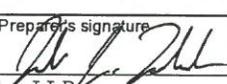
Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: MEMORIAL IS COMMITTED TO IMPROVING THE QUALITY OF LIFE OF THE PEOPLE IN OUR COMMUNITY.		
	2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	3 Number of voting members of the governing body (Part VI, line 1a)	8	
	4 Number of independent voting members of the governing body (Part VI, line 1b)	6	
	5 Total number of individuals employed in calendar year 2017 (Part V, line 2a)	3,634	
	6 Total number of volunteers (estimate if necessary)	454	
	7a Total unrelated business revenue from Part VIII, column (C), line 12	569,760	
7b Net unrelated business taxable income from Form 990-T, line 34	105,127		
Revenue	8 Contributions and grants (Part VIII, line 1h)	3,812,391	5,312,171
	9 Program service revenue (Part VIII, line 2g)	505,411,374	528,776,191
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	-678,041	-563,224
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	14,396,285	10,773,080
	12 Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	522,942,009	544,298,218
	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	2,418,189	1,994,226
	14 Benefits paid to or for members (Part IX, column (A), line 4)	0	0
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	183,402,987	182,459,922
	16a Professional fundraising fees (Part IX, column (A), line 11e)	0	0
	16b Total fundraising expenses (Part IX, column (D), line 25) ▶	0	0
Expenses	17 Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	258,951,287	267,366,711
	18 Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	444,772,463	451,820,859
	19 Revenue less expenses. Subtract line 18 from line 12	78,169,546	92,477,359
	Net Assets or Fund Balances	20 Total assets (Part X, line 16)	591,065,329
21 Total liabilities (Part X, line 26)		239,174,148	224,388,480
22 Net assets or fund balances. Subtract line 21 from line 20		351,891,181	297,800,724

COPY FOR PUBLIC INSPECTION

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: 	Date: 11/9/18			
	JEFFREY COSTELLO Type or print name and title CFO				
Paid Preparer Use Only	Print/Type preparer's name: JACOB ZEHNDER	Preparer's signature: 	Date: 11/07/2018	Check <input type="checkbox"/> if self-employed	PTIN: P01564049
	Firm's name ▶ ERNST & YOUNG U.S. LLP	Firm's EIN ▶ 34-6565596		Phone no. 312-879-2702	
	Firm's address ▶ 155 N WACKER DR CHICAGO, IL 60606				

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

For Paperwork Reduction Act Notice, see the separate instructions.

Form **990** (2017)

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:

MEMORIAL IS COMMITTED TO IMPROVING THE QUALITY OF LIFE OF THE PEOPLE IN OUR COMMUNITY.

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 [X] No

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

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 \$ 99,656,461. including grants of \$) (Revenue \$ 225,420,902.)

ANCILLARY SERVICES OFFERS THE FOLLOWING SERVICES FOR PATIENTS AND FACILITIES: - IMAGING SERVICES - OUTPATIENT PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY - INFUSION TREATMENTS - RADIATION ONCOLOGY THERAPY - CANCER RESEARCH - CARDIAC CATH LAB - SLEEP LAB - INTERVENTIONAL RADIOLOGY - ENVIRONMENTAL SERVICES - NUTRITIONAL SERVICES - PHARMACY SERVICES - LABORATORY. 2017 STATISTICS FOR THIS SERVICE UNIT INCLUDE: - 498,583 INPATIENT PROCEDURES - 423,526 OUTPATIENT PROCEDURES - 884 INPATIENT CATHS - 818 OUTPATIENT CATHS - 137,624 OUTPATIENT VISITS - 468,502 NONPATIENT MEALS.

4b (Code:) (Expenses \$ 104,532,630. including grants of \$) (Revenue \$ 166,801,431.)

PATIENT CARE UNIT SERVICES PROVIDES A WIDE VARIETY OF HOSPITAL SERVICES INCLUDING: - INPATIENT REHABILITATION CARF ACCREDITED - MEDICAL - POST SURGICAL - ORTHOPEDIC - ONCOLOGY - INTENSIVE AND INTERMEDIATE - HEART AND VASCULAR - MOTHER AND CHILD - SPECIAL CARE OBSTETRICS - NEONATAL INTENSIVE CARE LEVEL III - EMERGENCY - TRAUMA LEVEL II - PEDIATRICS - PEDIATRIC INTENSIVE CARE - PEDIATRIC HEMATOLOGY ONCOLOGY - MEDICAL FLIGHT PROGRAM - PEDIATRIC INTENSIVE CARE TRANSPORTS. 2017 STATISTICS FOR THIS SERVICE UNIT INCLUDE: - 102,044 PATIENT DAYS - 9,742 INPATIENT ER VISITS - 44,881 OUTPATIENT ER VISITS - 2,453 BIRTHS - 18,657 OBSERVATION STAYS - 353 MEDICAL FLIGHTS.

4c (Code:) (Expenses \$ 70,212,883. including grants of \$) (Revenue \$ 144,635,888.)

SURGICAL SERVICES PROVIDES THE FOLLOWING SERVICES: - GENERAL SURGERY - VASCULAR SURGERY - CARDIAC SURGERY - ORTHOPEDIC SURGERY - GYNECOLOGICAL SURGERY - TRAUMA SURGERY - GI LABS - PULMONARY SERVICES - PAIN CENTER - DAVINCI ROBOTIC SURGERY. 2017 STATISTICS FOR THIS SERVICE UNIT INCLUDE: - 3,727 INPATIENT PROCEDURES - 237 OPEN HEART PROCEDURES - 8,444 OUTPATIENT PROCEDURES.

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

(Expenses \$ 123,968,320. including grants of \$ 1,994,226.) (Revenue \$ 32,836.)

4e Total program service expenses 398,370,294.

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)? <i>If "Yes," complete Schedule A.</i>	X	
2 Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> (see instructions)?	X	
3 Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I.</i>		X
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? <i>If "Yes," complete Schedule C, Part II.</i>	X	
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? <i>If "Yes," complete Schedule C, Part III.</i>		X
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? <i>If "Yes," complete Schedule D, Part I.</i>		X
7 Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? <i>If "Yes," complete Schedule D, Part II.</i>		X
8 Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III.</i>		X
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? <i>If "Yes," complete Schedule D, Part IV.</i>		X
10 Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? <i>If "Yes," complete Schedule D, Part V.</i>	X	
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? <i>If "Yes," complete Schedule D, Part VI.</i>	X	
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? <i>If "Yes," complete Schedule D, Part VII.</i>		X
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? <i>If "Yes," complete Schedule D, Part VIII.</i>		X
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? <i>If "Yes," complete Schedule D, Part IX.</i>	X	
e Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X.</i>	X	
f Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? <i>If "Yes," complete Schedule D, Part X.</i>	X	
12a Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI and XII.</i>		X
b Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional.</i>	X	
13 Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E.</i>		X
14a Did the organization maintain an office, employees, or agents outside of the United States?		X
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? <i>If "Yes," complete Schedule F, Parts I and IV.</i>		X
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? <i>If "Yes," complete Schedule F, Parts II and IV.</i>		X
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? <i>If "Yes," complete Schedule F, Parts III and IV.</i>		X
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? <i>If "Yes," complete Schedule G, Part I</i> (see instructions).		X
18 Did the organization report more than \$15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? <i>If "Yes," complete Schedule G, Part II.</i>	X	
19 Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III.</i>		X

Part IV Checklist of Required Schedules (continued)

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Table with columns for line numbers (1a-14b), descriptions, and Yes/No checkboxes. Includes entries for 1a (260), 1b (0), 2a (3,634), 3a, 3b, 4a, 5a, 5b, 5c, 6a, 6b, 7a-7h, 8, 9a, 9b, 10a, 10b, 11a, 11b, 12a, 12b, 13a, 13b, 13c, 14a, 14b.

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

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

Section A. Governing Body and Management

Table with 4 columns: Question ID, Question Text, Yes, No. Rows include 1a, 1b, 2, 3, 4, 5, 6, 7a, 7b, 8, 8a, 8b, 9.

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

Table with 4 columns: Question ID, Question Text, Yes, No. Rows include 10a, 10b, 11a, 11b, 12a, 12b, 12c, 13, 14, 15a, 15b, 16a, 16b.

Section C. Disclosure

- 17 List the states with which a copy of this Form 990 is required to be filed IN,
18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
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: JEFFREY COSTELLO 615 N. MICHIGAN STREET SOUTH BEND, IN 46601 574-647-3549

Part VII 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

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

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

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

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

(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			
(1) PERRY WATSON III CHAIR- LEFT IN MARCH 2017	2.00 0.	X		X				0.	0.	0.
(2) PETER BARANAY CHAIR	2.00 2.00	X		X				2,472.	0.	0.
(3) KAREN BARNETT VICE CHAIR	2.00 0.	X		X				1,792.	0.	0.
(4) TIM DURHAM TRUSTEE	2.00 0.	X						0.	0.	0.
(5) HUGH HEDMAN MD TRUSTEE	2.00 0.	X						1,792.	0.	0.
(6) BRYAN BOYER TRUSTEE/EMPLOYED PHYSICIAN	2.00 40.00	X						0.	865,926.	34,491.
(7) MARK HARMAN TRUSTEE	2.00 0.	X						0.	0.	0.
(8) THOMAS HAUCH MD SECRETARY/TREASURER	2.00 0.	X		X				1,735.	0.	0.
(9) BRAD TOOTHAKER TRUSTEE	2.00 0.	X						2,972.	0.	0.
(10) JEFFREY P. COSTELLO CFO/ASST. TREASURER	2.00 46.00			X				0.	597,602.	178,765.
(11) KREG GRUBER CEO STARTING NOVEMBER 2017	2.00 46.00			X				0.	640,757.	180,513.
(12) CHERYL WIBBENS-LESH MD ASST. SECR./VP	40.00 2.00			X				375,310.	0.	37,332.
(13) PHILLIP NEWBOLD CEO - LEFT NOVEMBER 2017	2.00 46.00			X				0.	1,710,953.	233,242.
(14) LARRY TRACY PRESIDENT	40.00 0.			X				391,032.	0.	83,201.

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			
(15) KEITH SHERRY MD EMPLOYED PHYSICIAN	40.00 0.					X		327,764.	0.	35,897.
(16) DALE A. PATTERSON EMPLOYED PHYSICIAN	40.00 0.					X		331,825.	0.	33,783.
(17) MARION MAHONE EMPLOYEED PHYSICIAN	40.00 0.					X		270,422.	0.	19,554.
(18) MATTHEW R REED EMPLOYEED PHYSICIAN	40.00 0.					X		260,966.	0.	16,601.
(19) LINDA A MANSFIELD EMPLOYED PHYSICIAN	40.00 0.					X		261,641.	0.	31,519.
1b Sub-total								777,105.	3,815,238.	747,544.
c Total from continuation sheets to Part VII, Section A								1,452,618.	0.	137,354.
d Total (add lines 1b and 1c)								2,229,723.	3,815,238.	884,898.

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 **▶** 124

	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>		X
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>	X	
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>		X

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
ATTACHMENT 1		

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

Part VIII Statement of Revenue

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

				(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514	
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a						
	b Membership dues	1b						
	c Fundraising events	1c						
	d Related organizations	1d	2,983,222.					
	e Government grants (contributions)	1e	2,321,749.					
	f All other contributions, gifts, grants, and similar amounts not included above	1f	7,200.					
	g Noncash contributions included in lines 1a-1f: \$		163,470.					
	h Total. Add lines 1a-1f			5,312,171.				
Program Service Revenue	2a NET PATIENT REVENUE	Business Code	622110	522,579,366.	522,579,366.			
	b OUTPATIENT PHARMACY		561499	5,019,838.			5,019,838.	
	c JOINT VENTURE ACTIVITY		561499	979,127.	979,127.			
	d AMBULANCE SUPPLY		621910	112,343.	112,343.			
	e CASH DISCOUNTS		611710	51,595.	51,595.			
	f All other program service revenue			33,922.	33,922.			
	g Total. Add lines 2a-2f			528,776,191.				
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts).			262,479.			262,479.	
	4 Income from investment of tax-exempt bond proceeds			6,820.			6,820.	
	5 Royalties			6,050.			6,050.	
	6a Gross rents	(i) Real		230,879.				
		(ii) Personal						
		b Less: rental expenses		20,380.				
		c Rental income or (loss)		210,499.				
	d Net rental income or (loss)			210,499.			210,499.	
	7a Gross amount from sales of assets other than inventory	(i) Securities		18,259.				
		(ii) Other		16,584.				
		b Less: cost or other basis and sales expenses			1,019,365.			
		c Gain or (loss)		18,259.	-850,782.			
	d Net gain or (loss)			-832,523.			-832,523.	
	8a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18	a		235,156.				
		b Less: direct expenses	b	285,394.				
c Net income or (loss) from fundraising events. ATTCH 2				-50,238.			-50,238.	
9a Gross income from gaming activities. See Part IV, line 19	a							
	b Less: direct expenses	b						
	c Net income or (loss) from gaming activities			0.				
10a Gross sales of inventory, less returns and allowances	a							
	b Less: cost of goods sold	b						
	c Net income or (loss) from sales of inventory			0.				
Miscellaneous Revenue			Business Code					
11a HLC ATHLETIC CLUB			713940	3,999,234.	3,935,854.		63,380.	
	b VENDOR REBATES		561499	1,220,953.	1,220,953.			
	c CAFETERIA SALES		561499	850,107.			850,107.	
	d All other revenue		561499	4,536,475.	2,958,059.	569,760.	1,008,656.	
	e Total. Add lines 11a-11d			10,606,769.				
12 Total revenue. See instructions.			544,298,218.	531,871,219.	569,760.	6,545,068.		

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	1,994,226.	1,994,226.		
2 Grants and other assistance to domestic individuals. See Part IV, line 22	0.			
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16	0.			
4 Benefits paid to or for members	0.			
5 Compensation of current officers, directors, trustees, and key employees	897,641.		897,641.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0.			
7 Other salaries and wages	142,533,311.	117,019,848.	25,513,463.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	6,028,288.	4,949,224.	1,079,064.	
9 Other employee benefits	23,126,450.	18,986,815.	4,139,635.	
10 Payroll taxes	9,874,232.	8,106,744.	1,767,488.	
11 Fees for services (non-employees):				
a Management	783,313.	643,100.	140,213.	
b Legal	364,904.		364,904.	
c Accounting	292,535.		292,535.	
d Lobbying	25,952.	21,307.	4,645.	
e Professional fundraising services. See Part IV, line 17.	0.			
f Investment management fees	202,329.		202,329.	
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.)	43,120,184.	39,969,189.	3,150,995.	
12 Advertising and promotion	93,188.	76,507.	16,681.	
13 Office expenses	3,943,390.	3,237,523.	705,867.	
14 Information technology	62,843.	51,594.	11,249.	
15 Royalties	0.			
16 Occupancy	8,157,522.	6,697,326.	1,460,196.	
17 Travel	681,669.	559,650.	122,019.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0.			
19 Conferences, conventions, and meetings	83,448.	68,511.	14,937.	
20 Interest	5,520,522.	4,532,349.	988,173.	
21 Payments to affiliates	0.			
22 Depreciation, depletion, and amortization	30,463,544.	25,010,570.	5,452,974.	
23 Insurance	3,097,557.	2,543,094.	554,463.	
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 MEDICAL SUPPLIES	86,962,497.	86,962,497.		
b CORPORATE FEE	34,473,755.	28,302,953.	6,170,802.	
c BAD DEBT EXPENSE	28,872,159.	28,872,159.		
d HOSPITAL ASSESSMENT FEE	17,929,134.	17,929,134.		
e All other expenses	2,236,266.	1,835,974.	400,292.	
25 Total functional expenses. Add lines 1 through 24e	451,820,859.	398,370,294.	53,450,565.	
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)	0.			

Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year
Assets	1 Cash - non-interest-bearing	19,775.	1	19,951.
	2 Savings and temporary cash investments	25,071,146.	2	-160,911.
	3 Pledges and grants receivable, net	385,006.	3	513,766.
	4 Accounts receivable, net	93,322,501.	4	90,151,301.
	5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L	0.	5	0.
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions). Complete Part II of Schedule L	0.	6	0.
	7 Notes and loans receivable, net	0.	7	0.
	8 Inventories for sale or use	17,028,261.	8	16,812,808.
	9 Prepaid expenses and deferred charges	1,015,797.	9	1,075,123.
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 810,159,537.		
	b Less: accumulated depreciation	10b 437,839,333.		
		365,251,082.	10c	372,320,204.
	11 Investments - publicly traded securities	25,000,887.	11	2,681,368.
	12 Investments - other securities. See Part IV, line 11	0.	12	0.
	13 Investments - program-related. See Part IV, line 11	316,256.	13	295,382.
	14 Intangible assets	1,171,474.	14	1,171,474.
15 Other assets. See Part IV, line 11	62,483,144.	15	37,308,738.	
16 Total assets. Add lines 1 through 15 (must equal line 34)	591,065,329.	16	522,189,204.	
Liabilities	17 Accounts payable and accrued expenses	42,624,988.	17	39,242,145.
	18 Grants payable	0.	18	0.
	19 Deferred revenue	30,856.	19	21,589.
	20 Tax-exempt bond liabilities	159,778,646.	20	154,532,285.
	21 Escrow or custodial account liability. Complete Part IV of Schedule D	0.	21	0.
	22 Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L	0.	22	0.
	23 Secured mortgages and notes payable to unrelated third parties	670,966.	23	483,720.
	24 Unsecured notes and loans payable to unrelated third parties	0.	24	0.
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D	36,068,692.	25	30,108,741.
	26 Total liabilities. Add lines 17 through 25	239,174,148.	26	224,388,480.
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.			
	27 Unrestricted net assets	343,264,467.	27	290,986,527.
	28 Temporarily restricted net assets	8,628,350.	28	6,814,197.
	29 Permanently restricted net assets	0.	29	0.
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.			
	30 Capital stock or trust principal, or current funds		30	
	31 Paid-in or capital surplus, or land, building, or equipment fund		31	
	32 Retained earnings, endowment, accumulated income, or other funds		32	
	33 Total net assets or fund balances	351,892,817.	33	297,800,724.
34 Total liabilities and net assets/fund balances	591,066,965.	34	522,189,204.	

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	544,298,218.
2	Total expenses (must equal Part IX, column (A), line 25)	2	451,820,859.
3	Revenue less expenses. Subtract line 2 from line 1	3	92,477,359.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	351,892,817.
5	Net unrealized gains (losses) on investments	5	7,597,444.
6	Donated services and use of facilities	6	0.
7	Investment expenses	7	0.
8	Prior period adjustments	8	0.
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-154,166,896.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	297,800,724.

Part XII Financial Statements and Reporting

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

- 1** Accounting method used to prepare the Form 990: Cash Accrual 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:
 Separate basis Consolidated basis Both consolidated and separate basis
- 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:
 Separate basis Consolidated basis Both consolidated and separate basis
- 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.
- 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?
- 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	No
2a		X
2b	X	
2c	X	
3a	X	
3b	X	

SCHEDULE A
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

▶ Attach to Form 990 or Form 990-EZ.

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

OMB No. 1545-0047

2017

Open to Public Inspection

Name of the organization MEMORIAL HOSPITAL OF SOUTH BEND, INC	Employer identification number 35-0868132
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Part I Reason for Public Charity Status (All organizations must complete this part.) See instructions.

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

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

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

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

Schedule A (Form 990 or 990-EZ) 2017

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 Total. Add lines 1 through 3.						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f).						
6 Public support. Subtract line 5 from line 4						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
7 Amounts from line 4.						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 Total support. Add lines 7 through 10.						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First 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 2017 (line 6, column (f) divided by line 11, column (f)).	14	%
15 Public support percentage from 2016 Schedule A, Part II, line 14	15	%
16a 33 1/3% support test - 2017. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here . The organization qualifies as a publicly supported organization.		<input type="checkbox"/>
b 33 1/3% support test - 2016. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here . The organization qualifies as a publicly supported organization		<input type="checkbox"/>
17a 10%-facts-and-circumstances test - 2017. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here . Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization.		<input type="checkbox"/>
b 10%-facts-and-circumstances test - 2016. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here . Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization.		<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) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 Total. Add lines 1 through 5.						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b.						
8 Public support. (Subtract line 7c from line 6.)						

Section B. Total Support

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

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

Section C. Computation of Public Support Percentage

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

Section D. Computation of Investment Income Percentage

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

19a 33 1/3% support tests - 2017. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization .

b 33 1/3% support tests - 2016. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here**. The organization qualifies as a publicly supported organization ►

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

Part IV Supporting Organizations

(Complete only if you checked a box in line 12 on 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>		
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>		
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>		
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>		
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>		
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>		
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>		
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>		
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>		
b Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
c Substitutions only. Was the substitution the result of an event beyond the organization's control?		
6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? <i>If "Yes," provide detail in Part VI.</i>		
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>		
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>		
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>		
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>		
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>		
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 10b below.</i>		
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>		

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?	11 a	
b A family member of a person described in (a) above?	11 b	
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>	11 c	

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally Integrated Supporting Organizations

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

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

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

Section A - Adjusted Net Income		(A) Prior Year	(B) Current Year (optional)
1	Net short-term capital gain	1	
2	Recoveries of prior-year distributions	2	
3	Other gross income (see instructions)	3	
4	Add lines 1 through 3.	4	
5	Depreciation and depletion	5	
6	Portion of operating expenses paid or incurred for production or collection of gross income or for management, conservation, or maintenance of property held for production of income (see instructions)	6	
7	Other expenses (see instructions)	7	
8	Adjusted Net Income (subtract lines 5, 6, and 7 from line 4).	8	
Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1 Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):			
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).		

Schedule A (Form 990 or 990-EZ) 2017

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

Section D - Distributions	Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in Part VI). See instructions.	
7 Total annual distributions. Add lines 1 through 6.	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in Part VI). See instructions.	
9 Distributable amount for 2017 from Section C, line 6	
10 Line 8 amount divided by Line 9 amount	

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2017	(iii) Distributable Amount for 2017
1 Distributable amount for 2017 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2017 (reasonable cause required-explain in Part VI). See instructions.			
3 Excess distributions carryover, if any, to 2017			
a			
b From 2013			
c From 2014			
d From 2015			
e From 2016			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2017 distributable amount			
i Carryover from 2012 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4 Distributions for 2017 from Section D, line 7: \$			
a Applied to underdistributions of prior years			
b Applied to 2017 distributable amount			
c Remainder. Subtract lines 4a and 4b from 4.			
5 Remaining underdistributions for years prior to 2017, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, explain in Part VI. See instructions.			
6 Remaining underdistributions for 2017. Subtract lines 3h and 4b from line 1. For result greater than zero, explain in Part VI. See instructions.			
7 Excess distributions carryover to 2018. Add lines 3j and 4c.			
8 Breakdown of line 7:			
a Excess from 2013			
b Excess from 2014			
c Excess from 2015			
d Excess from 2016			
e Excess from 2017			

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

Schedule of Contributors

2017

▶ Attach to Form 990, Form 990-EZ, or Form 990-PF.
 ▶ Go to www.irs.gov/Form990 for the latest information.

Name of the organization MEMORIAL HOSPITAL OF SOUTH BEND, INC	Employer identification number 35-0868132
---	---

Organization type (check one):

Filers of:

Section:

Form 990 or 990-EZ

501(c)(³) (enter number) organization

4947(a)(1) nonexempt charitable trust **not** treated as a private foundation

527 political organization

Form 990-PF

501(c)(3) exempt private foundation

4947(a)(1) nonexempt charitable trust treated as a private foundation

501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule**.

Note: Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, contributions totaling \$5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

Special Rules

For an organization described in section 501(c)(3) filing Form 990 or 990-EZ that met the 33 1/3 % support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), that checked Schedule A (Form 990 or 990-EZ), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions of the greater of **(1)** \$5,000; or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h; or (ii) Form 990-EZ, line 1. Complete Parts I and II.

For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than \$1,000 *exclusively* for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I, II, and III.

For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled more than \$1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Don't complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions totaling \$5,000 or more during the year ▶ \$ _____

Caution: An organization that isn't covered by the General Rule and/or the Special Rules doesn't file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it doesn't meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization MEMORIAL HOSPITAL OF SOUTH BEND, INC

Employer identification number
35-0868132**Part I** Contributors (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1	INDIANA STATE DEPARTMENT OF HEALTH 2 N MERIDIAN ST INDIANAPOLIS, IN 46204	\$ 1,685,360.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
2	BEACON HEALTH FOUNDATION, INC 615 N MICHIGAN ST SOUTH BEND, IN 46601	\$ 2,983,222.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input checked="" type="checkbox"/> (Complete Part II for noncash contributions.)
3	INDIANA MEDICAL EDUCATION BOARD CLINICAL BUILDING 365, 541 CLINICAL DR INDIANAPOLIS, IN 46202	\$ 167,450.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
4	DEPARTMENT OF HEALTH AND HUMAN SERVICES 1101 WOOTTON PARKWAY, SUITE 600 ROCKVILLE, MD 20852	\$ 369,212.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
5	INDIANA CRIMINAL JUSTICE INSTITUTE 101 W. WASHINGTON STREET INDIANAPOLIS, IN 46204	\$ 55,968.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
6	SOUTH BEND COMMUNITY SCHOOL CORPORATION 215 SOUTH ST. JOSEPH STREET SOUTH BEND, IN 46601	\$ 43,451.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization MEMORIAL HOSPITAL OF SOUTH BEND, INC	Employer identification number 35-0868132
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Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
7	CHRISTOPHER REEVE FOUNDATION 636 MORRIS TURNPIKE, SUITE 3A SHORT HILLS, NJ 07078	\$ 7,200.	Person <input checked="" type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
		\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
		\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
		\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
		\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
		\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)
		\$ _____	Person <input type="checkbox"/> Payroll <input type="checkbox"/> Noncash <input type="checkbox"/> (Complete Part II for noncash contributions.)

Name of organization MEMORIAL HOSPITAL OF SOUTH BEND, INC

Employer identification number

35-0868132

Part II Noncash Property (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
8	GIFT SHOP	\$ 163,470.	12/31/2017

Name of organization MEMORIAL HOSPITAL OF SOUTH BEND, INC

Employer identification number
35-0868132

Part III *Exclusively* religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than \$1,000 for the year from any one contributor. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of *exclusively* religious, charitable, etc., contributions of \$1,000 or less for the year. (Enter this information once. See instructions.) ► \$ _____
Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
_____	_____ _____ _____	_____ _____ _____	_____ _____ _____

(e) Transfer of gift	
Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee
_____ _____ _____	_____ _____ _____

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
_____	_____ _____ _____	_____ _____ _____	_____ _____ _____

(e) Transfer of gift	
Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee
_____ _____ _____	_____ _____ _____

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
_____	_____ _____ _____	_____ _____ _____	_____ _____ _____

(e) Transfer of gift	
Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee
_____ _____ _____	_____ _____ _____

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held
_____	_____ _____ _____	_____ _____ _____	_____ _____ _____

(e) Transfer of gift	
Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee
_____ _____ _____	_____ _____ _____

SCHEDULE C
(Form 990 or 990-EZ)

Political Campaign and Lobbying Activities

OMB No. 1545-0047

2017

Open to Public Inspection

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.**

Department of the Treasury
Internal Revenue Service

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

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

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

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

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

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

Name of organization MEMORIAL HOSPITAL OF SOUTH BEND, INC	Employer identification number 35-0868132
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Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

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

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

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

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

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

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

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

Schedule C (Form 990 or 990-EZ) 2017

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.															
<table border="1" style="width: 100%;"> <thead> <tr> <th style="text-align: left;">If the amount on line 1e, column (a) or (b) is:</th> <th style="text-align: left;">The lobbying nontaxable amount is:</th> </tr> </thead> <tbody> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e.</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000.</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000.</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000.</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000.</td> </tr> </tbody> </table>		If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	Not over \$500,000	20% of the amount on line 1e.	Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.	Over \$17,000,000	\$1,000,000.		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:														
Not over \$500,000	20% of the amount on line 1e.														
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000.														
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000.														
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000.														
Over \$17,000,000	\$1,000,000.														
g Grassroots nontaxable amount (enter 25% of line 1f)															
h Subtract line 1g from line 1a. If zero or less, enter -0-															
i Subtract line 1f from line 1c. If zero or less, enter -0-															
j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?		<input type="checkbox"/> Yes	<input type="checkbox"/> No												

4-Year Averaging Period Under section 501(h)

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

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column (e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes," response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a)		(b)
	Yes	No	Amount
1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		25,952.
j Total. Add lines 1c through 1i			25,952.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?		X	

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 campaign activity 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.

SEE PAGE 4

Part IV Supplemental Information (continued)

LOBBYING DETAIL

SCHEDULE C, PART IV MEMORIAL HOSPITAL PAID DUES TO THE FOLLOWING ORGANIZATIONS FOR WHICH THE AMOUNT OR PERCENTAGE LISTED WAS ATTRIBUTED TO LOBBYING:

AAFP (AMERICAN ACADEMY OF FAMILY PHYSICIANS) - 16%

AASM (AMERICAN ACADEMY OF SLEEP MEDICINE) - 2%

AMA (AMERICAN MEDICAL ASSOCIATION) - 55%

APTA (AMERICAN PHYSICAL THERAPY ASSOCIATION) - 22%

INDIANA HOSPITAL ASSOCIATION - 21.78%

TRAUMA CENTER ASSOCIATION OF AMERICA - 29%

WHEN UNABLE TO ASCERTAIN ALLOCATION OF DUES ATTRIBUTED TO LOBBYING A CONSERVATIVE ESTIMATE OF 22% IS APPLIED.

SCHEDULE D (Form 990)

Supplemental Financial Statements

OMB No. 1545-0047

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.

2017

Attach to Form 990.

Open to Public Inspection

Department of the Treasury Internal Revenue Service

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

Name of the organization

Employer identification number

MEMORIAL HOSPITAL OF SOUTH BEND, INC

35-0868132

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.

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows include: 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?, 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?

Part II Conservation Easements.

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

Table with 2 columns: Held at the End of the Tax Year. Rows include: 1 Purpose(s) of conservation easements held by the organization (check all that apply), 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, 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?, 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)?, 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.

Table with 2 columns: Revenue, Assets. Rows include: 1a If the organization elected, as permitted under SFAS 116 (ASC 958), not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide, in Part XIII, the text of the footnote to its financial statements that describes these items. 1b If the organization elected, as permitted under SFAS 116 (ASC 958), to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items: (i) Revenue included on Form 990, Part VIII, line 1. (ii) Assets included in Form 990, Part X. 2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 (ASC 958) relating to these items: a Revenue included on Form 990, Part VIII, line 1. b Assets included in Form 990, Part X.

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

Schedule D (Form 990) 2017

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

- 3** Using the organization's acquisition, accession, and other records, check any of the following that are a significant use of its collection items (check all that apply):
- a** Public exhibition
 - b** Scholarly research
 - c** Preservation for future generations
 - d** Loan or exchange programs
 - e** Other _____
- 4** Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIII.
- 5** During the year, did the organization solicit or receive donations of art, historical treasures, or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? Yes No

Part IV Escrow and Custodial Arrangements.

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

- 1a** Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? Yes No
- b** If "Yes," explain the arrangement in Part XIII and complete the following table:
- | | Amount |
|--|-----------|
| c Beginning balance | 1c |
| d Additions during the year | 1d |
| e Distributions during the year | 1e |
| f Ending balance | 1f |
- 2a** Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? Yes No
- b** If "Yes," explain the arrangement in Part XIII. Check here if the explanation has been provided on Part XIII

Part V Endowment Funds.

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	33,854,961.	26,556,022.	29,619,029.	27,642,755.	24,661,171.
b Contributions	2,155,261.	9,605,449.	4,093,832.	2,833,644.	2,180,336.
c Net investment earnings, gains, and losses	2,479,263.	339,397.	-1,367,472.	-142,883.	1,785,965.
d Grants or scholarships	4,284,345.	2,645,907.	5,789,367.	714,487.	984,717.
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance	34,205,140.	33,854,961.	26,556,022.	29,619,029.	27,642,755.

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

- a** Board designated or quasi-endowment 79.8600 %
- b** Permanent endowment .2200 %
- c** Temporarily restricted endowment 19.9200 %

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

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

b If "Yes" on line 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.

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		21,318,068.		21,318,068.
b Buildings		486,870,628.	188,368,902.	298,501,726.
c Leasehold improvements		851,999.	851,999.	
d Equipment		293,352,469.	244,735,853.	48,616,616.
e Other		7,766,373.	3,882,579.	3,883,794.
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				372,320,204.

Part VII Investments - Other Securities.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

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

Part VIII Investments - Program Related.

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

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

Part IX Other Assets.

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

(a) Description	(b) Book value
(1) DUE FROM 3RD PARTY PAYORS	26,303,147.
(2) INT IN NET ASSETS OF REC ORG	6,814,197.
(3) INTEREST RECEIVABLE - SWAP	119,650.
(4) DUE FROM SELF INSURED TRUST	78.
(5) OTHER RECEIVABLES	3,434,746.
(6) 2016 BOND FUND	11,515.
(7) SWAP MARKET-MARKET ADJUST	625,405.
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.) ▶	37,308,738.

Part X Other Liabilities.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) INTEREST RATE SWAP	16,304,635.
(3) ASSET RETIREMENT OBLIGATION	4,589,729.
(4) IBNR	3,298,510.
(5) DUE TO THIRD PARTY	4,964,501.
(6) CAPITAL LEASE PAYABLE	513,221.
(7) MEDTRONIC O-ARM AGREEMENT	375,533.
(8) DUE FROM AFFILIATES	62,612.
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	30,108,741.

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 XIII Supplemental Information (continued)

PART V, LINE 4

THE BOARD HAS DISCRETION TO UTILIZE EACH YEAR THE INCOMES, REVENUES, AND PROFITS ARISING AND ACCRUING FROM THE ENDOWMENTS IN DEFRAYING COSTS ASSOCIATED WITH THE TRUST AND THE REMAINDER FOR SUPPORT, BETTERMENT, IMPROVEMENT, UPKEEP, EXPANSION, AND REPLACEMENT OF BEACON HEALTH SYSTEM, INC. AND ITS CORPORATE AFFILIATES. TERM ENDOWMENTS, WHICH ARE THE TEMPORARILY RESTRICTED NET ASSETS, ARE USED AS DESIGNATED BY THE DONOR. THE PERMANENT ENDOWMENT PROVIDES INCOME TO BE USED FOR HEALTH CARE EDUCATIONAL PURPOSES AND PATIENT CARE.

PART X, LINE 2

ASC 740, INCOME TAXES, REQUIRES THAT REALIZATION OF AN UNCERTAIN INCOME TAX POSITION IS MORE LIKELY THAN NOT (I.E., GREATER THAN 50% LIKELIHOOD OF RECEIVING A BENEFIT) BEFORE IT IS RECOGNIZED IN THE FINANCIAL STATEMENTS AS THE AMOUNT MOST LIKELY TO BE REALIZED ASSUMING A REVIEW BY TAX AUTHORITIES HAVING ALL RELEVANT INFORMATION AND APPLYING CURRENT CONVENTIONS. THIS INTERPRETATION ALSO CLARIFIES THE FINANCIAL STATEMENT CLASSIFICATION OF TAX-RELATED PENALTIES AND INTEREST AND SETS FORTH NEW DISCLOSURES REGARDING UNRECOGNIZED TAX BENEFITS. NO AMOUNT WAS RECORDED FOR THE YEARS ENDED DECEMBER 31, 2017 OR 2016

.

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	(b) Event #2	(c) Other events	(d) Total events
		MARATHON (event type)	(event type)	(total number)	(add col. (a) through col. (c))
Revenue	1	Gross receipts	235,156.		235,156.
	2	Less: Contributions			
	3	Gross income (line 1 minus line 2)	235,156.		235,156.
Direct Expenses	4	Cash prizes			
	5	Noncash prizes	18,570.		18,570.
	6	Rent/facility costs			
	7	Food and beverages	713.		713.
	8	Entertainment			
	9	Other direct expenses	266,111.		266,111.
	10	Direct expense summary. Add lines 4 through 9 in column (d) ▶			
11	Net income summary. Subtract line 10 from line 3, column (d) ▶				-50,238.

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				
Direct Expenses	2	Cash prizes				
	3	Noncash prizes				
	4	Rent/facility costs				
	5	Other 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 type="checkbox"/> No	
	7	Direct expense summary. Add lines 2 through 5 in column (d) ▶				
	8	Net gaming income summary. Subtract line 7 from line 1, column (d) ▶				

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

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	%
b An outside facility	13b	%

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

Name ▶ _____

Address ▶ _____

- 15 a 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 ▶ _____

Gaming manager compensation ▶ \$ _____

Description of services provided ▶ _____

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 to be distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ \$ _____

Part IV Supplemental Information. Provide the explanation 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).

PART II EVENT #1

MEMORIAL HOSPITAL OF SOUTH BEND FACILITATES AN ANNUAL SUNBURST MARATHON BY COLLECTING REGISTRATION PAYMENT AND ORGANIZING THE EVENT. ALL CONTRIBUTIONS ARE DIRECTED TO AND RECORDED BY BEACON HEALTH FOUNDATION. IT IS COMMON FOR THE EVENT TO BE RUN AT A LOSS AS ALL THE SPONSORSHIP AND CONTRIBUTION INCOME IS RECORDED BY BEACON HEALTH FOUNDATION.

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2017

Open to Public Inspection

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, question 20.**

▶ **Attach to Form 990.**

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

Department of the Treasury
Internal Revenue Service

Name of the organization

MEMORIAL HOSPITAL OF SOUTH BEND, INC

Employer identification number

35-0868132

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	X	
1b If "Yes," was it a written policy?	X	
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 checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %	X	
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 checked="" type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	X	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	X	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
5b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		X
5c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		
6a Did the organization prepare a community benefit report during the tax year?	X	
6b If "Yes," did the organization make it available to the public?	X	

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)			2,749,588.		2,749,588.	.65
b Medicaid (from Worksheet 3, column a)			91,380,678.	88,193,625.	3,187,053.	.75
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			94,130,266.	88,193,625.	5,936,641.	1.40
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			11,152,285.	2,091,689.	9,060,596.	2.14
f Health professions education (from Worksheet 5)			8,086,838.	1,615,746.	6,471,092.	1.53
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)			105,174.	102,767.	2,407.	
i Cash and in-kind contributions for community benefit (from Worksheet 8)			225,225.		225,225.	.05
j Total. Other Benefits			19,569,522.	3,810,202.	15,759,320.	3.72
k Total. Add lines 7d and 7j.			113,699,788.	92,003,827.	21,695,961.	5.12

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 Community support	1	200	34,734.		34,734.	
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building	2		42,165.		42,165.	
7 Community health improvement advocacy						
8 Workforce development						
9 Other						
10 Total	3	200	76,899.		76,899.	

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	X	
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		
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	84,404,035.
6 Enter Medicare allowable costs of care relating to payments on line 5	6	107,673,984.
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-23,269,949.
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	X	
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	X	

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

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %
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? 1

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)

1 MEMORIAL HOSPITAL OF SOUTH BEND, INC
 615 N MICHIGAN STREET
 SOUTH BEND IN 46545
 WWW.BEACONHEALTHSYSTEM.ORG
 16-005053-1

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
X	X	X	X		X	X			

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group MEMORIAL HOSPITAL OF SOUTH BEND, INC

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?		X
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C		X
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 If "Yes," indicate what the CHNA report describes (check all that apply):	X	
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>15</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	X	
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	X	
6b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	X	
7 Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the CHNA report was made widely available (check all that apply):	X	
a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>SEE SECTION C FOR FULL URL</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	X	
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>15</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	X	
a If "Yes," (list url): <u>SEE SECTION C FOR FULL URL</u>		
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		X
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group MEMORIAL HOSPITAL OF SOUTH BEND, INC

		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:	X	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200.0000</u> % and FPG family income limit for eligibility for discounted care of <u>350.0000</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input checked="" type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input type="checkbox"/> Insurance status		
f	<input type="checkbox"/> Underinsurance status		
g	<input type="checkbox"/> Residency		
h	<input checked="" type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	X	
15	Explained the method for applying for financial assistance? 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):	X	
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):	X	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE SECTION C FOR FULL URL</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE SECTION C FOR FULL URL</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE SECTION C FOR FULL URL</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input type="checkbox"/> Other (describe in Section C)		

Part V Facility Information (continued)

Billing and Collections

Name of hospital facility or letter of facility reporting group MEMORIAL HOSPITAL OF SOUTH BEND, INC

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

Name of hospital facility or letter of facility reporting group MEMORIAL HOSPITAL OF SOUTH BEND, INC

		Yes	No
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 <input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
	b <input checked="" type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> 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.		X
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.		X

Schedule H (Form 990) 2017

Part V Facility Information (continued)

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

PART V, SECTION B, LINE 5

DURING 2015, BEACON HEALTH SYSTEM CONDUCTED A JOINT COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) REPRESENTING APPROXIMATELY 267,000 RESIDENTS OF ST. JOSEPH COUNTY (SJC) AND APPROXIMATELY 200,000 RESIDENTS OF ELKHART COUNTY, WHICH REFLECT THE PRIMARY MARKET SERVICE AREAS FOR MEMORIAL HOSPITAL OF SOUTH BEND (MHSB), AND ELKHART GENERAL HOSPITAL (EGH), RESPECTIVELY. IN LATE 2014 THROUGH FEBRUARY 2015, DIALOGUE ON THE CHNA PLANNING AND COORDINATION OCCURRED AMONG BEACON HEALTH SYSTEM EXECUTIVES AND THE COMMUNITY BENEFIT STAFF FROM BOTH MHSB AND EGH. IT WAS AGREED THAT A THIRD PARTY CONSULTANT - HOLLERAN CONSULTING OF LANCASTER, PENNSYLVANIA - WOULD SERVE AS THE DATA GATHERING ENTITY FOR BOTH HOSPITALS.

AN ONLINE CHNA SURVEY CONDUCTED THROUGH AUGUST 2015 PROVIDED INSIGHT TO BARRIERS TO ACCESSING CARE, THE IMPACT OF SOCIAL DETERMINANTS OF HEALTH, RESOURCE UTILIZATION AND UNDERSERVED POPULATIONS. COMMUNITY ENGAGEMENT AND FEEDBACK ARE ESSENTIAL TO THE INTEGRITY AND VALIDITY OF THE SJC CHNA PROCESS. THEREFORE, INPUT WAS ACTIVELY SOLICITED AND SECURED FROM THREE SOURCES:

- KEY INFORMANTS WHO HOLD A BROAD KNOWLEDGE OF THE INTERESTS OF SJC, INCLUDING PUBLIC HEALTH, AND MINORITY, CULTURAL, AND UNDERSERVED POPULATIONS
- COMMUNITY MEMBERS AT LARGE REPRESENTING 267,618 SJC RESIDENTS
- COMMUNITY HEALTH ADVISORY COUNCIL REPRESENTING MEDICAL AND HEALTH SERVICES FIELDS.

Part V Facility Information (continued)

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

THE FIRST STAGE OF ASSESSMENT WAS SEEKING TO GATHER INPUT FROM KEY INFORMANTS. ORGANIZATIONS INVITED TO PROVIDE INPUT INCLUDED THE FOLLOWING: SAMARITAN COUNSELING CENTER; MDWISE, A MEDICAID MANAGED CARE ENTITY; HARPER CANCER RESEARCH INSTITUTE UNIVERSITY OF NOTRE DAME; JUNIOR LEAGUE OF SOUTH BEND; BRIDGES OUT OF POVERTY; CITY OF MISHAWAKA FIRE DEPARTMENT; MEMORIAL FAMILY RESIDENCY PROGRAM; YMCA OF MICHIANA; HOPE MINISTRIES, WHICH SERVES HOMELESS FAMILIES; GOODWILL INDUSTRIES; IMANI UNIDAD, A NOT-FOR-PROFIT ORGANIZATION PROVIDING COUNSELING TO MINORITIES AND PERSONS WITH HIV; SAINT MARY'S COLLEGE; BIKE MICHIANA COALITION; AND HEALTHY FAMILIES OF ST. JOSEPH COUNTY.

ADDITIONAL INPUT ON PERCEIVED HEALTH PRIORITIES AND BARRIERS TO ACCESSING CARE WAS SOLICITED FROM THE COMMUNITY AT LARGE THROUGH AN ONLINE SURVEY THAT COULD BE ACCESSED DIRECTLY FROM HOME OR WORK INTERNET OR THROUGH THE FREE, COMMUNITY SERVICE COMPUTERS LOCATED AT ST. JOSEPH COUNTY PUBLIC LIBRARIES. CONSIDERATION WAS GIVEN TO ENSURING THE EASE OF ACCESS TO SURVEY COMPLETION TO HARD TO REACH POPULATIONS, INCLUDING HISPANIC LATINO, AFRICAN AMERICAN, AND LOW-INCOME POPULATIONS. HARD COPIES OF THE SURVEY WERE PROVIDED AS WELL AS ASSISTANCE FOR THOSE WHO REQUESTED IT. FURTHERMORE, INPUT WAS SOLICITED AND RECEIVED FROM THE MEDICALLY UNDERSERVED, LOW-INCOME OR MINORITY POPULATIONS BY MAKING THE ASSESSMENT AVAILABLE AT COMMUNITY MEETINGS, CHURCH MEETINGS, NEIGHBORHOOD RESIDENTIAL CENTERS AND COMMUNITY CENTERS. THE ASSESSMENT WAS ALSO SHARED WITH LA CASA DE AMISTAD, A CHARITABLE ORGANIZATION THAT FUNCTIONS AS A

Part V Facility Information (continued)

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

COMMUNITY CENTER ON THE WEST SIDE OF SOUTH BEND FOR SPANISH SPEAKING FAMILIES. ALL SOURCES THAT WERE SOLICITED PROVIDED INPUT.

BASED UPON PRIMARY AND SECONDARY DATA, A PRIORITY SETTING WORKSHEET WAS CREATED. THE SECONDARY DATA PROFILE DEPICTS POPULATION AND HOUSEHOLD STATISTICS, EDUCATION AND ECONOMIC MEASURES, MORBIDITY AND MORTALITY RATES, DISEASE INCIDENCE RATES, AND OTHER HEALTH STATISTICS. INPUT FROM EACH SOURCE, WAS INSERTED INTO A SEPARATE COLUMN AND ASSIGNED A UNIQUE WEIGHTED PERCENTAGE BASED ON SEVERAL FACTORS (E.G., SAMPLE SIZE): KEY INFORMANTS (20%); COMMUNITY MEMBERS AT LARGE (40%); ADVISORY COUNCIL (20%); SECONDARY DATA (20%). THE 19 ROWS IN THE WORKSHEET REPRESENTED EACH OF THE POTENTIAL HEALTH AND SOCIAL ISSUES LISTED IN THE CHNA. AFTER TABULATING THE TOTAL SCORES FOR EACH ISSUE (RANGING FROM 0 -100%), THE FOLLOWING SIX ISSUES EMERGED WITH A SCORE GREATER THAN EIGHTY PERCENT (80%) - AND WERE SELECTED AS MHSB 2016-2018 PRIORITIES:

- ACCESS TO HEALTH CARE/UNINSURED
- MENTAL HEALTH/SUICIDE
- VIOLENCE/SAFETY/TRAUMA
- DIABETES
- MATERNAL/INFANT HEALTH/PRENATAL CARE
- OBESITY/OVERWEIGHT

THE FIRST THREE WERE ALSO DESIGNATED PRIORITIES FROM 2013 THROUGH 2015.

OF THE REMAINING THIRTEEN (13) ISSUES, NINE (9) WERE SCORED AT ZERO AND

Part V Facility Information (continued)

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

FOUR (4), CANCER, EDUCATION, POVERTY, AND SUBSTANCE/ALCOHOL ABUSE, WERE SCORED FROM FORTY (40) TO SIXTY (60) PERCENT. MHSB DOES NOT INTEND TO INCLUDE THEM IN ITS IMPLEMENTATION STRATEGY DUE TO OTHER COMMUNITY HEALTH NEEDS TAKING PRECEDENT, LIMITED RESOURCES, AND THE NEED BEING ADDRESSED BY ORGANIZATIONS WITHIN THE COMMUNITY.

PART V, SECTION B, LINE 6A & 6B

MEMORIAL HOSPITAL OF SOUTH BEND DEVELOPED THE 2015 ST. JOSEPH COUNTY CHNA IN PARTNERSHIP WITH ELKHART GENERAL HOSPITAL, A BEACON HEALTH SYSTEM CARE PARTNER, AND THE SAINT JOSEPH COUNTY HEALTH DEPARTMENT. ELKHART COUNTY RESIDENTS WERE SURVEYED AT THE SAME TIME.

PART V, SECTION B, LINE 7A, 7D & 10A

IN 2015, THE SAINT JOSEPH COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) AND IMPLEMENTATION STRATEGIES REPORT WERE SUBMITTED TO THE MEMORIAL HOSPITAL BOARD OF DIRECTORS FOR REVIEW AND WERE APPROVED IN 2015. THESE DOCUMENTS WERE SUBSEQUENTLY MADE WIDELY AVAILABLE TO THE COMMUNITY THROUGH POSTING ON THE MHSB WEBSITE AT BEACONHEALTHSYSTEM.ORG/CHNA, THROUGH HARD COPIES MADE AVAILABLE BY REQUEST, THROUGH PAPER COPY MADE AVAILABLE FOR MHSB ADMINISTRATION, AND THROUGH EMAIL TRANSMISSION UPON REQUEST. MHSB STAFF WERE ALSO AVAILABLE TO DISCUSS THE RESULTS OF THE CHNA AND THE 2015 IMPLEMENTATION STRATEGIES IN REQUESTED COMMUNITY FORUMS.

Part V Facility Information (continued)

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

PART V, SECTION B, LINE 11

MHSB PROVIDED LEADERSHIP THROUGHOUT THE 2015 CHNA PROCESS. THE DATA FROM THIS COLLECTIVE CHNA INPUT PROCESS IDENTIFIED NINETEEN HEALTH NEEDS:

1. ACCESS TO CARE/UNINSURED
2. AGING POPULATION
3. CANCER
4. CHRONIC RESPIRATORY DISEASE / ASTHMA
5. DENTAL HEALTH
6. DIABETES
7. EDUCATION
8. HEALTH DISPARITIES
9. HEART DISEASE
10. MATERNAL/INFANT HEALTH/PRENATAL CARE
11. MENTAL HEALTH/SUICIDE
12. OVERWEIGHT/OBESITY
13. POVERTY
14. REPRODUCTIVE HEALTH/PREGNANCIES/STDS
15. STROKE
16. SUBSTANCE ABUSE/ ALCOHOL ABUSE
17. TOBACCO
18. TRANSPORTATION
19. VIOLENCE/SAFETY/TRAUMA.

OF THESE, THE FOLLOWING SIX WERE IDENTIFIED AS BEING A PRIORITY FOR 2017:

ACCESS TO CARE/UNINSURED, MENTAL HEALTH/SUICIDE, VIOLENCE/SAFETY/TRAUMA,

Part V Facility Information (continued)

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

DIABETES, MATERNAL/INFANT HEALTH/PRENATAL CARE, AND OVERWEIGHT/OBESITY.

OF THE REMAINING THIRTEEN ISSUES, MHSB DOES NOT INTEND TO INCLUDE THEM IN ITS IMPLEMENTATION STRATEGY DUE TO THE PROMINENCE OF OTHER COMMUNITY HEALTH NEEDS, LIMITED RESOURCES, AND OTHER ORGANIZATIONS WITHIN THE COMMUNITY ADDRESSING THOSE NEEDS. WE WILL CONTINUE TO LEAD AND ENGAGE IN ACTIVE COMMUNITY DIALOGUES TO MEASURE AND ENSURE MOVEMENT TOWARD GOALS AS MHSB'S IMPLEMENTATION STRATEGY IS EXECUTED. WE ALSO INTEND TO CONTINUE HELPING SUPPORT OTHER COMMUNITY NEEDS THAT EMERGE FROM KEY COMMUNITY LEADERS AND STAKEHOLDERS, COMMUNITY MEMBERS AT LARGE, AND PREVALENCE OF HEALTH INDICATORS.

1. ACCESS TO HEALTH CARE/UNINSURED

WHILE THE ARRIVAL OF THE AFFORDABLE CARE ACT (ACA) PROVIDED MANY ST. JOSEPH COUNTY (SJC) RESIDENTS WITH NEEDED HEALTH COVERAGE, A LARGE SEGMENT OF OUR COUNTY CONTINUES TO FALL THROUGH THE CRACKS FOR MYRIAD REASONS INCLUDING INELIGIBILITY DUE TO LACK OF LEGAL RESIDENCY STATUS, THE UNAFFORDABILITY OF INDIANA ACA MARKETPLACE PROGRAMS FOR ELIGIBLE PERSONS, AND THE INCREASING TREND OF HIGH-DEDUCTIBLE EMPLOYER-SPONSORED PLANS THAT ARE CREATING DELAYS OR BARRIERS FOR INSURED PERSONS TO UTILIZE HEALTH CARE AT AN APPROPRIATE TIME.

MHSB DATA FROM YEAR 2017 INDICATES OUT OF 30,422 PATIENTS WITH A UNIQUE ID, 16% OF THE PATIENTS WERE UNINSURED AND 11.5% HAD NO PRIMARY CARE PROVIDER (PCP). FOR THOSE WHO ARE UNINSURED AND WITHOUT A PCP IT HINDERS

Part V Facility Information (continued)

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

THE COMPLETION OF ROUTINE WELLNESS VISITS AND COULD LEAD TO HIGHER DEMAND FOR ED SERVICES WHEN ILL. THIS CONFIRMS THE NEED FOR PRIORITIZING ACCESS TO CARE AMONG THEIR PATIENTS AND IN THE COMMUNITY.

PRIORITY FOCUS 1: ENSURE ACCESS TO HEALTH INSURANCE, EDUCATION AND SELF-MANAGEMENT SKILLS

PRIORITY FOCUS 2: PROVIDE SCREENINGS AND EDUCATION

PROGRAMS TO ADDRESS THIS NEED ARE AS FOLLOWS:

AGING IN PLACE (AIP)

AIP PROGRAMMING HELPS SENIORS IN LOW-INCOME HOUSING REMAIN PRODUCTIVELY AND SUCCESSFULLY INDEPENDENT BY PROVIDING THEM WITH CARING AND HOLISTIC SERVICES SO THEY CAN CONTINUE TO BE A RICH PART OF THE COMMUNITY AND SOCIETY. THE AIP PROGRAM PROVIDES A VARIETY OF SERVICES THAT SUPPORT ACCESS TO CARE, INCLUDING: HEALTH OVERSIGHT, MEDICATION ADHERENCE, ASSISTANCE IN CONNECTING PARTICIPANTS TO A PRIMARY CARE PHYSICIAN AND OTHER HEALTH RESOURCES. THE PROGRAM IS HOSTED AT THREE SOUTH BEND SITES (ROBERTSON'S APARTMENTS, MONROE CIRCLE COMMUNITY CENTER, AND HERITAGE PLACE AT LASALLE SQUARE).

OUTCOME

PRE- AND POST-INTERVENTION PACKETS CONSISTING OF A DEMOGRAPHIC QUESTIONNAIRE AND MORISKY MEDICATION ADHERENCE SCALE WERE DISTRIBUTED TO

Part V Facility Information (continued)

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

PARTICIPANTS IN DECEMBER OF 2015 AND AUGUST 2016. IN ADDITION, ATTENDANCE LOGS FROM NOVEMBER 2015 THROUGH OCTOBER 2016 WERE REVIEWED TO ASSESS HEALTH EDUCATION PARTICIPATION IN THE FOLLOWING ACTIVITIES: PHYSICAL HEALTH SEMINARS, NURSE VISITS, AND ESENIORCARE MEDICAL WORKSHOPS.

DURING THAT TIME PERIOD, 77% OF THE 115 AIP RESIDENTS REPORTED HAVING A PRIMARY CARE PHYSICIAN COMPARED TO 71% IN 2014 (NO DATA FROM 2015). ADDITIONALLY, 48% WERE ENGAGED IN HEALTH EDUCATION SERVICES, A 15% INCREASE FROM THE PREVIOUS YEAR. THE ACTIVITIES/EVENTS LISTED ABOVE WERE ALL PROVIDED ON A WEEKLY BASIS, WITH THE EXCEPTION OF THE PHYSICAL HEALTH SEMINARS WHICH OCCURRED MONTHLY. AN AVERAGE OF SIX RESIDENTS PARTICIPATED IN THE PHYSICAL HEALTH SEMINARS CONSISTENTLY. NURSING VISITS THAT ADDRESSED HEALTH CONCERNS AND BLOOD PRESSURE CHECKS ON AVERAGE COULD EXPECT TEN RESIDENTS. EVERY WEEK FROM NOVEMBER 2015 THROUGH AUGUST 2016, THE UNIVERSITY OF NOTRE DAME HOSTED ESENIORCARE MEDICAL WORKSHOPS TO HELP RESIDENTS ELECTRONICALLY MONITOR THEIR MEDICATION ADHERENCE. TWENTY-SIX (26) PARTICIPANTS ATTENDED THOSE WORKSHOPS WHERE THEY WERE TRAINED ON THE IMPORTANCE OF USING THE ADHERENCE COMPONENT OF THE APPLICATION ON THEIR TABLETS AND SETTING HEALTH GOALS.

IN 2017, 93 RESIDENTS CONSISTENTLY PARTICIPATED IN THE AGING IN PLACE (AIP) PROGRAM IN ST. JOSEPH COUNTY. AT 77%, THE PROGRAM MAINTAINED RESIDENTS HAVING A PRIMARY CARE PROVIDER. THE PROGRAM DID NOT MEET THE SECOND GOAL OF SUSTAINING THE PARTICIPATION RATE OF COMMUNITY MEMBERS IN HEALTH EDUCATION SERVICES PROVIDED THROUGH AIP, AS THE PERCENTAGE DROPPED

Part V Facility Information (continued)

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

BY 6.8%, THE PARTICIPATION WAS STILL HIGHER THAN THE 2015 PROGRAM YEAR BY NEARLY 8%. ACTIVITIES AND EVENTS, SUCH AS PHYSICAL HEALTH SEMINARS AND NURSE VISITS, WERE PROVIDED ON A MONTHLY AND SOME ON A WEEKLY BASIS WITH THE EXCEPTION OF NURSE VISIT WHICH CONCLUDED ON NOVEMBER 30, 2016.

BEACON HEALTH SYSTEM NAVIGATORS AND COVERING KIDS & FAMILIES PARTNERSHIP

IN 2016, BEACON HEALTH SYSTEM (BHS) AND COVERING KIDS & FAMILIES OF NORTH CENTRAL INDIANA (CKF), AN ENTITY OF UNITED HEALTH SERVICES, DEVELOPED A PLAN TO PROVIDE ACCESS TO COVERAGE FOR A WIDER RANGE OF POTENTIAL PATIENTS PRIOR TO PRESENTING AT ANY BEACON FACILITY. MEMORIAL HOSPITAL OF SOUTH BEND'S IMPLEMENTATION STRATEGY FOR ADDRESSING ACCESS TO HEALTH COVERAGE IS TO CONTINUE TO PROVIDE OUTREACH-BASED, FREE ENROLLMENT AND ADVOCACY SERVICES FOR LOW-INCOME AND/OR ELIGIBLE ST. JOSEPH COUNTY (SJC) RESIDENTS. CKF HEAVILY PROMOTED SJC ENROLLMENT SERVICES THROUGH ROBUST OUTREACH TO TARGET CATCHMENTS OF LOW-INCOME INDIVIDUALS. IN-REACH EFFORTS INCLUDED ENROLLMENT AWARENESS AND HEALTH COVERAGE EDUCATION AT MULTIPLE ACCESS POINTS THROUGHOUT BHS OVERALL, INCLUDING THE EMERGENCY ROOM, PATIENT ACCOUNTS, HEALTH INFORMATION MANAGEMENT, CASHIER'S OFFICE, SOCIAL SERVICES, PHYSICIANS' PRACTICES, AND OTHER SITES. DUE TO OUR AGREEMENT WITH THE INDIANA DEPARTMENT OF INSURANCE, INDIANA NAVIGATORS WERE ADVISED AGAINST COLLECTING ADDITIONAL INFORMATION (E.G., DEMOGRAPHICS) ON APPLICANTS.

OUTCOME

Part V Facility Information (continued)

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

IN 2016, BEACON/CKF ASSISTED 709 ST. JOSEPH COUNTY RESIDENTS IN APPLYING FOR HEALTH COVERAGE ASSISTANCE THROUGH THE AFFORDABLE CARE ACT, THE HEALTHY INDIANA PLAN, AND MEDICAID. IN 2015, THIS FIGURE WAS 242. FURTHERMORE, A TOTAL OF 558 ASSISTS FOR ELKHART AND ST. JOSEPH COUNTIES TOGETHER OCCURRED WITH APPLICANTS AND SUCCESSFUL ENROLLEES. ALTHOUGH WE PROVIDED ASSISTANCE TO THESE INDIVIDUALS DURING THE APPLICATION PROCESSES, WE WERE UNABLE TO VERIFY WHETHER AN INDIVIDUAL ULTIMATELY ENROLLED DUE TO SUCH FACTORS AS THE INABILITY TO SELECT A SPECIFIC PROGRAM AT TIME OF APPOINTMENT, MISSING OR INCOMPLETE DOCUMENTATION VERIFICATION, NEED TO FOLLOW UP WITH ESTABLISHED CLINICAL OR PRESCRIPTION PROVIDERS TO CONFIRM PARTICIPATION IN SPECIFIC PLANS, AND INABILITY TO COMMIT TO SPECIFIC PLANS DUE TO AFFORDABILITY ISSUES. BEACON HEALTH SYSTEM'S HEALTH INSURANCE TRACKER DATABASE HAS BEEN UPDATED TO APPROPRIATELY TRACK THE SUCCESS OF ENROLLMENT EFFORTS STARTING IN 2017.

IN 2017, INSURANCE ENROLLMENT PROVIDERS WERE ABLE TO SERVE 1,677 PEOPLE ACROSS THE REGION, WITH 86% GETTING HEALTH INSURANCE. A SIX-MONTH FOLLOW-UP PROCESS WAS PILOTTED TO DISCOVER AND RECORD HOW EFFECTIVE INITIAL EFFORTS WERE. PHONE CALLS WENT OUT TO 87 PARTICIPANTS WHO WERE SUCCESSFULLY ENROLLED, AND 59% SAID THEY NOW HAD A PCP.

NORTH CENTRAL INDIANA SICKLE CELL INITIATIVE (NCISCI)

THIS INITIATIVE RAISES AWARENESS OF SICKLE CELL DISEASE AND TRAIT THROUGH EDUCATION AND SCREENING THAT HELP REDUCE THE INCIDENCE OF THIS PAINFUL, AND SOMETIMES DEADLY, DISEASE. BOTH THE HEALTH COORDINATOR AND EDUCATOR

Part V Facility Information (continued)

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

PROVIDE NEWBORN SCREENING FOLLOW-UPS, REFERRALS, COUNSELING SESSIONS, HOME AND CLINIC VISITS WITH FAMILIES ON ADDITIONAL TOPICS SUCH AS THE DANGERS OF SECONDHAND SMOKE AND GETTING INSURANCE. CARE COORDINATION WITH SCHOOL NURSES, FAMILIES, COACHES, STUDENTS, PEDIATRICIANS, AND HEMATOLOGISTS IS ALSO PROVIDED FOR THE PURPOSE OF ENSURING INDIVIDUALS WITH SICKLE CELL DISEASE BECOME SUPPORTED BY A CONTINUUM OF CARE.

OUTCOME

THERE WERE 3,638 FAMILIES AND INDIVIDUALS REFERRED BY THE INDIANA NBS LABORATORY WITH SICKLE CELL TRAIT OR TRAIT OF ANOTHER HEMOGLOBINOPATHY. THESE FAMILIES RECEIVED CASE MANAGEMENT, COUNSELING, AWARENESS EDUCATION, AND/OR FREE SICKLE CELL TRAIT TESTING IN ST. JOSEPH AND ELKHART COUNTIES AND 31 SURROUNDING COUNTIES. SICKLE CELL CONFERENCES WERE ALSO PROVIDED.

2. MENTAL HEALTH/SUICIDE

THE SUICIDE RATE PER 100,000 IS HIGHER IN SJC (13.4) THAN THE NATION (12.6), AND MEMORIAL'S CHILDREN'S HOSPITAL REPORTED A DRAMATIC INCREASE IN PEDIATRIC PATIENTS HOSPITALIZED FROM FAILED-SUICIDE ATTEMPTS. THE YEARS OF POTENTIAL LIFE LOST BEFORE AGE 75 PER AGE-ADJUSTED 100,000 IS ALSO HIGHER IN SJC (7,424) THAN THE NATIONAL BENCHMARK OF 5,200. SJC REPORTED MORE AVERAGE DAYS OF POOR MENTAL HEALTH WHEN COMPARED TO THE NATIONAL BENCHMARK (3.7 VERSUS 2.3 OUT OF 30 DAYS). OF THE 549 COMMUNITY SURVEY RESPONDENTS, 27% REPORTED LIVING WITH SOMEONE DEPRESSED, MENTALLY ILL, OR SUICIDAL; UP FROM 14% IN 2012. MIRRORING THIS, 21.5% OF SJC

Part V Facility Information (continued)

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

RESPONDENTS REPORTED HAVING BEEN DIAGNOSED WITH AN ANXIETY DISORDER (15% IN 2012) AND 29.2% WERE DIAGNOSED WITH A DEPRESSIVE DISORDER (21% IN 2012). TO FACE THOSE CHALLENGES AND MEET THIS NEED, BEACON COMMUNITY HEALTH HAS CREATED THESE FOCUS AREAS AND INDICATORS TO ASSESS PROGRESS OVER TIME.

PRIORITY FOCUS 1: YOUTH AND ADOLESCENT DEVELOPMENT

PRIORITY FOCUS 2: MENTAL HEALTH IN AGING POPULATIONS

PRIORITY FOCUS 3: INCREASE YOUTH RESILIENCE

PRIORITY FOCUS 4: INCREASE AWARENESS OF SUICIDE PREVENTION

PROGRAMS TO ADDRESS THIS NEED ARE AS FOLLOWS-

AGING IN PLACE (AIP)

AIP PROGRAMMING HELPS SENIORS IN LOW-INCOME HOUSING REMAIN PRODUCTIVELY AND SUCCESSFULLY INDEPENDENT BY PROVIDING THEM WITH CARING AND HOLISTIC SERVICES SO THEY CAN CONTINUE TO BE A RICH PART OF THE COMMUNITY AND SOCIETY. THE PROGRAM IS HOSTED AT THREE SOUTH BEND SITES (ROBERTSON'S APARTMENTS, MONROE CIRCLE COMMUNITY CENTER, AND HERITAGE PLACE AT LASALLE SQUARE).

OUTCOME

NINETY-THREE (93) AGING ADULTS PARTICIPATED IN SOCIO-EMOTIONAL ACTIVITIES FOR THE 2017 PROGRAM YEAR WHICH IS 22% HIGHER FROM THE PREVIOUS YEAR. ON AVERAGE THIRTY-FOUR (34) RESIDENTS PARTICIPATED IN THE SOCIAL- EMOTIONAL

Part V Facility Information (continued)

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

SPECIAL EVENTS CONSISTENTLY.

DRUMBEAT

DRUMBEAT IS A PROGRAM PROVIDED BY THE ARC ALLIANCE FOR YOUTH AT THE JUVENILE JUSTICE CENTER. IT PROMOTES AND TEACHES HAND DRUMMING AS A TOOL FOR PROMOTING SOCIAL NETWORKS, RELATIONSHIP BUILDING, PHYSICAL EXERCISE, AND STRESS MANAGEMENT.

OUTCOME

AT THE JUVENILE JUSTICE CENTER, 34 YOUTH PARTICIPATED IN THE DRUMBEAT PROGRAM. OF THAT GROUP, 38% STARTED THE PROGRAM WITH DEPRESSION OR ANXIETY, COMPARED TO 21% AT ITS COMPLETION. IN COMPARISON, HP2020'S GOAL IS TO REDUCE THE PROPORTION OF ADOLESCENTS AGED 12 TO 17 WHO EXPERIENCE A MAJOR DEPRESSIVE EPISODE FROM 8.3% TO 7.5%. JJC YOUTH ALSO SAW THEIR EMOTIONAL REACTIVITY SCORES - REPRESENTING INCREASED RESILIENCE - CLIMB 23% BY THE END OF THE PROGRAM.

MARY MORRIS LEIGHTON LECTURE

THE MARY MORRIS LEIGHTON LECTURE, AN ANNUAL EVENT ORGANIZED BY BEACON COMMUNITY HEALTH AND SPONSORED BY THE LEIGHTON-OARE FOUNDATION, BRINGS THE OPPORTUNITY OF SHARING HEALTH AND WELLNESS INFORMATION WITH OUR COMMUNITY. EACH YEAR THE TOPIC CONNECTS BACK TO ONE OF OUR CHNA HEALTH PRIORITY AREAS. ALIGNING THE LECTURE FOCUS WITH OUR PRIORITY AREAS ENSURES THAT THE MOST VALUABLE HEALTH INFORMATION IS CONVEYED.

Part V Facility Information (continued)

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

OUTCOME

350 COMMUNITY MEMBERS ATTENDED AN EDUCATIONAL SEMINAR ON THE OPIOID EPIDEMIC. OF THE 170 WHO COMPLETED THE SURVEY:

-78% AGREED OR STRONGLY AGREED THE INFORMATION WAS USEFUL FOR THEIR PERSONAL HEALTH AND WELLNESS

-91% SAID THE INFORMATION PROMPTED THEM TO CONTINUE LEARNING MORE ABOUT THIS ISSUE IN OUR COMMUNITY

-89% AGREED OR STRONGLY AGREED ADDICTION IS A SERIOUS ISSUE IN OUR COMMUNITY AND 83% KNEW SOMEONE WITH A SUBSTANCE ABUSE ADDICTION

-87% AGREED OR STRONGLY AGREED OPIOID ADDICTION IS A SERIOUS ISSUE IN OUR COMMUNITY

-56% KNEW SOMEONE WITH AN OPIOID ADDICTION

-93% OF THOSE ATTENDING THE PANEL DISCUSSION SAID THE INFORMATION WAS USEFUL FOR THEIR OCCUPATION.

COMMUNITY PLUNGE

BEACON COMMUNITY HEALTH ORGANIZED A COMMUNITY PLUNGE AROUND THE OPIOID EPIDEMIC. A COMMUNITY PLUNGE IS A SMALL EVENT WHERE EXECUTIVE, STAKEHOLDERS, AND COMMUNITY LEADERS COME TOGETHER TO LEARN ABOUT AN ISSUE AFFECTING THE COMMUNITY AND WORK TOGETHER TO COME UP WITH ACTIONABLE SOLUTIONS. FOR THIS COMMUNITY PLUNGE, BEACON COMMUNITY HEALTH PUT TOGETHER A LOCAL DOCUMENTARY TITLED IN PLAIN SIGHT: THE HIDDEN OPIOID STRUGGLE IN INDIANA.

OUTCOME

Part V Facility Information (continued)

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

ROUGHLY 70 COMMUNITY STAKEHOLDERS PARTICIPATED IN THE PLUNGE. OF THE 32

RETURNED SURVEYS:

-87% AGREED OR STRONGLY AGREED THAT THE PLUNGE INCREASED THEIR KNOWLEDGE OF OPIOID PREVENTION STRATEGIES OFFERED ACROSS OUR REGION.

-93% AGREED OR STRONGLY AGREED THE PLUNGE INCREASED THEIR KNOWLEDGE OF OPIOID TREATMENT STRATEGIES OFFERED IN OUR REGION.

-93% AGREED OR STRONGLY AGREED THE PLUNGE HELPED THEM REALIZE THE COMPLEXITY OF THE CRISIS AND THE NEED FOR COORDINATED SERVICES.

-9 INDIVIDUALS EXPRESSED INTEREST IN BEING PART OF THE REGIONAL TASK FORCE.

-83% AGREED OR STRONGLY AGREED THE INFORMATION WAS PERSONAL USEFUL FOR THEIR HEALTH AND WELLNESS

-97% WERE PROMPTED TO CONTINUE LEARNING MORE ABOUT THIS ISSUE.

3. VIOLENCE/SAFETY/TRAUMA

THE VIOLENT CRIME RATE PER 100,000 IS HIGHER IN SJC (370) THAN IN ELKHART COUNTY (264), INDIANA (334) AND THE NATIONAL BENCHMARK (59). ALMOST 40% OF THE KEY INFORMANTS INDICATED VIOLENCE/SAFETY/TRAUMA WAS A KEY THEME. THE COMMUNITY SURVEY DATA SHOWED 23% HAD BEEN HIT, BEAT, KICKED, OR PHYSICALLY HURT BY A PARENT OR ADULT IN THE HOME, UP FROM THE 18.9% IN 2012. TO FACE THOSE CHALLENGES AND MEET THIS NEED, BEACON COMMUNITY HEALTH HAS CREATED THESE FOCUS AREAS AND INDICATORS TO ASSESS PROGRESS OVER TIME.

Part V Facility Information (continued)

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

PRIORITY FOCUS 1: TRAUMATIC SITUATION ASSISTANCE

PRIORITY FOCUS 2: SHOOTING INCIDENT TRACKING AND REDUCTION

PRIORITY FOCUS 3: SUPPORT FOR TRAUMA PATIENTS AT MEMORIAL HOSPITAL

PROGRAMS TO ADDRESS THIS NEED ARE AS FOLLOWS-

ACE INTERFACE

ACE INTERFACE WAS CREATED IN 2016 TO CREATE A TRAUMA INFORMED COMMUNITY THAT CONVEYS CARE AND COMPASSION FOR ALL PEOPLE, AND BUILDS RESILIENCE IN PEOPLE IMPACTED BY ACES (ADVERSE CHILDHOOD EXPERIENCES). BUILDING RESILIENCE NOT ONLY INCREASES THE LIKELIHOOD THAT ACES WILL NOT OCCUR BUT ALSO HELPS PEOPLE RECOVER FROM ACES, ENABLING THEM TO THRIVE IN SPITE OF ADVERSITY. TO ACHIEVE THIS GOAL, OUR PROJECT IS GEARED TO DIFFERENT AUDIENCES. THE AUDIENCE FOR GOAL ONE IS COMPRISED OF PROFESSIONALS WHO BECOME MASTER TRAINERS AND/OR FACILITATORS OF ACE PRESENTATIONS. THE PRESENTATIONS COVER THE ACE STUDY, WAYS CHILDHOOD ADVERSITY AFFECTS DEVELOPMENT AND HEALTH, AND HOW ANYONE CAN HELP REDUCE THE NEGATIVE IMPACT OF ACES ON INDIVIDUALS AND COMMUNITIES. THE AUDIENCE FOR GOAL TWO IS THE COMMUNITY MEMBERS WHO ATTEND THESE PRESENTATIONS.

OUTCOME

A TOTAL OF 556 INDIVIDUALS PARTICIPATED IN A FACILITATOR TRAINING OR PRESENTATION ON ACES. OVERALL, MEAN SCORES FROM THE SURVEY INDICATED COMMUNITY MEMBERS REALIZE TRAUMA IS WIDESPREAD, KNOW HOW TO RESPOND USING

Part V Facility Information (continued)

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

TRAUMA-INFORMED KNOWLEDGE, AND KNOW THAT COMPASSIONATE RESPONSES HELP RESIST RE-TRAUMATIZATION. THESE OUTCOMES ADDRESS THREE OF THE FOUR SAMHSA AREAS RELATED TO A TRAUMA-INFORMED APPROACH. QUALITATIVE RESPONSES SHOW ATTENDEES GAINED KNOWLEDGE IN HOW TO HELP PEOPLE WHO MAY HAVE EXPERIENCED TRAUMA AND BUILDING RESILIENCE. FEWER PARTICIPANTS INDICATED THEY KNEW HOW TO BUILD RESILIENCE. THE SIZE OF THE PRESENTATION TEAM HAS INCREASED BY 36% COMPARED TO 2016.

EMDR TRAINING-SOCIAL WORK INTERNS IN TRAUMA DEPARTMENT
MEMORIAL HOSPITAL OF SOUTH BEND TRAUMA TEAM SEEKS TO PROMOTE WELLNESS AND A POSITIVE QUALITY OF LIFE FOR ADULT PATIENTS WHO ARE RECOVERING FROM A TRAUMA INDUCED INJURY. AS TRAUMA CAN LEAD TO POSTTRAUMATIC STRESS DISORDER, TEAM MEMBERS AND INTERNS HAVE BEEN TRAINED IN EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR), ONE EMOTIONAL DEBRIEFING STRATEGY FOUND TO BE EFFECTIVE WITH TRAUMA VICTIMS.

OUTCOME

IN OCTOBER 2017, 12 PEOPLE WERE SCREENED FOR ACUTE TRAUMATIC INCIDENT PROCESSING. 6 ATIP PARTICIPANTS HAVE REPORTED A DECREASE IN THEIR EMOTIONAL DISTRESS BY AT LEAST 2 POINTS ON THE SUBJECT UNITS OF DESTRESS SCALE.

SOUTH BEND GUN VIOLENCE INTERVENTION

THE SOUTH BEND GROUP VIOLENCE INTERVENTION (SBGVI) UNITES COMMUNITY LEADERS AROUND A COMMON GOAL: TO STOP GUN VIOLENCE AND KEEP SOUTH BEND'S

Part V Facility Information (continued)

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

HIGHEST RISK CITIZENS ALIVE AND OUT OF PRISON. SBGVI IS A PARTNERSHIP AMONG 30 COMMUNITY LEADERS FROM LAW ENFORCEMENT, GOVERNMENT, EDUCATION, CIVIL SERVICE, HEALTH-CARE AND FAITH-BASED AGENCIES. BASED ON A PROVEN MODEL DEVELOPED BY DAVID M. KENNEDY, DIRECTOR OF THE NATIONAL NETWORK FOR SAFE COMMUNITIES AT JOHN JAY COLLEGE OF CRIMINAL JUSTICE, SBGVI ADVOCATES DIRECT, SUSTAINED ENGAGEMENT WITH STREET GROUPS THAT CAUSE THE MAJORITY OF SOUTH BEND'S GUN VIOLENCE. THE STRATEGY EMPOWERS COMMUNITY MEMBERS TO SET CLEAR MORAL STANDARDS AGAINST VIOLENCE IN THEIR COMMUNITIES AND RECLAIM A VOICE IN THE WAY THEY WANT TO LIVE. IT COORDINATES THE EFFORTS OF LOCAL, STATE AND FEDERAL LAW ENFORCEMENT TO FOCUS CRIME PREVENTION EFFORTS ON THE GROUPS MOST ASSOCIATED WITH GUN VIOLENCE. SBGVI ALSO DRAWS ON THE EXPERTISE OF SOCIAL SERVICE PROVIDERS TO OFFER GROUP MEMBERS A PATH AWAY FROM VIOLENCE.

OUTCOME

SBGVI HAD PROACTIVE COMMUNICATION WITH KNOWN MEMBERS OF VIOLENT GROUPS TO MAKE THEM AWARE OF THE STRATEGY, LAW ENFORCEMENT CONSEQUENCES OF THEIR ACTIONS, AND TO REFER THEM TO SERVICES PROVIDED BY PARTNER ORGANIZATIONS. 193 INDIVIDUALS ATTENDED A GROUP VIOLENCE INTERVENTION CALL-IN OR RECEIVED A CUSTOM NOTIFICATION DURING THE REPORTING PERIOD. THIS YEAR, WE DID NOT MEET OUR STATED GOALS OF ACHIEVING A REDUCTION IN CRIMINALLY ASSAULTED SHOOTINGS OR THE NUMBER OF GROUP MEMBER INVOLVED SHOOTINGS.

TRAUMA LIAISON/VIOLENT INJURY PREVENTION SPECIALIST

A NEW STAFF POSITION OF TRAUMA LIAISON WAS ESTABLISHED AT MEMORIAL

Part V Facility Information (continued)

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

HOSPITAL TO WORK WITH VICTIMS OF VIOLENT CRIME AND THEIR FAMILIES. THE PURPOSE OF THIS POSITION IS TO HELP VICTIMS OF VIOLENCE AND PREVENT VIOLENT PERSONAL INJURY, RETALIATION, AND RECIDIVISM AMONG THE POPULATION OF SOUTH BEND THROUGH RESEARCH, DATA MONITORING/EVALUATION, AND COMMUNITY INVOLVEMENT.

OUTCOME

FROM JANUARY TO APRIL, BEACON'S TRAUMA INTERVENTION SPECIALIST (TIS) WORKED WITH 83 VICTIMS OF VIOLENCE. 5% HAD REPEATED EXPERIENCES, COMPARED TO 11% OF THE 90 PEOPLE WHO DID NOT RECEIVE THESE SERVICES.

YWCA TAKE CHARGE

YWCA TAKE CHARGE IS A PRIMARY VIOLENCE PREVENTION PROGRAM FOR YOUTH IN SCHOOLS OR WITH COMMUNITY ORGANIZATIONS WITH A FOCUS ON INCREASING KNOWLEDGE OF COMPONENTS OF A HEALTHY RELATIONSHIP AND KNOWLEDGE OF ALL FORMS OF TEEN DATING VIOLENCE/ ABUSE.

OUTCOME

THE YWCA'S TAKE CHARGE PROGRAM HELPED 1,276 YOUTH INCREASE THEIR KNOWLEDGE OF DATING VIOLENCE AND ABUSE BY 13%. 1,824 STUDENTS PARTICIPATED IN THE PROGRAM WITHIN ST. JOSEPH AND ELKHART COUNTIES SCHOOLS INCLUDING A JUVENILE JUSTICE FACILITY AND LOCAL YOUTH ORGANIZATIONS. IN ST. JOSEPH COUNTY PRE-SCORES INDICATED 78% HAD KNOWLEDGE OF ALL FORMS OF TEEN DATING VIOLENCE AND ABUSE, HOWEVER, BY THE COMPLETION OF THE PROGRAM 90% HAD A BETTER UNDERSTANDING. IN ELKHART

Part V Facility Information (continued)

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

COUNTY THE PRE-SCORE WAS 74% WITH A POST-SCORE OF 76%. WHEN ASKED ABOUT THEIR KNOWLEDGE OF A HEALTHY RELATIONSHIP, ST. JOSEPH COUNTY PRE-SCORE WAS AT 72% AND ELKHART COUNTY WAS AT 75%. THERE WAS AN INCREASE AT THE COMPLETION OF THE PROGRAM TO 89% FOR ST. JOSEPH COUNTY AND 86% FOR ELKHART COUNTY.

4. DIABETES

RESULTS FROM THE KEY INFORMANT SURVEY SHOW THAT IN BOTH ELKHART AND ST. JOSEPH COUNTIES, THE FOURTH MOST PRESSING HEALTH CONCERN IS DIABETES. DATA SHOWS 20% OF SJC RESPONDENTS REPORTED HAVING BEEN DIAGNOSED WITH DIABETES, COMPARED TO FEWER THAN 8% IN ELKHART COUNTY. IN SJC THE PERCENTAGE OF RESPONDENTS WITH DIABETES, PRE-DIABETES, OR GESTATIONAL DIABETES HAS INCREASED FROM 2012 COMMUNITY MEMBER SURVEY RESPONSES. APPROXIMATELY 49% OF DIABETIC RESPONDENTS IN SJC MAINTAIN AN A1C LEVEL OF 7% OR BELOW, COMPARED WITH 37% IN ELKHART COUNTY. TO FACE THOSE CHALLENGES AND MEET THIS NEED, COMMUNITY HEALTH ENHANCEMENT HAS CREATED THESE FOCUS AREAS AND INDICATORS TO ASSESS PROGRESS OVER TIME.

PRIORITY FOCUS 1: DIABETES DISEASE MANAGEMENT

PRIORITY FOCUS 2: DIABETES PREVENTION

PROGRAMS TO ADDRESS THIS NEED ARE AS FOLLOWS-

YMCA-DIABETES PREVENTION PROGRAM (DPP)

Part V Facility Information (continued)

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

THE YMCA CITY OF SOUTH BEND'S DIABETES PREVENTION PROGRAM (DPP) HELPS THOSE AT HIGH RISK FOR DEVELOPING TYPE-2 DIABETES (I.E., OVERWEIGHT WITH PRE-DIABETIC CONDITIONS) TO ADOPT AND MAINTAIN MORE HEALTHY LIFESTYLE HABITS, AND PREVENT THE ONSET OF THE DISEASE. THE YMCA'S DPP IS PART OF A FOUR-YEAR PARTNERSHIP WITH THE CENTER FOR DISEASE CONTROL'S NATIONAL DIABETES PREVENTION PROGRAM, AND IS CONSIDERED A NATIONAL LEADER IN THE EFFORT TO COMBAT THIS GROWING EPIDEMIC AND CURB THE DEVASTATING EFFECTS THAT DIABETES IS HAVING ON INDIVIDUALS AND OUR COUNTRY AS A WHOLE.

OUTCOME

THE YMCA SERVED 45 PRE-DIABETICS WHO COMPLETED THE 12 MONTH PROGRAM IN 2017. OF THIS COHORT, 42% REPORTED ENGAGING IN 150 MINUTES OF EXERCISE EACH WEEK, AND 25% MET THEIR WEIGHT LOSS GOAL OF 7%. THEIR SUCCESS RATE FOR EXERCISING IS LOWER THAN HP2020'S GOAL OF 49%. LESSONS LEARNED FROM THE 2016-2107 GROUP HELPED THE YMCA ADAPT MOTIVATIONAL SUPPORT FOR THE NEXT GROUP SCHEDULED TO COMPLETE THE PROGRAM IN 2018. THESE ADAPTATIONS ARE MAKING A DIFFERENCE AS 54% ARE REPORTED TO HAVE ALREADY ACHIEVED THEIR WEIGHT LOSS GOAL.

5. MATERNAL/INFANT HEALTH/PRENATAL CARE

MULTIPLE HEALTH MEASURES FROM THE 2015 CHNA SUPPORT THE ISSUE OF MATERNAL/INFANT HEALTH/PRENATAL CARE AS A COMMUNITY HEALTH PRIORITY. THE TEENAGE BIRTH RATE IS HIGHER IN SJC (28.4) THAN THE NATION OVERALL (26.5). BOTH ST. JOSEPH AND ELKHART COUNTIES HAVE LOW FIRST TRIMESTER

Part V Facility Information (continued)

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

PRENATAL CARE RATES AMONG BLACK/AFRICAN AMERICAN RESIDENTS (APPROXIMATELY 50%). INFANT AND NEONATAL MORTALITY RATES ARE LIKEWISE HIGHER IN SJC (8.7 AND 6.7, RESPECTIVELY) WHEN COMPARED TO INDIANA AND THE NATION. SEVERAL PERINATAL HEALTH INDICATORS WERE ALSO NOTED, INCLUDING SMOKING RATES DURING PREGNANCY; AND LOW BIRTH WEIGHT. UNFORTUNATELY, AN EARLIER PROGRAM - PRENATAL CARE COORDINATION - WAS TERMINATED IN JULY 2015 DUE TO REDUCTIONS IN STATE FUNDING. THIS ACTION DIRECTLY IMPACTED APPROXIMATELY 250 LOW-INCOME PREGNANT WOMEN PER YEAR. IN ADDITION TO COMMUNITY HEALTH PROVIDING PRENATAL CARE FOR LOW-INCOME VULNERABLE AND AT-RISK MOTHERS AND BABIES THROUGH A NEW PERINATAL AND INFANT HEALTH PROJECT (PIHP), THIS HAS CREATED A CLEAR NEED TO COLLABORATE WITH OTHER LOCAL PUBLIC HEALTH SERVICES TO ADDRESS PRENATAL CARE. TO FACE THOSE CHALLENGES AND MEET THIS NEED, COMMUNITY HEALTH ENHANCEMENT HAS CREATED THESE FOCUS AREAS AND INDICATORS TO ASSESS PROGRESS OVER TIME.

PRIORITY FOCUS 1: PROVIDE ACTIVE CASE MANAGEMENT FOR LOW-INCOME PREGNANT MOTHERS AND INFANTS DURING AND AFTER PREGNANCY

PRIORITY FOCUS 2: DIABETES MANAGEMENT DURING PREGNANCY

PRIORITY FOCUS 3: SEXUAL HEALTH EDUCATION

PRIORITY FOCUS 4: IDENTIFY VARIABLES THAT DECREASE INFANT MORTALITY

PROGRAMS TO ADDRESS THIS NEED ARE AS FOLLOWS-

PRENATAL CARE COORDINATION (PCC) AND PERINATAL AND INFANT HEALTH (PIHP)

THERE ARE TWO PRIMARY CH PROVIDERS OF PROGRAMMING IN THIS HEALTH NEED

Part V Facility Information (continued)

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

AREA: PRENATAL CARE COORDINATION (PCC) IN ELKHART, PERINATAL AND INFANT HEALTH (PIHP) IN SJC. BOTH PROGRAMS HAVE PREVIOUS EXPERIENCE IN ACHIEVING POSITIVE OUTCOMES WITH THEIR HIGH-NEED PARTICIPANT GROUPS. IN 2017, FOR THE FIRST TIME THESE PROGRAMS USED THE SAME DATA COLLECTION SYSTEM AND RE-WORDED THEIR INDIVIDUAL GOALS TO BE SIMILAR ACROSS COUNTIES SO THAT COMPARISONS COULD BE MADE, JOINT CHALLENGES COULD BE IDENTIFIED AND ADDRESSED, AND MEANINGFUL APPROACHES COULD BE SHARED. BOTH PROGRAMS ALSO PARTICIPATED IN A FOCUS GROUP TARGETING THIS PRIORITY NEED, WHICH INCREASED COMMUNICATION AND STRATEGIC SUPPORT FOR IMPROVING HEALTH IN THIS AREA ACROSS THE REGION.

OUTCOME

TOGETHER, THEIR PROGRAMS SERVED 416 MOTHERS AND DELIVERED 324 LIVE BIRTHS ACROSS THE REGION IN 2017. IN BEACON COMMUNITY HEALTH PROGRAMS, ONLY 4% OF MOTHERS CONTINUED SMOKING DURING PREGNANCY. COUNTY RATES FOR SMOKING OR SUBSTANCE ABUSE ARE 11% IN ST. JOSEPH COUNTY, AND 14% IN THE STATE OF INDIANA. OF THE MOTHERS, WHO PARTICIPATED IN OUR PROGRAMS:

- 26% WERE SEVERELY OBESE.
- 35% WERE A HEALTHY WEIGHT.
- 17% HAD AN ACE SCORE GREATER THAN 4.

WITH THEIR MATERNAL SUPPORT:

- ONLY 5% OF THE BABIES WERE BORN PRETERM (<37 WEEKS)
- 6% WEIGHED LESS THAN 2,500 GRAMS.
- 3% SPENT TIME IN THE NICU.

Part V Facility Information (continued)

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

SAFETY AND SAFE SLEEP

THE CHILDHOOD SAFETY AND SAFE SLEEP CLASSES WERE BOTH DESIGNED TO INCREASE EDUCATION TO OUR COMMUNITY. THE SAFETY CLASS IS AIMED AT PARENTS AND CAREGIVERS OF CHILDREN AGES BIRTH TO TEEN. A VARIETY OF TOPICS ARE COVERED TO PREVENT ACCIDENTS AND INJURIES. PREVENTABLE CHILDHOOD ACCIDENTS ARE ONE OF THE TOP CAUSES OF CHILDHOOD DEATHS. HOME NEEDS ARE DISCUSSED AND FAMILIES ARE GIVEN ITEMS NEEDED TO MAKE HOMES SAFER FOR CHILDREN. THIS CLASS IS OFFERED MONTHLY TO THE COMMUNITY. THE SAFE SLEEP PROGRAM IS AIMED AT PARENTS AND CAREGIVERS TO PREVENT SIDS (SUDDEN INFANT DEATH SYNDROME). DURING THE CLASS THE CAREGIVERS ARE GIVEN EDUCATION, SURVIVAL KIT, AND A PACK AND PLAY. THIS PROGRAM IS OFFERED TO CAREGIVERS AND PARENTS OF CHILDREN UNDER THE AGE OF 1 OR CURRENTLY 25 WEEKS OR MORE PREGNANT. THIS CLASS IS OFFERED TWICE A MONTH OR ON IMMEDIATE NEED BASIS. WITH OUR CURRENT COMMUNITY HEALTH PROGRAMS THROUGH MEMORIAL WE EDUCATE ALL PATIENTS IN BOTH SAFETY AND SAFE SLEEP.

OUTCOME

IN 2017 THERE WAS AN INCREASE IN PARTICIPATION OF SAFE SLEEP/SAFETY PROGRAM. 231 PARENTS OR CAREGIVERS WERE SERVED IN ST JOSEPH COUNTY. THIS IS AN INCREASE OF 15 CAREGIVERS FROM 2016 DATA. IN ADDITION TO PROVIDING PLANNED CLASSES THE PROGRAM IS AVAILABLE TO THE MOTHER AND BABY UNIT FOR IMMEDIATE NEEDS, CPS AND THE SOUTH BEND FIRE DEPARTMENT. PRESCREENING AND POST EDUCATION TESTS SHOW AN INCREASE OF KNOWLEDGE IN 98% OF CAREGIVERS ON TOPICS DISCUSSED. ADDITIONALLY, 31% OF FAMILIES EDUCATED ON CHILDHOOD SAFETY INDICATED A DECREASED CHANCE OF CHILDHOOD INJURY OR DEATH BY

Part V Facility Information (continued)

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

ATTENDING CLASS.

SCHOOL HEALTH AND WELLNESS EDUCATORS

THE SCHOOL HEALTH AND WELLNESS EDUCATOR TEAM PROVIDES EDUCATION AND TRAINING TO AT-RISK INTERMEDIATE AND HIGH SCHOOL YOUTH WITHIN SOUTH BEND COMMUNITY SCHOOL CORPORATION. THEY PREPARE CHILDREN FOR A WORLD OF COMPLEX RELATIONSHIPS, PROMOTING HEALTHY DECISION MAKING THROUGH NEUROSCIENCE EDUCATION, DIGITAL TRAINING, AND SEXUAL HEALTH CURRICULUM (DRAW THE LINE/RESPECT THE LINE FOR STUDENTS IN GRADES 6-8). THIS EDUCATION IS AN IMPORTANT PRE-EMPTIVE STEP TO PREVENTING ADVERSE MATERNAL/INFANT HEALTH OUTCOMES. THE CURRICULA HELP DEVELOP RESPONSIBLE ATTITUDES, RESILIENT BEHAVIOR AND RESPECT FOR BOUNDARIES.

OUTCOME

A TOTAL OF 2,388 SOUTH BEND COMMUNITY SCHOOL CORPORATION 6TH THROUGH 8TH GRADE STUDENTS RECEIVED THE DRAW THE LINE RESPECT THE LINE (DTL/RTL) SEXUAL HEALTH CURRICULUM DURING THE 2016-2017 SCHOOL YEARS. TO HELP DETERMINE THE LASTING EFFECTS OF THE TEAM'S CURRICULA, AND ALSO FUNCTION AS A MEASURE FOR FURTHER OUTCOMES OF WHETHER THERE ARE ANY ADDITIONAL AREAS OF INFLUENCE WHERE STUDENTS CAN BE REACHED FOR INTERVENTION, A HIGH SCHOOL FOLLOW-UP SURVEY IS ADMINISTERED TO STUDENTS PREDOMINANTLY IN THE 9TH AND 11TH GRADES. 26% OF STUDENTS WITH THREE YEARS OF PROGRAMMING IN DTL/RTL, REPORTED THEY WERE LESS LIKELY TO ENGAGE IN SEX WHILE IN HIGH SCHOOL, 80% DESCRIBED KNOWING HOW TO RESIST PEER PRESSURE AND HOW TO RESPECT LIMITS FOR THEMSELVES, AND MORE LIKELY TO RESPECT OTHERS' LIMITS.

Part V Facility Information (continued)

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

BEDS AND BRITCHES, ETC. (BABE)

SINCE 1992, THE BEDS AND BRITCHES, ETC. (B.A.B.E.) PROGRAM HAS OFFERED INCENTIVES TO EXPECTANT MOTHERS AND PARENTS TO PROMOTE RESPONSIBLE PARENTING. ENCOURAGING RESPONSIBILITY AND IMPROVING SELF-ESTEEM, THE PROGRAM PROVIDES GOODS AND SERVICES THAT NEW PARENTS NEED TO NURTURE HEALTHY BABIES AND FOSTER SKILLS THAT WILL HELP THE FAMILY THROUGH LIFE.

OUTCOME

IN 2017, 1,627 INDIVIDUALS WERE ASSISTED AT THE B.A.B.E, WHICH PARTNERED WITH 47 VENDORS (9 MORE THAN 2016) TO PROVIDE INCENTIVES FOR PARENTS.

51,962 COUPONS WERE DISTRIBUTED IN 2017, AND 29,876 WERE REDEEMED.

6. OVERWEIGHT/OBESITY

OVER 17% OF CHILDREN IN SJC ARE OVERWEIGHT AND/OR OBESE. WITH THE CORRELATION BETWEEN NUMEROUS ADVERSE CHRONIC AND EMERGENT HEALTH CONDITIONS, BEING OVERWEIGHT OR OBESE WAS CITED AS THE MOST SIGNIFICANT COMMUNITY HEALTH ISSUE IN THE KEY INFORMANT SURVEY AND A HIGH PRIORITY DURING GROUP DISCUSSIONS. TO FACE THOSE CHALLENGES AND MEET THIS NEED, COMMUNITY HEALTH ENHANCEMENT HAS CREATED THESE FOCUS AREAS AND INDICATORS TO ASSESS PROGRESS OVER TIME.

PRIORITY FOCUS 1: COMMUNITY AND YOUTH ENGAGEMENT IN PHYSICAL ACTIVITY

PRIORITY FOCUS 2: KNOWLEDGE AND CONSUMPTION OF HEALTHY FOOD

Part V Facility Information (continued)

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

PROGRAMS TO ADDRESS THIS NEED ARE AS FOLLOWS-

FIT NOGGINS

FIT NOGGINS PROVIDES YOUTH, AGES 6-12 A FUN WAY TO INCREASE PHYSICAL ACTIVITY.

OUTCOME

27 ELEMENTARY-AGED CHILDREN PARTICIPATED IN THE PROGRAM. 55% OF THE CHILDREN WERE PHYSICALLY ACTIVE AT LEAST 30 MINUTES DURING AT LEAST 4 OF THE LAST 7 DAYS. BY THE END OF THE PROGRAM, 81% OF THE CHILDREN HAD BEEN PHYSICALLY ACTIVE DURING THAT SAME TIME SEGMENT.

OPERATION FITKIDS

OPERATION FITKIDS ENCOURAGES YOUTH TO BE PHYSICALLY ACTIVE AND EAT HEALTHY IN A FUN AND ENGAGING WAY, PROVIDING HEALTHIER CHOICES AND INCREASING PHYSICAL ACTIVITY.

OUTCOME

WITH THE OPERATION FIT KIDS, 46.58% (TOTAL = 73) KIDS COMPLETED CONE RUN IN LESS TIME, 53.03% KIDS (TOTAL = 66) HAD MORE STEPS IN 5 MINUTES, AND 47.06% KIDS (TOTAL = 68) CLIMBED A LADDER IN LESS TIME. FOUR OF SJC'S PROGRAMS FOCUSED ON INCREASING PHYSICAL ACTIVITY FOR CHILDREN: FIT NOGGINS, FIT KIDS, MADISON STEAM ACADEMY/LEEPER PARK, AND UNITY GARDENS. COLLECTIVELY, THEY SERVED 749 CHILDREN AND 94% INCREASED THEIR PHYSICAL

Part V Facility Information (continued)

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

ACTIVITY LEVELS BY THE END OF PROGRAMMING.

LEEPER PARK/MADISON PRIMARY CENTER

THE PURPOSE OF OUR PARK FOUNDATION, MADISON PRIMARY CENTER, LEEPER PARK, AND MEMORIAL HOSPITAL COLLABORATION IS TO POSITIVELY IMPACT CHILDHOOD OBESITY. THIS PROGRAM IS FIVE YEARS IN DURATION. A COLLEGE STUDENT AND COMMUNITY BUSINESS PARTNER TEAM-BUILDING AND PROJECT MANAGEMENT APPROACH IS UTILIZED TO EXECUTE THE PLAN AND LEVERAGE RESOURCES TO ACHIEVE A BIG GOAL. THE PARK IS BEING REVITALIZED AND RESTORED SPECIFICALLY TO ENCOURAGE PHYSICAL ENGAGEMENT.

OUTCOME

THERE WERE 500 STUDENTS INVOLVED IN THE PROGRAM. 80% OF THE SCHOOL DAYS FOCUSED ON INCREASED CONSUMPTION OF FRUIT AND VEGETABLES. TO ENSURE INCREASED PHYSICAL ACTIVITIES FLEX ACTIVE SEATING OR STAND DESKS WERE IMPLEMENTED IN ALL FIRST GRADE CLASSROOMS.

UNITY GARDENS

UNITY GARDENS FOOD AND FUN IMMERSION INCLUDED PROGRAMS AND ACTIVITIES DESIGNED TO ENHANCE THE GARDEN EXPERIENCE AND CONNECTION WITH FRESH PRODUCE FOR NEIGHBORS AND THE COMMUNITY. THIS PROGRAM TARGETED VULNERABLE AGGREGATES WITHIN THE AREA SURROUNDING LASALLE SQUARE UNITY GARDEN, ESPECIALLY THE BEACON HEIGHTS APARTMENTS COMMUNITY. INCREASED GARDEN INVOLVEMENT FOR YOUTH AND ADULTS WAS DESIGNED TO IMPROVE ACCESS TO FRESH

Part V Facility Information (continued)

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

PRODUCE, AND SUBSEQUENTLY DECREASE OBESITY RATES AND INCREASE FOOD SECURITY LONG TERM. IN ADDITION, OPPORTUNITIES FOR INCREASED PHYSICAL ACTIVITY WERE ACTIVELY PLANNED, NOT ONLY WITH EVENTS, BUT ALSO IN THE STRUCTURAL PLAN OF THE UNITY GARDEN.

OUTCOME

THERE WERE 4,147 TOTAL PARTICIPANTS FOR ALL UNITY GARDEN PROGRAMMING. THE DATA FROM THE PEDOMETERS REVEALS INCREASED ACTIVITY THROUGHOUT THE WEEK OF GARDEN CAMP. DAILY AVERAGES WERE: MONDAY-6,790, TUESDAY-7,760, WEDNESDAY-7,784, THURSDAY-8,088, AND FRIDAY-9,024. THIS IS PARTICULARLY INTERESTING SINCE THE TRACKING REFLECTED A VARIETY OF CAMPERS; NOT JUST THE SAME 50-100 EACH WEEK. ATTENDANCE DATA FROM GARDEN CAMP, LUNCH & LEARN, GARDEN GUIDES, CHEF DEMO, POT LUCK PICNICS, REVEALS INCREASED PARTICIPATION AND CONSUMPTION OF FRUITS AND VEGETABLES THROUGHOUT THE GARDEN. THERE WERE OVER 3,197 VISITORS TOTAL, COMPARED TO 1,673 VISITORS IN 2016.

PART V, SECTION B, LINE 13H

FINANCIAL ASSISTANCE CRITERIA

THE POLICY ALLOWS FOR PATIENTS TO QUALIFY FOR ASSISTANCE BY TWO MEANS: FINANCIAL OR CATASTROPHIC. THE FINANCIAL ASSISTANCE PROGRAM ALSO ALLOWS FOR PARTIAL ASSISTANCE OR FULL ASSISTANCE BASED ON ELIGIBILITY CRITERIA IN THIS POLICY.

FINANCIAL ASSISTANCE

Part V Facility Information (continued)

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

1. A PATIENT QUALIFYING FOR FINANCIAL ASSISTANCE IS A PERSON WHO IS UNINSURED OR UNDERINSURED, RECEIVES CARE AND UNABLE TO PAY THEIR BILL.
2. TO BE ELIGIBLE FOR ASSISTANCE UNDER THE FINANCIAL ASSISTANCE GUIDELINES, A PERSON'S INCOME SHALL BE AT OR BELOW A PERCENTAGE OF THE FEDERAL POVERTY LEVEL (FPL) AS DETERMINED BY FEDERAL POVERTY GUIDELINES. HOUSEHOLD SIZE AND INCOME DETERMINES THE % OF FPL. MEMORIAL HOSPITAL OF SOUTH BEND, OR ITS DESIGNEE, MAY CONSIDER OTHER FINANCIAL ASSETS AND LIABILITIES OF THE PERSON WHEN DETERMINING ELIGIBILITY.
3. MEMORIAL HOSPITAL OF SOUTH BEND WILL USE THE MOST CURRENT POVERTY INCOME GUIDELINES ISSUED BY THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES TO DETERMINE AN INDIVIDUAL'S ELIGIBILITY FOR FINANCIAL ASSISTANCE. THE POVERTY INCOME GUIDELINES ARE PUBLISHED ANNUALLY IN THE FEDERAL REGISTER AND FOR THE PURPOSES OF THIS POLICY WILL BECOME EFFECTIVE THE FIRST DAY OF THE MONTH FOLLOWING THE MONTH OF PUBLICATION.
4. TO QUALIFY UNDER THE FINANCIAL ASSISTANCE PORTION OF THIS POLICY, A COMPLETED, SIGNED FINANCIAL ASSISTANCE APPLICATION MUST BE SUBMITTED AND PROOF OF INCOME, PROOF OF NO INCOME, PROOF OF LACK OF FINANCIAL ASSETS AND OTHER REQUIRED DOCUMENTS MUST ACCOMPANY THE APPLICATION.

CATASTROPHIC ASSISTANCE CRITERIA

1. A PATIENT QUALIFYING FOR CATASTROPHIC ASSISTANCE IS A PERSON WHOSE HOSPITAL BILLS EXCEED A SPECIFIED PERCENTAGE OF THE PERSON'S ANNUAL GROSS INCOME AS SET FORTH IN THE POLICY AND WHO IS UNABLE TO PAY THE REMAINING BILL.
2. TO BE ELIGIBLE FOR CATASTROPHIC ASSISTANCE THE AMOUNT OWED BY THE

Part V Facility Information (continued)

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

PATIENT MUST EXCEED ONE HUNDRED FIFTY (150) PERCENT OF THE PATIENT'S ANNUAL GROSS INCOME AND THE PATIENT MUST BE UNABLE TO PAY THE REMAINING BILL. MEMORIAL HOSPITAL OF SOUTH BEND MAY CONSIDER OTHER FINANCIAL ASSETS AND LIABILITIES OF THE PERSON WHEN DETERMINING ABILITY TO PAY.

3. IF A DETERMINATION IS MADE THAT A PATIENT HAS THE ABILITY TO PAY THE REMAINDER OF THE BILL, SUCH A DETERMINATION DOES NOT PREVENT A REASSESSMENT OF THE PATIENT'S ABILITY TO PAY AT A LATER DATE SHOULD THEIR FINANCIAL CIRCUMSTANCES CHANGE.

4. AFTER ELIGIBILITY IS DETERMINED UNDER THIS PROVISION, ASSISTANCE WILL BE PROVIDED TO DISCOUNT THE BILL BY 75% OF THE CURRENT BALANCE.

PART V, SECTION B, LINE 16 A, B, & C

THE FINANCIAL ASSISTANCE POLICY, APPLICATION AND PLAIN LANGUAGE SUMMARY CAN ALL BE FOUND AT: BEACONHEALTHSYSTEM.ORG/ASSIST

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? 6

Name and address	Type of Facility (describe)
1 MEMORIAL SLEEP DISORDER CENTER 53990 CARMICHAEL DRIVE SOUTH BEND IN 46601	OUTPATIENT CLINIC PROVIDING SLEEP RELATED DIAGNOSIS AND TREATMENT
2 MEMORIAL HEALTH PLEX 111 W JEFFERSON ST SOUTH BEND IN 46601	OUTPATIENT REHABILITATION FACILITY AND FITNESS FACILITY
3 MEMORIAL BREAST CARE CENTER 100 NAVARRE PLACE SOUTH BEND IN 46601	OUTPATIENT DIAGNOSIS AND TREATMENT
4 MEMORIAL CHILDREN'S THERAPY CENTER 100 NAVARRE PLACE SOUTH BEND IN 46601	OUTPATIENT DIAGNOSIS AND TREATMENT
5 MEMORIAL RADIOLOGY 100 NAVARRE PLACE SOUTH BEND IN 46601	OUTPATIENT DIAGNOSIS AND TREATMENT
6 MEMORIAL LIGHTHOUSE PHYSICAL THERAPY 6913 N MAIN STREET GRANGER IN 46530	OUTPATIENT DIAGNOSIS AND TREATMENT
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.

PART VI, DESCRIPTIONS FOR PART I, LINE 3C

FACTORS TO BE CONSIDERED FOR FINANCIAL ASSISTANCE

HOUSEHOLD SIZE AND INCOME

THE FOLLOWING FACTORS MAY BE CONSIDERED IN DETERMINING THE ELIGIBILITY OF THE PATIENT FOR ASSISTANCE AND MUST BE PROVIDED BY ALL INCOME EARNING RESIDENTS IN THE COUNTABLE HOUSEHOLD UNIT UNLESS THEY ARE NOT DEPENDENTS BASED ON IRS GUIDELINES FOR DETERMINING WHETHER A HOUSEHOLD MEMBER CAN BE CONSIDERED A DEPENDENT.

1. INDIANA WORKFORCE WAGE REPORT FOR LAST 2 QUARTERS (UNEMPLOYMENT INCOME)
2. LAST 3 PAY STUBS OR A LETTER OR PRINTOUT FROM EMPLOYER(S) PROVIDING VERIFICATION OF GROSS INCOME IF CURRENTLY EMPLOYED. THIS DOCUMENTATION SHOULD NOT BE MORE THAN 30 DAYS OLD FROM DATE OF ISSUE AND INCLUDE YEAR-TO-DATE INFORMATION.
3. LAST 3 BANK STATEMENTS (INCLUDING EXPLANATIONS OF REGULAR DEPOSITS NOT EXPLAINED BY PAY STUBS)
4. SOCIAL SECURITY AWARD OR ENTITLEMENT LETTER OR OTHER PROOF OF GROSS

Part VI Supplemental Information

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- 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.

MONTHLY AWARD.

5. RETIREMENT INCOME.
6. INVESTMENT INCOME.
7. STATEMENT FROM PERSON(S) THAT ARE PROVIDING DIRECT SUPPORT.
8. NUMBER OF DEPENDENTS.
9. MOST RECENT TAX RETURN (INCLUDING W2 AND ALL SUPPORTING SCHEDULES).
10. OTHER FINANCIAL OBLIGATIONS.
11. AMOUNT AND FREQUENCY OF HOSPITAL/MEDICAL BILLS.
12. OTHER FINANCIAL RESOURCES THAT PRODUCE INCOME.
13. IF SELF-EMPLOYED, GROSS INCOME LESS COST OF GOODS SOLD AND EMPLOYEE SALARIES.

FINANCIAL CAPACITY

1. INDIVIDUALS WITH THE FINANCIAL CAPACITY TO PURCHASE HEALTH INSURANCE COVERAGE THROUGH THE HEALTH INSURANCE MARKETPLACE MAY BE REQUIRED TO PURCHASE AND WILL BE PROVIDED ACCESS TO MEET WITH AN INDIANA CERTIFIED NAVIGATOR AS A MEANS OF ASSURING ACCESS TO HEALTHCARE SERVICES, FOR THEIR OVERALL PERSONAL HEALTH, AND FOR THE PROTECTION OF THEIR INDIVIDUAL

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.
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- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
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- 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.

ASSETS.

2. INDIVIDUALS HAVE BEEN FOUND THEY ARE INELIGIBLE FOR MEDICAID OR OTHER AFFORDABLE HEALTH CARE COVERAGE MUST PROVIDE PROOF OF DENIAL.
3. FOOD STAMPS OR SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP) WILL NOT BE COUNTED AS INCOME.
4. COSMETIC SERVICES ARE NOT ELIGIBLE FOR ANY TYPE OF ASSISTANCE AND CANNOT BE INCLUDED IN THE AMOUNT OF HOSPITAL/MEDICAL BILLS OWED.

PART VI, DESCRIPTIONS FOR PART I, LINE 6A

BEACON HEALTH SYSTEM, INC, EIN 45-3864076, PREPARES THE ANNUAL COMMUNITY BENEFIT REPORTING FOR MEMORIAL HOSPITAL OF SOUTH BEND, INC.

PART VI, DESCRIPTIONS FOR PART I, LINE 7, COLUMN F

BAD DEBT EXPENSE REMOVED FROM TOTAL EXPENSES \$ 28,872,159

PART VI, DESCRIPTIONS FOR PART I, LINE 7G

NOT APPLICABLE

Part VI Supplemental Information

Provide the following information.

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- 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.
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- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART VI, DESCRIPTIONS FOR PART I, LINE 7

COSTING METHODOLOGY

THE COSTING METHOD USED TO CALCULATE FINANCIAL ASSISTANCE REPORTED ON LINES 7 A THROUGH D WAS THE COST-TO-CHARGE RATIO AS DERIVED ON TAX FORM 990, SCHEDULE H, WORKSHEET 2. ALL OTHER COMMUNITY BENEFITS WERE CALCULATED USING DIRECT COSTS.

PART VI, DESCRIPTIONS FOR PART II

LINE 3. COMMUNITY SUPPORT

YOUTH ASSET DEVELOPMENT

THE MY BROTHER'S KEEPER (MBK) COMMUNITY CHALLENGE WAS ANNOUNCED BY THE WHITE HOUSE IN FEBRUARY 2014 AS AN INITIATIVE AIMED AT IMPROVING THE OUTCOMES OF BOYS AND YOUNG MEN OF COLOR. THE MBK COMMUNITY CHALLENGE ENCOURAGES COMMUNITIES TO IMPLEMENT A CRADLE-TO-COLLEGE-AND-CAREER STRATEGY INTENDED TO IMPROVE THE OUTCOMES FOR YOUNG PEOPLE REGARDLESS OF WHO THEY ARE, WHERE THEY COME FROM, OR THE CIRCUMSTANCES INTO WHICH THEY ARE BORN. NEARLY 200 MAYORS, TRIBAL LEADERS, AND COUNTY EXECUTIVES ACROSS

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43 STATES AND THE DISTRICT OF COLUMBIA HAVE ACCEPTED THE MBK COMMUNITY CHALLENGE. SOUTH BEND ACCEPTED THE CHALLENGE IN OCTOBER 2015, JOINING HUNDREDS OF CITIES IN RECOGNIZING THE OPPORTUNITY GAPS FACING BOYS AND YOUNG MEN OF COLOR AND IN COMMITTING TO RECTIFY THE DISPARITIES.

A COMMUNITY ACTION SUMMIT WAS HELD THAT SAME MONTH. COMMUNITY PARTNERS CAME TOGETHER AND TALKED ABOUT THE EFFORTS NEEDED TO ELIMINATE THE OPPORTUNITY GAPS, POINTED OUT BARRIERS, BROUGHT TO LIGHT CHALLENGES THE YOUTH FACE IN OUR COMMUNITY, AND STRATEGIZED WAYS THAT WE AS A COMMUNITY CAN ENSURE THAT YOUNG PEOPLE ARE BETTER POSITIONED TO SUCCEED.

SEVERAL SPECIFIC CHALLENGES THAT BOYS AND YOUNG MEN OF COLOR FACE WERE IDENTIFIED AT THE SUMMIT. THESE INCLUDED VIOLENCE, ACCESS TO QUALITY EARLY CHILDHOOD EDUCATION TO GET BOYS OF COLOR OFF TO A GOOD START WHEN THEY ENTER KINDERGARTEN, POLICE-COMMUNITY RELATIONS, AND ACCESS TO EMPLOYMENT OPPORTUNITIES THAT WOULD ALLOW YOUNG MEN OF COLOR TO SUPPORT THEMSELVES AND THEIR FAMILIES. BASED ON THIS FEEDBACK, THE SOUTH BEND MBK INITIATIVE WILL FOCUS ON THE FOLLOWING:

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- GETTING A HEALTHY START AND ENTERING SCHOOL READY TO LEARN
- KEEPING KIDS ON TRACK AND GIVING THEM SECOND CHANCES
- SUCCESSFULLY ENTERING THE WORKFORCE

AS THE ANCHOR ORGANIZATION, BEACON HEALTH SYSTEM NETWORKS AND COLLABORATES WITH MBK COMMUNITY PARTNERS TO COMPLETE THE MISSION OF CLOSING OPPORTUNITY GAPS FOR BOYS AND YOUNG MEN OF COLOR. BEACON HEALTH SYSTEM HAS COMMITTED TO SPEARHEADING THE DEVELOPMENT AND IMPLEMENTATION OF DATA-DRIVEN OUTCOMES; ENSURING EFFICIENCY; AND FACILITATING ANALYSIS, MANAGEMENT, AND PRESENTATION OF DATA.

IN THE TWO YEARS SINCE SOUTH BEND JOINED THE MBK CHALLENGE, MUCH OF THE FOCUS HAS BEEN ON IMPLEMENTING DATA COLLECTION AMONG THE PARTNER PROGRAMS. THE OUTCOME DATA GATHERED IN 2017 IDENTIFIED THE NEED FOR A SYSTEMATIC PROCESS OF DATA COLLECTION.

WE REVIEWED CURRENT MBK PROGRAMMING PRACTICES AND FOUND THREE AREAS OF OPPORTUNITY FOR IMPROVEMENT. THROUGHOUT THIS PROCESS WE WILL UTILIZE THE

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TALENT AND SKILLS PROVIDED BY THE MBK ADVISORY COUNCIL TO HELP US SUPPORT
THE COMMUNITY PARTNERS, AS NOTED BELOW.

FIRST, WE WANT TO MAKE SURE THAT EACH PROGRAM HAS INDIVIDUAL, MEASURABLE
GOALS AND INDICATORS. THIS WILL MEAN MEETING PERIODICALLY THROUGHOUT THE
YEAR TO PROVIDE SUPPORT. OVER THE NEXT YEAR WE WANT TO SEE SPECIFIC,
MEASURED OUTCOMES FROM EACH PROGRAM. THIS WILL HELP US DETERMINE WHAT
SUCCESSSES THE PROGRAM SEES, AND WHERE THEY CAN IMPROVE PROGRAMMING.

NEXT, WE WANT TO ALIGN THE DATA BEING COLLECTED BY OUR COMMUNITY
PARTNERS. WE WILL ENSURE THAT EACH OF THEM ARE COLLECTING DATA RELEVANT
TO THE INDICATORS CHOSEN TO REPRESENT OUR SUCCESS AT ADDRESSING THE
DISPARITIES FOR BOYS AND YOUNG MEN OF COLOR IN OUR COMMUNITY. EACH OF THE
INDICATORS REPRESENTS SUCCESS FOR ONE OF THE MILESTONES ABOVE, SO ALL OF
THE PROGRAMS ADDRESSING EACH MILESTONE WILL COLLECT THE SAME INDICATOR
DATA.

FINALLY, WE RECOGNIZE THAT OUR COMMUNITY PARTNERS WANT TO ENSURE THEIR

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PROGRAM IS ACCESSIBLE. WE WILL FOSTER COLLABORATION BETWEEN COMMUNITY PARTNERS AND OTHER ORGANIZATIONS IN THE CITY TO HELP INCREASE PARTICIPATION. WE WILL ALSO ASSIST COMMUNITY PARTNERS WITH FINDING RESOURCES TO SUPPORT THEIR PROGRAMS, AND WILL ENCOURAGE COMMUNITY PARTNER COLLABORATION FOR RESOURCE SUPPORT AS WELL.

PEDIATRIC HEALTH NEEDS ASSESSMENT

AS THE ONLY COMPREHENSIVE CHILDREN'S HOSPITAL IN OUR REGION, BEACON CHILDREN'S HOSPITAL HAS A RESPONSIBILITY TO KNOW AND UNDERSTAND THE HEALTH NEEDS AND CONCERNS OF ITS LOCAL PATIENT POPULATION. FOR THIS REASON, BEACON COMMUNITY HEALTH AND BEACON CHILDREN'S HOSPITAL DEVELOPED A PEDIATRIC HEALTH NEEDS ASSESSMENT (PHNA) IN 2016.

BEACON COMMUNITY HEALTH CONDUCTED THE ASSESSMENT WITH THE FOLLOWING SIX AREA COUNTIES: ELKHART, LAKE, LAPORTE, MARSHALL, PORTER, AND ST. JOSEPH.

PRIMARY AREAS OF FOCUS TAKEN FROM THE PHNA AND BEGINNING IN 2017 ARE ASTHMA, MENTAL HEALTH/SUICIDE, AND OBESITY. WORK WILL INCLUDE GAINING AN

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UNDERSTANDING OF INITIATIVES AND PROGRAMS CURRENTLY ADDRESSING THESE PRIORITIES, IDENTIFYING GAPS AND OPPORTUNITIES, AND CREATING AND IMPLEMENTING STRATEGIES TO IMPROVE HEALTH IN THE THREE FOCUS AREAS. INITIAL EFFORTS WILL BE FOCUSED IN ELKHART AND ST. JOSEPH COUNTIES, WITH PLANS TO SHARE INFORMATION AND BUILD RELATIONSHIPS WITH THE OTHER FOUR COUNTIES.

MANY OF THE PHNA INITIATIVES CROSS INTO OUR CHNA PRIORITIES, AND THESE HAVE BEEN INCLUDED THERE FOR MORE CONSISTENCY. THE PHNA WILL BE ROLLED INTO THE NEXT COMMUNITY HEALTH NEEDS ASSESSMENT MOVING FORWARD, ALLOWING FOR MORE CONSISTENCY AND ALIGNMENT OF GOALS AND OBJECTIVES.

U-TURN FOR YOUTH: PREVENTING SUICIDE AND IMPROVING MENTAL HEALTH IN OUR COMMUNITY IS A PHILANTHROPICALLY FUNDED INITIATIVE TO BRING MENTAL HEALTH INFORMATION PROGRAMS TO OUR COMMUNITY ON A WIDE SCALE. THANKS TO THIS INITIATIVE, COMMUNITY HEALTH IS ABLE TO REACH THOUSANDS OF STUDENTS, TEACHERS, HEALTH CARE PROFESSIONALS, AND COMMUNITY MEMBERS WITH SUICIDE PREVENTION AND MENTAL HEALTH PROGRAMS.

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DURING THE FIRST YEAR OF PROGRAMMING, U-TURN FOR YOUTH IMPLEMENTED QUESTION, PERSUADE, REFER (QPR) GATEKEEPER SUICIDE PREVENTION, ADOLESCENT DEPRESSION AWARENESS PROGRAM (ADAP) AND THIS IS (NOT) ABOUT DRUGS. QPR IS OF PARTICULAR NOTE BECAUSE THE PROGRAM MEETS A STATE-MANDATED NEED FOR SBCSC STUDENTS AND TEACHERS TO ATTEND OR PARTICIPATE IN AT LEAST TWO HOURS OF EVIDENCE-BASED IN-SERVICE YOUTH SUICIDE AND PREVENTION TRAINING.

IN 2017, BEACON COMMUNITY HEALTH TRAINED 160 SOUTH BEND COMMUNITY SCHOOL CORPORATION (SBCSC) TEACHERS AND SCHOOL STAFF MEMBERS USING QPR, WITH DATA SHOWING INCREASED KNOWLEDGE OF SUICIDE PREVENTION REFERRAL FROM 20% TO 93% AFTER TRAINING.

U-TURN FOR YOUTH HAS ALSO IMPLEMENTED ADOLESCENT DEPRESSION AWARENESS PROGRAM (ADAP) CREATED BY JOHNS HOPKINS UNIVERSITY. ADAP SEEKS TO EDUCATE HIGH SCHOOL STUDENTS, TEACHERS, AND PARENTS ABOUT ADOLESCENT DEPRESSION. THE CURRICULUM INCREASES AWARENESS ABOUT DEPRESSION AND BIPOLAR DISORDER, STRESSING THE NEED FOR EVALUATION AND TREATMENT, WHILE DECREASING THE

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STIGMA ASSOCIATED WITH MOOD DISORDERS. THE PROGRAM'S KEY MESSAGE IS THAT DEPRESSION AND BIPOLAR DISORDER ARE TREATABLE, AND HELP IS AVAILABLE.

WE WERE ABLE TO REACH 356 STUDENTS WITH ADAP, AND STRATEGY IS ALREADY BEING IMPLEMENTED BASED ON WHAT WE LEARNED IN YEAR ONE. STUDENTS RATING THEIR CONFIDENCE LEVEL AS HIGH WHEN ASKING ABOUT SUICIDAL INTENTION WAS INCREASED FROM 17% TO 29% POST-TRAINING.

ALONG WITH QPR AND ADAP, WE IMPLEMENTED THIS IS (NOT) ABOUT DRUGS - AN EDUCATIONAL PROGRAM CREATED BY OVERDOSE LIFELINE, INC TO RAISE AWARENESS OF THE RISKS OF MISUSING PRESCRIPTION OPIOIDS AND THE CONNECTION BETWEEN MISUSE AND ADDICTION, HEROIN USE, AND OVERDOSE. STUDENTS ARE ENCOURAGED TO MAKE GOOD CHOICES AND PROVIDED WITH THE SKILLS TO COMBAT PEER PRESSURE, GAIN SUPPORT, AND RESOURCES FOR MAKING DECISIONS ABOUT THEIR OWN BODY AND HEALTH.

WE ADMINISTERED PRE AND POST-PROGRAM SURVEYS TO THE 180 STUDENTS WHO TOOK THIS IS (NOT) ABOUT DRUGS. MORE THAN HALF (52.7%) OF THE STUDENTS WHO

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ATTENDED SAID THE INFORMATION PRESENTED IN THE TRAINING WAS GOOD/HELPFUL.

OF THE TOTAL, 16 STUDENTS SAID THAT THEY KNEW SOMEONE MISUSING PRESCRIPTION PAIN MEDICINE, AND 136 OF THE STUDENTS (ABOUT 79%) SAID THEY ARE NOW LESS LIKELY TO ABUSE PRESCRIPTION PAIN MEDICINE OR DO HEROIN. OVERALL, THE EDUCATION CHANGED THE PERCEPTION OF THE STUDENTS; THERE WAS A NOTICEABLE INCREASE IN POSITIVE RESPONSES TO EACH STATEMENT ON THE POST-SURVEY.

ASTHMA IS NOT A FOCUS OF U-TURN, BUT IT REMAINS AN IMPORTANT PHNA HEALTH NEED. IN THE LAST YEAR, WORK WAS STARTED TO PREVENT AND DECREASE ACUTE ASTHMA EMERGENCIES AMONG THE PEDIATRIC POPULATION OF THE REGION. TWO INFORMATIONAL EVENTS WERE PILOTTED, THE ASTHMA NURSES NIGHT AND THE ASTHMA FAMILY NIGHT. THE NURSES WERE TAKEN THROUGH THE STEPS TO CORRECTLY IDENTIFY A RESPIRATORY EMERGENCY REQUIRING 911, MANY OF WHOM WERE ALREADY VERY FAMILIAR WITH IT. THE FAMILIES WERE TREATED TO A NIGHT AT HEALTHWORKS! KIDS MUSEUM WITH INFORMATIONAL BREAK-OUT SESSIONS RUN BY MEMORIAL PEDIATRICIAN DR. CHARISSE JOHNSON. BOTH THE FAMILIES AND NURSES AGREED THAT THE NIGHTS WERE FUN AND INFORMATIONAL. WE CAN'T WAIT TO DO

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EVEN BETTER NEXT YEAR.

LINE 6. COALITION BUILDING

THE ST. JOSEPH COUNTY HEALTH IMPROVEMENT ALLIANCE WAS FORMED IN THE FALL OF 2011 AFTER OUR COUNTY COMPLETED THE NATIONAL PUBLIC HEALTH PERFORMANCE STANDARDS ASSESSMENT THROUGH THE CENTERS FOR DISEASE CONTROL AND PREVENTION AND THE UNIVERSITY OF PURDUE. AFTER COMPLETION OF THE ASSESSMENT, THE WEAKEST AREAS IDENTIFIED WERE 1) COMMUNITY DATA AND 2) COMMUNITY PARTNERSHIPS. A GROUP OF STAKEHOLDERS CONVENE AND PARTICIPATED IN LEAN SIX SIGMA TRAINING FOR PUBLIC HEALTH PROFESSIONALS AND CONTINUED MOVING FORWARD WITH THE GROUP.

IN 2017, THE EXECUTIVE DIRECTOR OF BEACON COMMUNITY HEALTH WAS ASKED TO REPRESENT BEACON HEALTH SYSTEM AS ONE OF SIX ANCHOR ORGANIZATIONS. THIS GROUP, NOW RECOGNIZED AS THE ST. JOSEPH COUNTY HEALTH IMPROVEMENT ALLIANCE GROUP, HAS MET SEVERAL TIMES SINCE THE ORIGINAL ASSESSMENT. TOGETHER, THE GROUP WORKED ON A VISION, MISSION, AND DIRECTION FOR THE GROUP. AS A RESULT OF THESE BRAINSTORMING SESSIONS, THE GROUP DECIDED TO

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FOCUS ON OUR STAKEHOLDERS TOP PRIORITIES IN ORDER TO INCREASE PUBLIC HEALTH INFRASTRUCTURE AND ULTIMATELY IMPROVE THE COMMUNITY'S HEALTH. THE ULTIMATE GOAL IS TO IMPROVE THE HEALTH OF OUR COMMUNITY BY COLLABORATIVELY WORKING TOGETHER TO DECREASE DUPLICATION OF SERVICES AND INCREASE THE UTILIZATION OF EXISTING SERVICES AND RESOURCES.

PART VI, DESCRIPTIONS FOR PART III, LINE 2

THE CORPORATION EVALUATES THE COLLECTABILITY OF ITS ACCOUNTS RECEIVABLE BASED ON THE LENGTH OF TIME THE RECEIVABLE IS OUTSTANDING, PAYOR CLASS, AND THE ANTICIPATED FUTURE UNCOLLECTIBLE AMOUNTS BASED ON HISTORICAL EXPERIENCE. ACCOUNTS RECEIVABLE ARE CHARGED TO THE ALLOWANCE FOR DOUBTFUL ACCOUNTS WHEN THEY ARE DEEMED UNCOLLECTIBLE. THE COSTING METHODOLOGY IS THE SAME AS THE TAX FORM 990, SCHEDULE H, WORKSHEET 2 METHODOLOGY. PATIENT CARE COST IS ADJUSTED BY NON-PATIENT ACTIVITY EXPENSES, AND PATIENT CARE CHARGES. THE AMOUNT OF BAD DEBT REPORTED ON PART III, LINE 2 IS CALCULATED BY APPLYING THE COST-TO-CHARGE RATIO, AS DETERMINED BY WORKSHEET 2, TO TOTAL BAD DEBT EXPENSE PER THE AUDITED FINANCIAL STATEMENTS.

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PART VI, DESCRIPTIONS FOR PART III, LINE 3

BAD DEBT ATTRIBUTABLE TO THE FAP IS ESTIMATED BASED ON THE HISTORICAL TREND OF THE SOURCES OF THE BAD DEBT (50%). THE MAJORITY OF BAD DEBT IS ATTRIBUTABLE TO UNINSURED PATIENTS WHICH REPRESENT THE MAJORITY OF THE POPULATION THAT WOULD FALL UNDER THE FAP. WE HAVE APPLIED THE HISTORICAL ESTIMATE TO THE TOTAL BAD DEBT EXPENSE TO DETERMINE THE AMOUNT ATTRIBUTABLE TO THE FAP.

PART VI, DESCRIPTIONS FOR PART III, LINE 4

THE PROVISION FOR BAD DEBTS IS BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS TAKING INTO CONSIDERATION THE TRENDS IN HEALTH CARE COVERAGE, HISTORICAL ECONOMIC TRENDS, AND OTHER COLLECTION INDICATORS. MANAGEMENT ASSESSES THE ADEQUACY OF THE ALLOWANCES PERIODICALLY THROUGHOUT THE YEAR BASED UPON HISTORICAL WRITE-OFF EXPERIENCE BY MAJOR PAYOR CATEGORY. THE RESULTS OF THE REVIEW ARE THEN UTILIZED TO MAKE MODIFICATIONS, AS NECESSARY, TO THE PROVISION FOR BAD DEBTS TO PROVIDE FOR AN APPROPRIATE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS.

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A SIGNIFICANT PORTION OF THE CORPORATION'S UNINSURED PATIENTS WILL BE UNABLE OR UNWILLING TO PAY FOR THE SERVICES PROVIDED. THUS, THE CORPORATION RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS RELATED TO UNINSURED PATIENTS IN THE PERIOD THE SERVICES ARE PROVIDED.

PART VI, DESCRIPTIONS FOR PART III, LINE 8

RATIONALE FOR INCLUSION OF THE MEDICARE SHORTFALL AS A COMMUNITY BENEFIT PARTICIPATION IN THE GOVERNMENTAL MEDICARE PROGRAM DOES NOT PROVIDE THE OPPORTUNITY FOR A HOSPITAL TO NEGOTIATE A REIMBURSEMENT RATE OR STRUCTURE THAT WOULD ALLOW THE HOSPITAL TO COVER THE COST OF THE MEDICAL SERVICE RENDERED TO THE PROGRAM PARTICIPANT, AS WOULD BE THE CASE IN CONTRACTUAL NEGOTIATIONS WITH COMMERCIAL INSURANCE COMPANIES. NOR IS THE HOSPITAL ALLOWED TO PROVIDE ONLY THE SERVICES FOR WHICH REIMBURSEMENT COVERS THE DIRECT COST OF CARE. THIS PRODUCES THE SAME SHORTFALL OUTCOME AS DOES THE PARTICIPATION IN THE MEDICAID PROGRAM. THE MEDICAID PROGRAM IS RECOGNIZED AS A COMMUNITY BENEFIT ON SCHEDULE H AND ON COMMUNITY BENEFIT REPORTS FOR MOST STATES. THE QUALITY AND COST OF THE PATIENT CARE IS THE SAME REGARDLESS OF PAYOR SOURCE. HENCE THE ACCEPTANCE OF MEDICARE

Part VI Supplemental Information

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REIMBURSEMENT REPRESENTS A REDUCTION OR RELIEF OF THE GOVERNMENT BURDEN
TO PAY THE FULL COST OF CARE PROVIDED.

PART VI, DESCRIPTIONS FOR PART III, LINE 9B

COLLECTIONS PRACTICES

PATIENTS KNOWN TO QUALIFY FOR FINANCIAL ASSISTANCE FOLLOW THE SAME
COLLECTION POLICY AS ALL INDIVIDUALS WITH BALANCES REMAINING AFTER
APPLICATION OF FINANCIAL ASSISTANCE.

CREDIT AND COLLECTIONS POLICY:

MEMORIAL HOSPITAL OF SOUTH BEND RELIES ON TIMELY PAYMENT OF PATIENT
ACCOUNTS RECEIVABLE TO ALLOW THE HOSPITAL TO CONTINUE TO PROVIDE
HIGH-QUALITY MEDICAL CARE AND TO SECURE THE LATEST IN HEALTH CARE
TECHNOLOGY FOR ITS PATIENTS. MEMORIAL HOSPITAL, RECOGNIZING THE BURDEN
THAT UNEXPECTED HEALTH CARE EXPENSES CAN PLACE ON PATIENTS AND THEIR
FAMILIES, WILL ASSIST PATIENTS TO RESOLVE OPEN ACCOUNTS FOR HOSPITAL
SERVICES BY WORKING WITH THIRD PARTY PAYERS TO ADJUDICATE PATIENT'S
INSURANCE CLAIMS AND BY PROVIDING ALTERNATIVE PAYMENT PLANS FOR PATIENTS.

Part VI Supplemental Information

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THE HOSPITAL ALSO PROVIDES SUBSIDIZED CARE FOR THOSE PATIENTS WHO QUALIFY. HOWEVER, WITH THE EXCEPTION OF SOME GOVERNMENT AND CONTRACTED CARE PLANS, ULTIMATE RESPONSIBILITY FOR RESOLUTION OR PAYMENT OF ACCOUNTS RESTS WITH THE PATIENT. PATIENTS ARE EXPECTED TO WORK WITH HOSPITAL PERSONNEL TO RESOLVE ACCOUNTS WITH THEIR INSURANCE COMPANIES AND/OR EMPLOYERS AS APPROPRIATE. WHERE THERE IS AN ESTIMATED SELF-PAY BALANCE DUE, MEMORIAL HOSPITAL WILL ASK NON-EMERGENCY PATIENTS TO PAY THAT BALANCE PRIOR TO OR AT THE TIME OF ADMISSION/REGISTRATION.

1. IF A PATIENT DOES NOT QUALIFY FOR FINANCIAL ASSISTANCE AND DOES NOT PAY THEIR ACCOUNT ACCORDING TO THE OPTIONS PROVIDED, THEN THE PATIENT'S ACCOUNT WILL BE PROCESSED ACCORDING TO THE BAD DEBT WRITE OFF POLICY.

2. IF A PATIENT HAS BEGUN MAKING PAYMENTS BUT THEN IS LATER DETERMINED TO QUALIFY UNDER THE FAP, MEMORIAL HOSPITAL WOULD ISSUE A REFUND TO THE PATIENT FOR ANY AMOUNT THAT HAS BEEN DETERMINED TO EXCEED THEIR NEWLY DETERMINED FINANCIAL RESPONSIBILITY.

Part VI Supplemental Information

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- 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.

3. MEMORIAL HOSPITAL OF SOUTH BEND MAY REQUEST AND COLLECT A DEPOSIT, BASED ON THE PATIENT'S TOTAL ESTIMATED PORTION OF A BILL, FROM APPROPRIATE NON-EMERGENCY INPATIENT ADMISSIONS, SAME DAY SURGERY PATIENTS, AND PATIENTS SCHEDULED FOR HIGH-DOLLAR OUTPATIENT PROCEDURES PRIOR TO OR AT THE TIME OF ADMISSION OR REGISTRATION. IN THE EVENT THAT A REQUEST FOR PAYMENT IS NOT MADE PRIOR TO OR AT THE TIME OF THE PATIENT'S ARRIVAL, A FINANCIAL COUNSELOR MAY CALCULATE THE ESTIMATED DEPOSIT AMOUNT AND CONFER WITH THE PATIENT/GUARANTOR FOR PAYMENT FOLLOWING THE ADMISSION OR REGISTRATION PROCESS VIA A FINANCIAL INTERVIEW. (IN SOME INSTANCES, THIS COULD OCCUR WHILE THE PATIENT IS IN HIS/HER ASSIGNED ROOM.) AT THE TIME OF DISCHARGE, EMERGENCY PATIENTS MAY BE REQUESTED TO PAY ANY CO-PAY OR DEDUCTIBLE.

4. WHERE APPROPRIATE, MEMORIAL HOSPITAL OF SOUTH BEND WILL IDENTIFY, AND REQUEST PAYMENT OF, AGED PATIENT BALANCES AS PART OF THE REQUEST FOR DEPOSIT. PAYMENT FOR OPEN PRIOR BALANCES WILL NOT DELAY CARE FOR EMERGENCY OR MEDICALLY NECESSARY CARE. AGED OPEN PRIOR BALANCES WILL BE CONSIDERED BY THE COLLECTION STAFF IN PATIENT ACCOUNT SERVICES WHENEVER

Part VI Supplemental Information

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PAYMENT ARRANGEMENTS OR AN ALTERNATIVE PAYMENT PROGRAM IS DEVELOPED FOR A PATIENT.

5. UNINSURED PATIENTS ARE GIVEN A 35% DISCOUNT FROM GROSS CHARGES.

6. MEMORIAL HOSPITAL OF SOUTH BEND WILL CONDUCT FINANCIAL INTERVIEWS WITH PATIENTS AND/OR GUARANTORS WHEN NECESSARY. ALL FINANCIAL INTERVIEWS WILL BE CONDUCTED IN AN ENVIRONMENT THAT IS BOTH PRIVATE AND PROFESSIONAL.

7. IN ADDITION TO CASH, CHECK, AND CREDIT CARDS, THE APPROVED PAYMENT ARRANGEMENT METHODS MIGHT INCLUDE:

A. HOSPITAL PAYMENT PLAN - A PAYMENT PLAN WITH THE HOSPITAL IS NOT TO EXCEED THREE MONTHS. EXCEPTIONS MUST BE APPROVED BY THE MANAGER OF PATIENT ACCOUNT SERVICES OR REVENUE CYCLE DIRECTOR. PATIENTS MAY BE REQUIRED TO SIGN A PROMISSORY NOTE BASED ON THE AGREED UPON PAYMENT ARRANGEMENT.

B. CAREPAYMENT - AN EXTENDED PAYMENT PLAN WHICH ALLOWS THE PATIENT AN EXTENDED PERIOD NOT TO EXCEED 36 MONTHS AT 0% INTEREST TO PAY THEIR

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BALANCE BETWEEN \$100 AND \$15,000. PATIENTS MAY BE AUTOMATICALLY ENROLLED IN THE CAREPAYMENT PLAN IF THEIR ACCOUNT HAS NOT BEEN PAID IN FULL 2 MONTHS AFTER THEIR FIRST STATEMENT. ALL PATIENTS ARE ELIGIBLE PROVIDED THAT THEY PROVIDE A VALID SOCIAL SECURITY NUMBER, ARE OVER 18 AND HAVE NOT PREVIOUSLY DEFAULTED ON THEIR CAREPAYMENT ACCOUNT.

C. MEDICAID/HIP - PATIENTS WHO DO NOT HAVE COVERAGE WHEN THEY PRESENT TO THE HOSPITAL FOR TREATMENT WILL BE SCREENED FOR OTHER COVERAGE THROUGH STATE ASSISTANCE PROGRAMS. AN ELIGIBILITY SPECIALIST WILL ASSIST THE PATIENT/GUARANTOR TO COMPLETE AND SUBMIT ALL NECESSARY FORMS REQUIRED BY THE INDIANA DEPARTMENT OF PUBLIC AID FOR THESE TYPES OF PROGRAMS.

D. HOSPITAL FINANCIAL ASSISTANCE (UNCOMPENSATED CARE) - REASONABLE EFFORTS WILL BE MADE TO DETERMINE IF PATIENTS ARE ELIGIBLE FOR FINANCIAL ASSISTANCE THROUGH THE HOSPITAL FINANCIAL ASSISTANCE PROGRAM. ALL FINANCIAL ASSISTANCE MUST BE APPROVED ACCORDING TO THE FAP FOR THE HOSPITAL. (REFER TO THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY)

8. EXTRAORDINARY COLLECTION ACTIONS WILL NOT BE TAKEN UNTIL AFTER MEMORIAL HOSPITAL HAS MADE REASONABLE EFFORTS TO DETERMINE IF A PATIENT

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WILL QUALIFY FOR FINANCIAL ASSISTANCE. EXTRAORDINARY COLLECTION ACTIONS
INCLUDE SUIT, WAGE GARNISHMENT, LIEN OR ADVERSE CREDIT BUREAU REPORTING.

PART VI, LINE 2, NEEDS ASSESSMENT

MHSB MONITORS COMMUNITY HEALTH STATUS AND EMERGING HEALTH TRENDS THROUGH
HEALTH AND SOCIOECONOMIC INDICATORS, AND CONSISTENT AND CANDID DIALOGUE
WITH ITS REGIONAL COMMUNITY HEALTH PARTNERS. THE DATA AND THE
RELATIONSHIPS WITH COMMUNITY HEALTH PARTNERS ARE USED BY MHSB TO IDENTIFY
HEALTH NEEDS AND TO SUBSEQUENTLY DRIVE DECISION-MAKING AND STRATEGIC
DIRECTION OF COMMUNITY HEALTH IMPROVEMENT ACTIVITIES.

DATA SOURCES INCLUDE LOCAL PUBLIC HEALTH SURVEILLANCE DATA, HEALTH CARE
COVERAGE DATA, VITAL STATISTICS, SOCIOECONOMIC DATA, ECONOMIC DEVELOPMENT
DATA, YOUTH AND ADULT BEHAVIORAL RISK FACTOR DATA, AND SOCIAL DEMOGRAPHIC
AGGREGATES.

MHSB COMMUNITY HEALTH ENHANCEMENT STAFF MAINTAIN FREQUENT COMMUNICATION
WITH MULTIPLE COMMUNITY HEALTH AND SOCIAL SERVICES AGENCIES TO ASSESS

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CURRENT OR SURFACING COMMUNITY HEALTH NEEDS, AND INITIATE DIALOGUE TO ASCERTAIN COMMUNITY INPUT ON HOW THE HOSPITAL CAN BEST HELP TO ADDRESS IDENTIFIED NEEDS. THE COMMUNICATION NETWORK INCLUDES REGULAR CONTACT WITH HEALTH SAFETY NET AGENCIES WITHIN THE COUNTY, TO ALIGN WITH LOCAL PUBLIC HEALTH INITIATIVES.

PART VI, LINE 3, PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE WHEN PATIENTS PRESENT TO OUR HOSPITAL, THEY ARE OFFERED THE OPPORTUNITY TO MEET WITH OUR ELIGIBILITY SPECIALISTS. OUR ELIGIBILITY SPECIALISTS DISCUSS THE POTENTIAL ELIGIBILITY OF THE PATIENT FOR MULTIPLE ASSISTANCE PROGRAMS, INCLUDING OUR OWN INTERNAL FINANCIAL ASSISTANCE PROGRAM. OUR STATEMENTS ALSO INCLUDE A NOTICE THAT FINANCIAL ASSISTANCE IS AVAILABLE TO PATIENTS, AND THEY CAN CONTACT OUR CUSTOMER SERVICE GROUP FOR GUIDELINES.

PART VI, LINE 4, COMMUNITY INFORMATION ESTABLISHED IN 1830, SJC, INDIANA HAS BECOME THE FOURTH LARGEST COUNTY IN THE STATE OF INDIANA. THE COUNTY SPANS 467 SQUARE MILES, WHICH INCLUDES A

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COMFORTABLE MIX OF RURAL CULTURAL HERITAGE AND URBAN AMENITIES. SJC IS ALSO THE REGIONAL CENTER FOR HIGHER EDUCATION, WITH MORE THAN EIGHT COLLEGES AND UNIVERSITIES, INCLUDING BUT NOT LIMITED TO THE UNIVERSITY OF NOTRE DAME, INDIANA UNIVERSITY SOUTH BEND, IVY TECH COMMUNITY COLLEGE, PURDUE UNIVERSITY, HOLY CROSS COLLEGE, BETHEL COLLEGE AND ST. MARY'S COLLEGE.

THE HEART OF MHSB IS LOCATED WITHIN A MILE OF THE UNIVERSITY OF NOTRE DAME, TEN MILES SOUTH OF THE MICHIGAN STATE LINE, AND FORTY MILES EAST OF LAKE MICHIGAN. THROUGH THE YEARS THE ENVIRONMENT OF SOUTH BEND, THE LARGEST CITY IN ST. JOSEPH COUNTY, HAS CHANGED FROM A FOCUS ON MANUFACTURING (STUDEBAKER, BOSCH, AND UNIROYAL) TO HEALTH, EDUCATION AND CUSTOMER SERVICES.

ACCORDING TO THE U.S. CENSUS, THE POPULATION FOR ST JOSEPH COUNTY IN 2015 WAS ESTIMATED AT 268,441 INDIVIDUALS. IN 2015 THE RACIAL STATISTICS IN THE COUNTY ARE 74% CAUCASIANS, 12% AFRICAN AMERICA, 8% HISPANIC, 2% ASIAN AND 4% OTHER. AS EXPECTED, WITH AN AREA WELL-SATURATED WITH

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POST-SECONDARY EDUCATIONAL INSTITUTIONS, THE COUNTY HAS HIGHER THAN WOULD BE PROJECTED EDUCATIONAL LEVELS; 88% OF THE POPULATION ARE HIGH SCHOOL GRADUATES, AND 27% HAVE A BACHELOR'S DEGREE OR HIGHER. THE MEDIAN HOUSEHOLD INCOME WAS \$46,881; PERSONS BELOW THE POVERTY LEVEL ACCOUNTED FOR 17% OF THE POPULATION; WHILE THE POVERTY RATE AMONG CHILDREN UNDER 18 WAS 25%. THIS NEED IS EVEN MORE PRONOUNCED IN SOUTH BEND, THE COUNTY SEAT WHERE THE MEDIAN HOUSEHOLD INCOME IN 2015 WAS ESTIMATED AT \$34,523 WITH 28% OF THE RESIDENTS LIVING BELOW THE POVERTY LEVEL.

THE POPULATION MIX IN SURROUNDING COUNTIES IS DIVERSE AND INCLUDES LARGE NUMBERS OF FIRST-GENERATION EUROPEAN, AFRICAN, MIDDLE EASTERN IMMIGRANTS, AFRICAN AMERICANS, ASIANS, HISPANICS, AND AMISH. MHSB MAKES A SPECIAL EFFORT TO FOCUS ON THOSE POPULATIONS WITH THE HIGHEST UNMET NEEDS, SPECIFICALLY THOSE PERSONS WHO ARE KNOWN AS VULNERABLE, THROUGH CHRONIC DISEASES, LOWER-INCOME AND POVERTY, MEMBERS OF A MINORITY POPULATION AND/OR THE UNINSURED.

PART VI, LINE 5, PROMOTION OF COMMUNITY HEALTH

Part VI Supplemental Information

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THE MISSION OF MEMORIAL HOSPITAL OF SOUTH BEND (MHSB), AS A BEACON HEALTH SYSTEM PARTNER, IS TO ENHANCE THE PHYSICAL, MENTAL, EMOTIONAL AND SPIRITUAL WELL-BEING OF THE COMMUNITIES WE SERVE. BEACON HEALTH SYSTEM IS COMMITTED TO CLINICAL EXCELLENCE, COMPASSIONATE CARE, AND THE ONGOING IMPROVEMENT OF QUALITY OF LIFE. OUR COMMITMENT WILL LEAD THE HEALTH SYSTEM TO BE THE COMMUNITY'S PROVIDER OF OUTSTANDING QUALITY, SUPERIOR VALUE AND COMPREHENSIVE HEALTH CARE SERVICES. BOTH BEACON HEALTH SYSTEM AND MHSB HAVE COMMUNITY BOARDS OF DIRECTORS, AND CONSISTENTLY INVEST FUNDS TO IMPROVE THE QUALITY OF LIFE FOR OUR COMMUNITIES.

BEACON HEALTH SYSTEM VALUES REFLECT AN UNWAVERING COMMITMENT TO THE COMMUNITIES WE SERVE. MHSB, AS A BEACON HEALTH SYSTEM PARTNER, HAS AS ITS VALUES:

- PATIENTS ARE AT THE CENTER - PATIENT NEEDS, CARE AND SAFETY ARE OUR TOP PRIORITY.
- TRUST - OUR ACTIONS WILL FIRMLY DEMONSTRATE RELIABILITY ON OUR INTEGRITY, ABILITIES AND OUR CHARACTER.
- RESPECT - WE WILL TREAT OUR PATIENTS, COMMUNITY MEMBERS AND EACH OTHER

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WITH THE HIGHEST LEVEL OF REGARD, DEMONSTRATING AN UNDERSTANDING OF
DIFFERENT PERSPECTIVES, CULTURES, INTERESTS AND NEEDS OF OTHERS.

- INTEGRITY - WE WILL CONTINUALLY DO THE RIGHT THING FOR OUR PATIENTS,
ASSOCIATES AND COMMUNITIES WE SERVE.

- COMPASSION - WE WILL DEMONSTRATE THE EMOTIONAL CAPACITIES OF EMPATHY
AND SYMPATHY, AND EXPRESS THE DESIRE TO HELP.

MEMORIAL HOSPITAL OF SOUTH BEND'S (MHSB) GOVERNING BODY IS COMPRISED OF
PERSONS WHO RESIDE IN SAINT JOSEPH COUNTY. THE BOARD OF DIRECTORS, WHO
SERVE WITHOUT PAY, GUIDE THE SYSTEM IN ITS MISSION TO PROVIDE HIGH
QUALITY, AFFORDABLE HEALTH CARE TO THE COMMUNITIES IT SERVES. THE BOARD'S
ROLES INCLUDE GUARANTEEING FAIR AND EQUAL ACCESS, APPROVING NEW MEDICAL
STAFF MEMBERS AND APPROVING LONG-TERM STRATEGIES FOR THE CONTINUED
SUCCESS OF THE HOSPITAL. ADDITIONALLY, MHSB EXTENDS MEDICAL STAFF
PRIVILEGES TO ALL QUALIFIED PHYSICIANS IN OUR COMMUNITY.

MHSB SEEKS TO PROMOTE THE HEALTH AND WELL-BEING OF SAINT JOSEPH COUNTY
RESIDENTS, WITH SPECIFIC FOCUS ON THE MOST VULNERABLE POPULATIONS, BY

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- 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.

PROVIDING EDUCATION TO AID IN EARLY DETECTION AND PREVENTION OF DISEASE AND TO IMPROVE THE HEALTH STATUS OF THE COMMUNITY AS A WHOLE. A KEY MECHANISM BY WHICH THIS GOAL IS CARRIED OUT IS MHSB'S SERIOUS, CONSISTENT, DELIBERATE SEARCH FOR AND PARTNERSHIP WITH LIKE-MINDED ORGANIZATIONS. MHSB CONTINUES TO SEEK OUT PARTNERSHIPS WITH MULTIPLE COMMUNITY ENTITIES TO ADDRESS THE NEEDS OF THE MEDICALLY UNDERSERVED AND TO IMPROVE THE HEALTH STATUS OF OUR COMMUNITY. THESE COLLABORATIVE ALLIANCES INCLUDED LOCAL PUBLIC HEALTH, SCHOOLS, CHURCHES, SOCIAL SERVICE AGENCIES, MINORITY ADVOCACY GROUPS, VICTIM ASSISTANCE, AND COMMUNITY HEALTH PROVIDERS.

MEMORIAL HOSPITAL TITHES 10% OF THE PREVIOUS YEAR'S INCOME FROM OPERATIONS FOR COMMUNITY BENEFIT INVESTMENT IN THE COMMUNITY. THIS INVESTMENT IS IN ADDITION TO THE HOSPITAL'S FINANCIAL ASSISTANCE, PREVENTION, AND EDUCATION ACTIVITIES SUPPORTED THROUGH ITS OPERATING BUDGET. THE COMMUNITY HEALTH ENHANCEMENT COUNCIL OF THE BOARD MAKES ONGOING POLICY AND OVERSEES THE ADMINISTRATION OF THE FUND AND DETERMINES SPECIFIC INVESTMENT ALLOCATIONS BASED UPON THE ASSETS AND NEEDS OF THE

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.

COMMUNITY. VOLUNTEERS AND STAFF ARE COMMITTED TO PRUDENTLY INVESTING THESE RESOURCES IN AN ACCOUNTABLE MANNER.

PART VI, LINE 6, AFFILIATED HEALTH CARE SYSTEM

IN 2011, MHSB AFFILIATED WITH ELKHART GENERAL HOSPITAL OF ELKHART, INDIANA, UNDER THE NAME OF BEACON HEALTH SYSTEM. BOTH ORGANIZATIONS CONTINUE AS FULL-CARE PROVIDERS FOR THEIR RESPECTIVE COUNTIES, AND BOTH ORGANIZATIONS ARE COMMITTED TO PROMOTING THE HEALTH OF THE COMMUNITIES THEY SERVE. THE BEACON HEALTH SYSTEM BOARD OF DIRECTORS CONSISTS OF 8 VOTING BOARD MEMBERS.

PART VI, LINE 7 STATE FILING OF COMMUNITY BENEFIT REPORT

MEMORIAL HOSPITAL SOUTH BEND PREPARES A COMMUNITY BENEFIT REPORT BOTH FOR THE STATE OF INDIANA AND FOR THE ANNUAL REPORT, WHICH IS POSTED AT BEACONHEALTHSYSTEM.ORG/CHNA.

**SCHEDULE I
(Form 990)**

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

OMB No. 1545-0047

2017

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

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.

Name of the organization

MEMORIAL HOSPITAL OF SOUTH BEND, INC

Employer identification number

35-0868132

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.

1 (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) NORTHEAST NEIGHBORHOOD REVITALIZATION ORGAN 803 LINCOLNWAY WEST SOUTH BEND, IN 46616	35-2118149	501(C)(3)	50,000.				CORPORATE SPONSOR
(2) AMERICAN CANCER SOCIETY 601 W. EDISON RD MISHAWAKA, IN 46545	13-1788491	501(C)(3)	8,500.				SPONSORSHIP
(3) THE CENTER FOR THE HOMELESS 813 SOUTH MICHIGAN SOUTH BEND, IN 46601	35-1768544	501(C)(3)	32,000.				AUCTION SPONSOR
(4) UNITED WAY OF ST. JOSEPH 3517 E. JEFFERSON SOUTH BEND, IN 46660	35-1063368	501(C)(3)	50,000.				CORPORATE SPONSOR
(5) UNITY GARDENS, INC. PO BOX 10022 SOUTH BEND, IN 46628	27-0901122	501(C)(3)	40,450.				PROJECT SPONSOR
(6) INDIANA UNIVERSITY FOUNDATION PO BOX 500 BLOOMINGTON, IN 47402	35-6018940	501(C)(3)	15,000.				SPONSORSHIP
(7) YMCA OF MICHIANA, INC 1201 NORTHSIDE BLVD. SOUTH BEND, IN 46615	35-0868216	501(C)(3)	40,000.				DIABETES PREVENTION
(8) CENTER FOR HOSPICE CARE FOUNDATION 111 SUNNYBROOK CT SOUTH BEND, IN 46637	30-0433147	501(C)(3)	15,000.				CROSSROADS CAMPAIGN
(9) BEACON MEDICAL GROUP, INC. 615 N. MICHIGAN STREET SOUTH BEND, IN 46601	35-1536132	501(C)(3)	1,523,576.				CONTRIBUTION FOR CLI FOR CLINICS
(10) BETHEL COLLEGE 1001 BETHEL CIRCLE MISHAWAKA, IN 46545	35-0935587	501(C)(3)	35,000.				NURSING LAB DONATION
(11) DOWNTOWN SOUTH BEND 217 S MICHIGAN ST SOUTH BEND, IN 46601	35-1546291	501(C)(6)	50,000.				COMMUNITY SPONSOR
(12) SOUTH BEND PARKS FOUNDATION, INC 321 E WALTER STREET SOUTH BEND, IN 46614	27-3843043	501(C)(3)	40,000.				SPONSORSHIP

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

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

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

Schedule I (Form 990) (2017)

**SCHEDULE I
(Form 990)**

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

OMB No. 1545-0047

2017

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

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.

Name of the organization

MEMORIAL HOSPITAL OF SOUTH BEND, INC

Employer identification number

35-0868132

Part I General Information on Grants and Assistance

- 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
- 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.

1 (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) ST. JOSEPH COUNTY HEALTH DEPARTMENT 227 W JEFFERSON BLVD SOUTH BEND, IN 46601	35-6000194	501(C)(3)	6,000.				PROJECT SPONSOR
(2) YWCA 1102 S FELLOWS ST SOUTH BEND, IN 46617	35-0868226	501(C)(3)	15,000.				PROGRAM SPONSOR
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							

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

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

Schedule I (Form 990) (2017)

Part III Grants and Other Assistance to Domestic Individuals. Complete if the organization answered "Yes" on Form 990, Part IV, line 22.
Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of non-cash assistance
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.

GRANT MONITORING PROCEDURES

SCH I, PART I, QUESTION 2

DONATIONS AND GRANTS GIVEN TO ORGANIZATIONS THAT IMPROVE THE HEALTH AND

WELL-BEING OF OUR COMMUNITY ARE MONITORED THROUGH OUTCOME MEASUREMENT

REPORTS THAT ARE PROVIDED TO MEMORIAL BY THE VARIOUS ORGANIZATIONS. THESE

REPORTS INFORM US OF HOW THE DONATIONS AND GRANTS WERE USED.

**SCHEDULE J
(Form 990)**

Department of the Treasury
Internal Revenue Service

Compensation Information

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

- ▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 23.
- ▶ Attach to Form 990.
- ▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2017

**Open to Public
Inspection**

Name of the organization

MEMORIAL HOSPITAL OF SOUTH BEND, INC

Employer identification number

35-0868132

Part I Questions Regarding Compensation

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

- | | |
|---|---|
| <input type="checkbox"/> First-class or charter travel | <input type="checkbox"/> Housing allowance or residence for personal use |
| <input checked="" type="checkbox"/> Travel for companions | <input type="checkbox"/> Payments for business use of personal residence |
| <input checked="" type="checkbox"/> Tax indemnification and gross-up payments | <input checked="" type="checkbox"/> Health or social club dues or initiation fees |
| <input type="checkbox"/> Discretionary spending account | <input type="checkbox"/> Personal services (such as, maid, chauffeur, chef) |

b If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain

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

3 Indicate which, if any, of the following the 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?
 - b** Participate in, or receive payment from, a supplemental nonqualified retirement plan?
 - c** Participate in, or receive payment from, an equity-based compensation arrangement?
- If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.

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

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

- a** The organization?
 - b** Any related organization?
- If "Yes" on line 5a or 5b, describe in Part III.

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

- a** The organization?
 - b** Any related organization?
- If "Yes" on line 6a or 6b, describe in Part III.

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

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

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

	Yes	No
1a	X	
2	X	
3		
4a		X
4b	X	
4c		X
5a		X
5b		X
6a		X
6b		X
7	X	
8		X
9		

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

Schedule J (Form 990) 2017

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

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 JEFFREY P. COSTELLO CFO/ASST. TREASURER	(i)	0.	0.	0.				
	(ii)	459,929.	108,072.	29,601.	159,176.	19,589.	776,367.	
2 KEITH SHERRY MD EMPLOYED PHYSICIAN	(i)	326,474.	0.	1,290.	11,034.	24,863.	363,661.	
	(ii)	0.	0.	0.				
3 KREG GRUBER CEO STARTING NOVEMBER 2017	(i)	0.	0.	0.				
	(ii)	515,723.	111,282.	13,752.	159,087.	21,426.	821,270.	
4 CHERYL WIBBENS-LESH MD ASST. SECR./VP	(i)	337,315.	34,025.	3,970.	12,319.	25,013.	412,642.	
	(ii)	0.	0.	0.				
5 DALE A. PATTERSON EMPLOYED PHYSICIAN	(i)	319,374.	11,931.	520.	10,800.	22,983.	365,608.	
	(ii)	0.	0.	0.				
6 PHILLIP NEWBOLD CEO - LEFT NOVEMBER 2017	(i)	0.	0.	0.				
	(ii)	807,254.	215,000.	688,699.	217,827.	15,415.	1,944,195.	135,543.
7 BRYAN BOYER TRUSTEE/EMPLOYED PHYSICIAN	(i)	0.	0.	0.				
	(ii)	860,014.	3,501.	2,411.	11,152.	23,339.	900,417.	
8 MARION MAHONE EMPLOYED PHYSICIAN	(i)	249,812.	11,370.	9,240.	10,800.	8,754.	289,976.	
	(ii)	0.	0.	0.				
9 MATTHEW R REED EMPLOYED PHYSICIAN	(i)	249,823.	10,903.	240.	10,465.	6,136.	277,567.	
	(ii)	0.	0.	0.				
10 LARRY TRACY PRESIDENT	(i)	365,382.	18,750.	6,900.	58,888.	24,313.	474,233.	
	(ii)	0.	0.	0.				
11 LINDA A MANSFIELD EMPLOYED PHYSICIAN	(i)	249,953.	11,238.	450.	10,706.	20,813.	293,160.	
	(ii)	0.	0.	0.				
12	(i)							
	(ii)							
13	(i)							
	(ii)							
14	(i)							
	(ii)							
15	(i)							
	(ii)							
16	(i)							
	(ii)							

Part III Supplemental Information

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

PART I, LINE 1A

MEMORIAL HOSPITAL OF SOUTH BEND, INC. REIMBURSES DIRECTORS FOR THE TAX EFFECT OF THE 1099 REPORTABLE BENEFITS OF COMPLIMENTARY USE OF MEMORIAL'S HEALTH AND LIFESTYLE CENTER AND SPOUSAL TRAVEL. BEACON HEALTH SYSTEM ALSO REIMBURSES FOR DIRECT EXPENSES RELATED TO ANY TRAVEL ON THE ORGANIZATION'S BEHALF.

SPOUSAL TRAVEL FOR THE FOLLOWING INDIVIDUALS WAS INCLUDED IN TAXABLE COMPENSATION: PHIL NEWBOLD AND KREG GRUBER

HEALTH OR SOCIAL CLUB DUES FOR THE FOLLOWING INDIVIDUALS WAS INCLUDED IN TAXABLE COMPENSATION: PETER BARANAY, THOMAS HAUCH, BRAD TOOTHAKER, KAREN BARNETT AND HUGH HEDMAN, MD.

TAX INDEMNIFICATION AND GROSS-UP PAYMENTS FOR THE FOLLOWING INDIVIDUALS WAS INCLUDED IN TAXABLE COMPENSATION: PETER BARANAY, THOMAS HAUCH, BRAD TOOTHAKER, KAREN BARNETT AND HUGH HEDMAN, MD.

PART I, LINE 3

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.

MEMORIAL HOSPITAL OF SOUTH BEND, INC. USES A RELATED ORGANIZATION'S (BEACON HEALTH SYSTEM, INC.) COMPENSATION REVIEW PROCESS. THIS REVIEW PROCESS INCLUDES AN EXTENSIVE EXAMINATION USING COMPARABLE MARKET DATA THAT IS THEN REVIEWED BY AN INDEPENDENT CONSULTANT HIRED BY, AND REPORTING TO, THE BOARD OF DIRECTORS. RECOMMENDATIONS ARE PRESENTED TO THE BOARD FOR DELIBERATION AND FINAL DECISION.

SCH. J - PART 1, LINE 4B - EXECUTIVE RETENTION PLAN

BEACON HEALTH SYSTEM IMPLEMENTED AN EXECUTIVE RETENTION PLAN TO ATTRACT AND RETAIN KEY EMPLOYEES BY PROVIDING ADDITIONAL DEFERRED COMPENSATION. THE CHIEF EXECUTIVE OFFICER WILL PARTICIPATE IN THE PLAN AND WILL SELECT OTHER PARTICIPANTS PURSUANT TO THE GUIDELINES SET BY THE EMPLOYER'S BOARD OF DIRECTORS. THE EMPLOYER MAY MAKE CONTRIBUTIONS UNDER THE PLAN AND HAS SOLE DISCRETION OVER WHETHER TO MAKE A CONTRIBUTION. VESTING OCCURS ON JANUARY 1 OF THE FIFTH YEAR FOR WHICH SUCH CONTRIBUTIONS ARE MADE FOR PARTICIPANTS WHO HAVE BEEN CONTINUOUSLY EMPLOYED. THE PLAN ALSO ALLOWS VESTING TO OCCUR IF THE PARTICIPANT ATTAINS THE AGE OF 62.

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.

THE FOLLOWING INDIVIDUALS RECEIVED VESTED PAYMENTS IN 2017, REFLECTED IN COLUMN (B)(III):

. PHIL NEWBOLD \$135,543

THE FOLLOWING INDIVIDUALS RECEIVED DEFFERED PAYMENTS IN 2017 THAT WILL VEST IN FUTURE YEARS, WHICH ARE REFLECTED IN COLUMN C:

. PHIL NEWBOLD, \$197,348

. JEFFREY COSTELLO, \$77,367

. KREG GRUBER, \$83,287

. LARRY TRACY, \$51,968

BEACON HEALTH SYSTEM IMPLEMENTED AN EXECUTIVE LONGEVITY BONUS PLAN FOR THE PURPOSE OF PROVIDING A LONGEVITY BONUS FOR ITS' DESIGNATED EXECUTIVES. THIS UNFUNDED PLAN WAS EFFECTIVE APRIL 1, 2014. THE PARTICIPANTS MUST REMAIN IN AN ACTIVE EMPLOYMENT STATUS WITH BEACON FOR A PERIOD OF 5 CONSECUTIVE YEARS FROM THE EFFECTIVE DATE TO BE ELIGIBLE TO RECEIVE THE FULL LONGEVITY BONUS AMOUNT AT WHICH TIME VESTING IS 100%. VESTING PRIOR TO THE 5 YEARS IS AT 0%. THE MAXIMUM BONUS AWARD AT 100%

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.

VESTING IS \$325,000.

THE FOLLOWING INDIVIDUALS RECEIVED DEFFERED PAYMENTS IN 2017 THAT WILL VEST IN FUTURE YEARS, WHICH ARE REFLECTED IN COLUMN C:

. JEFFREY COSTELLO, \$65,000

. KREG GRUBER, \$65,000

SCH. J - PART 1, LINE 7 - INCENTIVE PLANS

THE ORGANIZATION HAS THREE INCENTIVE PLANS (EMPLOYEE, MANAGEMENT AND EXECUTIVE) WHICH HAVE A NET OPERATING INCOME TO BUDGET MEASUREMENT FOR THE PAYOUT THRESHOLD.

THE EMPLOYEE PLAN SHARES THE EXCESS OVER BUDGET NET OPERATING INCOME WITH THE NON-MANAGMENT EMPLOYEES FOR BEACON HEALTH SYSTEM, INC AND THE AFFILIATED ENTITIES. THE EMPLOYEE INCENTIVE HAS A MAXIMUM CAP OF \$4,500,000. THE PAYOUT AND AMOUNT OF THE PAYOUT FOR THE EMPLOYEE INCENTIVE PLAN IS MADE AT THE DISCRETION OF THE BOARD.

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.

THE MANAGEMENT INCENTIVE PLAN PAYS A SLIDING PERCENTAGE OF BASE COMPENSATION IF THE NET OPERATING INCOME IS EQUAL TO OR GREATER THAN 80% OF THE BUDGETED NET OPERATING INCOME. THE SLIDING SCALE CAPS WHEN OPERATING INCOME REACHES 120% OF THE BUDGETED OPERATING INCOME. THE PAYOUT OF THE MANAGEMENT INCENTIVE PLAN IS MADE AT THE DISCRETION OF THE BOARD.

EXECUTIVES ARE COVERED UNDER THE BEACON HEALTH SYSTEM EXECUTIVE SHORT-TERM INCENTIVE PLAN (ESTIP). THE ESTIP PLAN PAYS A SLIDING PERCENTAGE OF BASE COMPENSATION IF THE NET OPERATING INCOME IS EQUAL TO OR GREATER THAN 80% OF THE BUDGETED NET INCOME. THE SLIDING SCALE CAPS WHEN OPERATING INCOME REACHES 120% OF THE BUDGETED OPERATING INCOME. THE PAYOUT OF THE ESTIP IS MADE AT THE DISCRETION OF THE BOARD.

**SCHEDULE K
(Form 990)**

Supplemental Information on Tax-Exempt Bonds

OMB No. 1545-0047

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.**

2017

▶ **Attach to Form 990.**

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

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

Name of the organization
MEMORIAL HOSPITAL OF SOUTH BEND, INC

Employer identification number
35-0868132

Part I Bond Issues

(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
						Yes	No	Yes	No	Yes	No
A IN FINANCE AUTHORITY	35-1602316	45471AQL9	09/08/2017	37,240,000.	REFUND BONDS ISSUED 03/16/2006		X		X		X
B HOSPITAL AUTHORITY OF SAINT JOSEPH COUNTY	35-6311914	79062WAA6	05/21/2013	45,523,353.	REFUND BONDS ISSUED 05/10/2007		X		X		X
C INDIANA FINANCE AUTHORITY	35-1602316	45471ALS9	05/21/2013	96,069,836.	REFUND BOND ISSD 2/3/98 & 10/22/08		X		X		X
D INDIANA FINANCE AUTHORITY	35-1602316	000000000	04/29/2013	7,492,187.	URGENT CARE HELICOPTER		X		X		X

Part II Proceeds

	A		B		C		D	
1 Amount of bonds retired					17,860,721.		4,926,300.	
2 Amount of bonds legally defeased								
3 Total proceeds of issue	37,240,000.		45,523,353.		96,069,836.		7,492,187.	
4 Gross proceeds in reserve funds								
5 Capitalized interest from proceeds								
6 Proceeds in refunding escrows								
7 Issuance costs from proceeds			511,271.		764,791.		66,925.	
8 Credit enhancement from proceeds								
9 Working capital expenditures from proceeds								
10 Capital expenditures from proceeds							7,425,262.	
11 Other spent proceeds	37,240,000.		45,012,082.		95,305,045.			
12 Other unspent proceeds								
13 Year of substantial completion	2000		2009		2003		2013	
	Yes	No	Yes	No	Yes	No	Yes	No
14 Were the bonds issued as part of a current refunding issue?	X		X		X			X
15 Were the bonds issued as part of an advance refunding issue?		X		X		X		X
16 Has the final allocation of proceeds been made?	X		X		X		X	
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X		X		X	

Part III Private Business Use

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?				X		X		X
2 Are there any lease arrangements that may result in private business use of bond-financed property?				X		X		X

Part III Private Business Use (Continued)

2017A, 2013A, 2013B, 2013C BONDS SERIES

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?			X		X			X
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?			X		X			
c Are there any research agreements that may result in private business use of bond-financed property?				X		X		X
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶		%		%		%		%
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶		%		%		%		%
6 Total of lines 4 and 5		%		%		%		%
7 Does the bond issue meet the private security or payment test?				X		X		X
8a Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?				X		X		X
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of		%		%		%		%
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?			X		X		X	

Part IV Arbitrage

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X		X		X		X
2 If "No" to line 1, did the following apply?								
a Rebate not due yet?		X		X		X		X
b Exception to rebate?	X			X		X		X
c No rebate due?		X	X		X		X	
If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed.								
3 Is the bond issue a variable rate issue?	X			X		X		X
4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?	X			X		X		X
b Name of provider	WELLS FARGO BANK, NA							
c Term of hedge	21.700							
d Was the hedge superintegrated?		X						
e Was the hedge terminated?		X						

Part VI **Supplemental Information.** Provide additional information for responses to questions on Schedule K (see instructions) *(Continued)*

PART III, COLUMN A

COLUMN A IS NOT COMPLETED BECAUSE SUCH BONDS WERE ISSUED AFTER 12/31/2002
TO REFUND, THROUGH A SERIES OF REFUNDINGS, BONDS ISSUED BEFORE
01/01/2003.

PART IV, LINE 2C, COLUMN B - D

REBATE REPORT DATED MAY 11, 2017, SHOWED THAT NO REBATE WOULD BE DUE.

SCHEDULE L
(Form 990 or 990-EZ)

Transactions With Interested Persons

OMB No. 1545-0047

2017

Open To Public Inspection

Department of the Treasury
Internal Revenue Service

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b.**

▶ **Attach to Form 990 or Form 990-EZ.**

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

Name of the organization: **MEMORIAL HOSPITAL OF SOUTH BEND, INC**
Employer identification number: **35-0868132**

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

1	(a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected?	
				Yes	No
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

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.

1	(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
				(1)									
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													
Total ▶							\$						

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

1	(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

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
ATTACHMENT 1					
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

Part V Supplemental Information

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

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
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

Part V Supplemental Information

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

ATTACHMENT 1

SCHEDULE L, PART IV

(A) NAME OF INTERESTED PERSON VALLEY SCREEN PROCESSING
 (B) RELATIONSHIP BOARD MEMBER GREATER THAN 35% OWNERSHIP
 (C) AMOUNT 285,349.
 (D) DESCRIPTION OF TRANSACTION PURCHASED SERVICES
 (E) SHARING ORGANIZATION REVENUE? YES X NO

**SCHEDULE M
(Form 990)**

Noncash Contributions

OMB No. 1545-0047

2017

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

- ▶ Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.
- ▶ Attach to Form 990.
- ▶ Go to www.irs.gov/Form990 for the latest information.

Name of the organization

MEMORIAL HOSPITAL OF SOUTH BEND, INC

Employer identification number

35-0868132

Part I Types of Property

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art - Works of art				
2 Art - Historical treasures				
3 Art - Fractional interests				
4 Books and publications				
5 Clothing and household goods				
6 Cars and other vehicles				
7 Boats and planes				
8 Intellectual property				
9 Securities - Publicly traded				
10 Securities - Closely held stock				
11 Securities - Partnership, LLC, or trust interests				
12 Securities - Miscellaneous				
13 Qualified conservation contribution - Historic structures				
14 Qualified conservation contribution - Other				
15 Real estate - Residential				
16 Real estate - Commercial				
17 Real estate - Other				
18 Collectibles				
19 Food inventory				
20 Drugs and medical supplies				
21 Taxidermy				
22 Historical artifacts				
23 Scientific specimens				
24 Archeological artifacts				
25 Other ▶ (<u>ATCH 1</u>)		1 .	163,470 .	
26 Other ▶ (_____)				
27 Other ▶ (_____)				
28 Other ▶ (_____)				

29 Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement **29**

	Yes	No
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?		X
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?		X
32a Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions?		X
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.		

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

Schedule M (Form 990) (2017)

JSA

7E1298 1.000

3270GV 608V

V 17-7.2F

PAGE 124

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.

SCHEDULE M, PART I

FOR 2017, THE QUANTITY IN COLUMN B ILLUSTRATES THE NUMBER OF CONTRIBUTIONS.

SCHEDULE M, PART I, LINE 25

THE GIFT SHOP NON-CASH CONTRIBUTION WAS RECEIVED BY BEACON HEALTH FOUNDATION (EIN 35-1536129) AND TRANSFERRED TO MEMORIAL HOSPITAL OF SOUTH BEND, INC.

SCHEDULE M, PART I, LINE 31

BEACON HEALTH FOUNDATION HAS A WRITTEN POLICY FOR REVIEW OF ALL GIFTS, IT DOES NOT SPEAK SPECIFICALLY TO NON-STANDARD GIFTS, HOWEVER THERE IS A REVIEW PROCESS IN PLACE.

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.

ATTACHMENT 1

SCHEDULE M, PART I - OTHER NONCASH CONTRIBUTIONS

<u>DESCRIPTION</u>	<u>(A) CHECK</u>	<u>(B) NUMBER OF CONTRIBUTIONS</u>	<u>(C) REVENUES REPORTED</u>	<u>(D) METHOD OF DETERMINING</u>
GIFT SHOP NON-CASH CONTRI	X	1.	163,470.	COST DONATED PROPERT
TOTALS		<u>1.</u>	<u>163,470.</u>	

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

Department of the Treasury
Internal Revenue Service

Name of the organization

MEMORIAL HOSPITAL OF SOUTH BEND, INC

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

2017

**Open to Public
Inspection**

Employer identification number

35-0868132

CORE FORM, PART I, LINE 6

VOLUNTEERS - MEMORIAL HOSPITAL OF SOUTH BEND HAS A DEPARTMENT CALLED
AMBASSADOR AND CUSTOMER SERVICES. IT IS THE RESPONSIBILITY OF THIS
DEPARTMENT TO RECRUIT, ORIENT, PROCESS AND PLACE NEW AMBASSADORS IN
APPROXIMATELY 30 SERVICE AREAS OF THE HOSPITAL. IT IS ALSO THE
RESPONSIBILITY OF THE DEPARTMENT TO FOLLOW UP, SCHEDULE AND RECOGNIZE
AMBASSADORS. SOME OF THE AREAS OF SERVICE INCLUDE A MAJOR SURGERY
WAITING ROOM, PATIENT ESCORTS, FLOWER DELIVERY, MAIL DELIVERY, LIVING
HISTORY PROGRAM, EMERGENCY DEPARTMENT VOLUNTEERS AND COOKIE BAKERS. IN
2017, MEMORIAL HAD 454 VOLUNTEERS IN THIS PROGRAM WHO SERVED 42,163
HOURS.

CORE FORM, PART III, LINE 4D

OTHER PROGRAM SERVICES

OTHER PROGRAM SERVICES INCLUDE PSYCHIATRIC DEPARTMENTS, SOCIAL SERVICES,
COMMUNITY OUTREACH PROGRAMS, TITHING, GRANTS, AND SUPPORTING SERVICES
SUCH AS ADMINISTRATION, FINANCE, PAYROLL, PATIENT ACCOUNTING, LAUNDRY
SERVICES, HEALTH AND LIFESTYLE CENTER, AND MEDICAL RECORDS. DUE TO THE
NON-REVENUE GENERATING OR COMMUNITY INVESTMENT NATURE OF MANY OF THE
PROGRAMS, THEY OPERATE AT A LOSS. SEE SCHEDULE H FOR DETAILS ON THE
HOSPITALS TITHING AND COMMUNITY OUTREACH REPRESENTED IN OTHER PROGRAM
SERVICES.

CORE FORM, PART VI, SECTION A, QUESTION 6

Name of the organization MEMORIAL HOSPITAL OF SOUTH BEND, INC	Employer identification number 35-0868132
--	--

MEMBERS OF THE ORGANIZATION - BEACON HEALTH SYSTEM, INC. IS THE SOLE CORPORATE MEMBER OF MEMORIAL HOSPITAL OF SOUTH BEND, INC.

CORE FORM, PART VI, SECTION A, QUESTION 7A

ELECTION OF BOARD MEMBERS

THE CORPORATE MEMBER SHALL APPOINT THE BOARD OF DIRECTORS OF MEMORIAL HOSPITAL OF SOUTH BEND AND SHALL HAVE SUCH POWERS OF ADVANCE APPROVAL REGARDING CORPORATE ACTIONS AS ARE DELINEATED IN THE BY-LAWS OF MEMORIAL HOSPITAL OF SOUTH BEND.

CORE FORM, PART VI, SECTION A, QUESTION 7B

DECISIONS OF THE BOARD OF DIRECTORS

DECISIONS OF THE BOARD OF DIRECTORS MUST BE APPROVED BY THE CORPORATE MEMBER.

CORE FORM, PART VI, SECTION B, LINE 11B

FORM 990 REVIEW PROCESS

THE ORGANIZATION INCORPORATES NUMEROUS PARTIES IN THE PRODUCTION AND REVIEW OF THE FORM 990 AND ASSOCIATED SCHEDULES. SENIOR ACCOUNTING STAFF AND MANAGEMENT COMPLETE THE FORM 990 AND SCHEDULES. SOME FORMS AND SCHEDULES ARE REVIEWED BY THE CONTROLLER. SUBSEQUENT TO THOSE STEPS, THE ORGANIZATION ENGAGED ERNST & YOUNG TO REVIEW THE COMPLETED FORM 990 AND APPROPRIATE SCHEDULES. PRIOR TO FILING THE RETURN, THE CFO, THE COMPENSATION COMMITTEE OF THE ORGANIZATION AND THE CEO CONDUCT A GENERAL OVERVIEW OF THE FORM 990, INCLUDING APPLICABLE COMPENSATION SCHEDULES. IN

Name of the organization MEMORIAL HOSPITAL OF SOUTH BEND, INC	Employer identification number 35-0868132
--	--

ADDITION, EACH BOARD MEMBER RECEIVES NOTIFICATION OF THE IRS FORM 990
PLACEMENT ON THE ORGANIZATION'S BOARD PORTALS WHICH ALLOWS FOR BOARD
MEMBER REVIEW PRIOR TO FILING THE RETURN.

CORE FORM, PART VI, SECTION B, LINE 12C

CONFLICT OF INTEREST DISCLOSURE

THERE ARE THREE SEPARATE FORMS THAT ARE SENT OUT THROUGH THE INTERNAL
AUDIT DEPARTMENT TO KEY EMPLOYEES OR BOARD MEMBERS REGARDING CONFLICT OF
INTEREST. THEY ARE AS FOLLOWS:

1. THE FIRST IS A CONFLICT OF INTEREST STATEMENT THAT IS SENT TO SENIOR
LEVEL ADMINISTRATION, MANAGEMENT, AND SELECT STAFF SUCH AS PURCHASING
DEPARTMENT EMPLOYEES. THE PURPOSE OF THE STATEMENT IS TO REQUIRE THESE
EMPLOYEES TO DISCLOSE ANY POTENTIAL CONFLICT OF INTERESTS THEY MAY HAVE.
THE STATEMENTS ARE SENT IN JANUARY OF EACH YEAR FOR THE PREVIOUS YEAR
ACTIVITIES AND WE PURSUE THE REPLIES TO GET A 100% RESPONSE RATE. IN THE
CURRENT YEAR WE SENT OUT OVER 320 STATEMENTS AND ARE WORKING TO ACHIEVE A
100% RESPONSE RATE. EACH RESPONSE IS REVIEWED BY THE DIRECTOR OF INTERNAL
AUDIT AND THE RESULTS ARE REPORTED TO THE CEO OF BEACON HEALTH SYSTEM,
THE AUDIT COMMITTEE CHAIRMAN, AS WELL AS THE AUDIT COMMITTEE OF THE BOARD
OF DIRECTORS.

2. THE SECOND STATEMENT IS THE BOARD DUALITY OF INTEREST STATEMENT THAT
IS SENT TO CURRENT BOARD MEMBERS, FORMER BOARD MEMBERS FROM THE LAST FIVE
YEARS, AND OTHER KEY EMPLOYEES. THE DUALITY OF INTEREST STATEMENT IS SENT

Name of the organization MEMORIAL HOSPITAL OF SOUTH BEND, INC	Employer identification number 35-0868132
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USING A WEB BASED SURVEY TOOL PROVIDED BY ERNST & YOUNG. THE REPLIES ARE REVIEWED BY THE DIRECTOR OF INTERNAL AUDIT. THE RESULTS OF THE SURVEYS ARE SUMMARIZED USING THE WEB BASED TOOL, AND ARE REVIEWED BY ERNST & YOUNG IN COMPLETING THE 990. THE RESULTS ARE REPORTED TO THE CEO OF BEACON HEALTH SYSTEM, THE AUDIT COMMITTEE CHAIRMAN, AND THE AUDIT COMMITTEE OF THE BOARD OF DIRECTORS.

3. THE THIRD STATEMENT IS ENTITLED "CODE OF ETHICS FOR SENIOR FINANCIAL OFFICERS". THE STATEMENT REQUIRES AN ACKNOWLEDGEMENT FORM TO BE SIGNED BY BEACON HEALTH SYSTEM'S KEY FINANCIAL EMPLOYEES THAT BEACON'S FINANCIAL INFORMATION IS TO THE BEST OF THEIR KNOWLEDGE TRUE AND ACCURATE. THIS STATEMENT WAS SENT OUT IN EARLY MARCH 2018 AND THE SIGNED ACKNOWLEDGEMENTS ARE KEPT BY THE DIRECTOR OF INTERNAL AUDIT. IN 2018, 17 DESIGNATED EMPLOYEES WERE REQUESTED TO SIGN THE FORM AND WE HAD A 100% COMPLIANCE RATE. ANY POTENTIAL CONFLICTS OF INTERESTS ARE REVIEWED BY INDEPENDENT PARTIES BOTH INTERNAL AND EXTERNAL TO THE ORGANIZATION, AND IF NECESSARY, CORRECTIVE ACTION WOULD BE TAKEN TO RESOLVE A TRUE CONFLICT. THE INDIVIDUAL WITH THE POTENTIAL CONFLICT OF INTEREST WOULD BE EXCLUDED FROM ALL REVIEW PROCEEDINGS.

CORE FORM, PART VI, SECTION B, LINE 15A & 15B

COMPENSATION DETERMINATION PROCESS

MEMORIAL HOSPITAL OF SOUTH BEND'S PARENT, BEACON HEALTH SYSTEM, INC. HAS AN EXTENSIVE EXAMINATION THAT IS CONDUCTED, FOR VICE PRESIDENT AND HIGHER, USING COMPARABLE MARKET DATA THAT IS THEN REVIEWED BY AN

Name of the organization MEMORIAL HOSPITAL OF SOUTH BEND, INC	Employer identification number 35-0868132
--	--

INDEPENDENT CONSULTANT HIRED BY, AND REPORTING TO, THE BOARD OF DIRECTORS. HUMAN RESOURCES CONDUCTS THE ANALYSIS AND MAKES RECOMMENDATIONS TO THE CEO WHO THEN MAKES THE RECOMMENDATIONS FOR ALL OTHER EXECUTIVES/OFFICERS TO THE BOARD FOR APPROVAL. THE INDEPENDENT CONSULTING GROUP SEPARATELY MAKES THE RECOMMENDATIONS REGARDING THE CEO'S COMPENSATION TO THE BOARD FOR APPROVAL. RECOMMENDATIONS ARE PRESENTED TO THE COMPENSATION COMMITTEE OF THE BEACON HEALTH SYSTEM, INC. BOARD FOR DELIBERATION AND FINAL DECISION. DELIBERATION AND FINAL DECISION ARE PERFORMED BY THE INDEPENDENT MEMBERS OF THE BOARD.

CORE FORM, PART VI, SECTION C, LINE 19

AVAILABILITY OF ORGANIZATIONAL DOCUMENTS

THE GOVERNING DOCUMENTS AND CONFLICT OF INTEREST POLICY ARE NOT MADE AVAILABLE TO THE PUBLIC. THE FINANCIAL STATEMENTS ARE DISTRIBUTED QUARTERLY TO THE ELECTRONIC MUNICIPAL MARKET ACCESS (EMMA) WEBSITE AS PART OF THE CONTINUING DISCLOSURES FOR THE BEACON HEALTH SYSTEM, INC. BONDS.

PART XI, LINE 9

OTHER CHANGES IN THE NET ASSETS OF FUND BALANCES

WRITE OFF INTER COMPANY, BEACON MEDICAL GROUP, INC.	233,467
WRITE OFF INTER COMPANY, ELKHART GENERAL HOSPITAL, INC.	(1,634,462)
WRITE OFF INTER COMPANY, BEACON HEALTH SYSTEM, INC.	(150,747,165)
WRITE OFF INTER COMPANY, BEACON HEALTH VENTURES, INC.	(610)
CHANGE IN INTEREST IN RECIPIENT ORG	(1,814,153)
LOSS ON BOND REFUNDING	(203,968)

Name of the organization MEMORIAL HOSPITAL OF SOUTH BEND, INC	Employer identification number 35-0868132
--	--

OTHER VARIANCE DUE TO ROUNDING (5)

TOTAL (154,166,896)

ATTACHMENT 1

990, PART VII- COMPENSATION OF THE FIVE HIGHEST PAID IND. CONTRACTORS

<u>NAME AND ADDRESS</u>	<u>DESCRIPTION OF SERVICES</u>	<u>COMPENSATION</u>
BALFOUR BEATTY CONSTRUCTION LLC 3100 MCKINNON STREET, 6TH FLOOR DALLAS, TX 75201	CONSTRUCTION	15,739,063.
ELKHART CLINIC, LLC P.O. BOX 2968 ELKHART, IN 46515	PHYSICIAN SERVICES	4,859,733.
SOUTH BEND EMERGENCY PHYSICIANS 615 N MICHIGAN SOUTH BEND, IN 46601	PHYSICIAN SERVICES	7,749,947.
SOUTH BEND MEDICAL FOUNDATION 530 N LAFAYETTE BLVD SOUTH BEND, IN 46601	LAB SERVICES	17,700,860.
NORTHERN INDIANA ANESTHESIA SERVICES, PC 1513 E JACKSON ROAD ELKHART, IN 46516	ANESTHESIA	4,758,701.

ATTACHMENT 2

FORM 990, PART VIII - FUNDRAISING EVENTS

<u>DESCRIPTION</u>	<u>GROSS INCOME</u>	<u>DIRECT EXPENSES</u>	<u>NET INCOME</u>
SUNBURST MARATHON	235,156.	285,394.	-50,238.
TOTALS	<u>235,156.</u>	<u>285,394.</u>	<u>-50,238.</u>

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No. 1545-0047

2017

**Open to Public
Inspection**

▶ 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.

Department of the Treasury
Internal Revenue Service

Name of the organization

MEMORIAL HOSPITAL OF SOUTH BEND, INC

Employer identification number

35-0868132

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

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) BEACON MEDICAL GROUP, INC. 615 N. MICHIGAN STREET SOUTH BEND, IN 46601 35-1536132	PHY PRACTICES	IN	501(C)(3)	10	BHS	X	
(2) BEACON HEALTH FOUNDATION, INC. 615 N. MICHIGAN STREET SOUTH BEND, IN 46601 35-1536129	FINANCIAL SUP	IN	501(C)(3)	7	BHS	X	
(3) ELKHART GENERAL HOSPITAL, INC. 600 EAST BOULEVARD ELKHART, IN 46514 35-0877574	HOSPITAL	IN	501(C)(3)	3	BHS	X	
(4) MEMORIAL ENDOWMENT FUND FOR MEM HOS P.O. BOX 1602 SOUTH BEND, IN 46634 35-6068581	ENDOWMENT	IN	501(C)(3)	12D	MHSB	X	
(5) BEACON HEALTH SYSTEM, INC. 615 N. MICHIGAN STREET SOUTH BEND, IN 46601 45-3864076	PARENT ORG	IN	501(C)(3)	12A	N/A		X
(6)							
(7)							

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

Schedule R (Form 990) 2017

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	
(1)												
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												

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) BEACON HEALTH VENTURES, INC. 35-1901068 615 N. MICHIGAN STREET SOUTH BEND, IN 46601	HOME MEDICAL	IN	N/A	C					
(2) BEACON HEALTH VENTURES MICHIGAN, INC. 20-8259773 615 N MICHIGAN ST SOUTH BEND, IN 46601	HOME MEDICAL	MI	N/A	C					
(3)									
(4)									
(5)									
(6)									
(7)									

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.

	Yes	No
1 During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?		
a Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity		X
b Gift, grant, or capital contribution to related organization(s)	X	
c Gift, grant, or capital contribution from related organization(s)	X	
d Loans or loan guarantees to or for related organization(s)		X
e Loans or loan guarantees by related organization(s)		X
f Dividends from related organization(s)		X
g Sale of assets to related organization(s)		X
h Purchase of assets from related organization(s)		X
i Exchange of assets with related organization(s)		X
j Lease of facilities, equipment, or other assets to related organization(s)		X
k Lease of facilities, equipment, or other assets from related organization(s)		X
l Performance of services or membership or fundraising solicitations for related organization(s)		X
m Performance of services or membership or fundraising solicitations by related organization(s)		X
n Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)		X
o Sharing of paid employees with related organization(s)		X
p Reimbursement paid to related organization(s) for expenses	X	
q Reimbursement paid by related organization(s) for expenses	X	
r Other transfer of cash or property to related organization(s)	X	
s Other transfer of cash or property from related organization(s)	X	

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) BEACON HEALTH VENTURES, INC	Q	208,609.	ACTUAL CHARGES
(2) ELKHART GENERAL HOSPITAL, INC	P	215,328.	ACTUAL CHARGES
(3) ELKHART GENERAL HOSPITAL, IN	Q	9,926,807.	ACTUAL CHARGES
(4) ELKHART GENERAL HOSPITAL, INC	R	7,502,174.	INTERCO TRNSFR
(5) BEACON HEALTH FOUNDATION	C	2,983,222.	ACTUAL CHARGES
(6) BEACON HEALTH FOUNDATION	Q	100,672.	ACTUAL CHARGES

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.

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

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) BEACON MEDICAL GROUP	B	1,523,576.	ACTUAL CHARGES
(2) BEACON MEDICAL GROUP	P	2,332,952.	WRITE OFF INTER
(3) BEACON MEDICAL GROUP	Q	5,699,460.	CASH TRANSFER
(4) BEACON MEDICAL GROUP	R	110,337.	WRITE OFF INTER
(5)			
(6)			

Part VI **Unrelated Organizations Taxable as a Partnership.** Complete if the organization answered "Yes" on Form 990, Part IV, line 37.

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.

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners section 501(c)(3) organizations?		(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		Yes	No	
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													
(11)													
(12)													
(13)													
(14)													
(15)													
(16)													

Part VII **Supplemental Information**

Provide additional information for responses to questions on Schedule R. See instructions.
