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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.

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

OMB No. 1545-0047

2019

Open to Public Inspection

A For the 2019 calendar year, or tax year beginning 01-01-2019 , and ending 12-31-2019

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

C Name of organization
Memorial Hospital of South Bend Inc
% JEFFREY COSTELLO
Doing business as

Number and street (or P.O. box if mail is not delivered to street address) | Room/suite
615 N MICHIGAN STREET

City or town, state or province, country, and ZIP or foreign postal code
SOUTH BEND, IN 46601

D Employer identification number
35-0868132

E Telephone number
(574) 647-3549

G Gross receipts $ 605,839,935

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? ☐ Yes ☑ No

H(b) Are all subordinates included? ☐ Yes ☐ No
If "No," attach a list. (see instructions)

H(c) Group exemption number ▶

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

J Website: ▶ beaconhealthsystem.org

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

L Year of formation: 1923

M State of legal domicile: IN

Part I Summary

1 Briefly describe the organization's mission or most significant activities:
SEE SCHEDULE O

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

3	Number of voting members of the governing body (Part VI, line 1a)	**3**	8
4	Number of independent voting members of the governing body (Part VI, line 1b)	**4**	6
5	Total number of individuals employed in calendar year 2019 (Part V, line 2a)	**5**	4,150
6	Total number of volunteers (estimate if necessary)	**6**	441
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	184,425
b	Net unrelated business taxable income from Form 990-T, line 39	**7b**	91,975

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	4,212,683	3,624,914
9	Program service revenue (Part VIII, line 2g)	588,328,326	580,204,402
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	289,708	236,908
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	12,403,981	21,363,371
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	605,234,698	605,429,595
13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	2,391,343	2,269,667
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)	193,387,208	206,896,415
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0	0
b	Total fundraising expenses (Part IX, column (D), line 25) ▶0		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	289,795,056	300,860,109
18	Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	485,573,607	510,026,191
19	Revenue less expenses. Subtract line 18 from line 12	119,661,091	95,403,404

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	538,957,796	554,946,020
21	Total liabilities (Part X, line 26)	220,825,979	214,953,940
22	Net assets or fund balances. Subtract line 21 from line 20	318,131,817	339,992,080

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: 2020-11-13

JEFFREY COSTELLO CFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
				P01564049

Firm's name ▶ ERNST & YOUNG US LLP — Firm's EIN ▶

Firm's address ▶ 155 N WACKER DRIVE 20 FLOOR
CHICAGO, IL 60606 — Phone no. (312) 879-2702

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

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:

BEACON HEALTH SYSTEM, INC. IS COMMITTED TO ENHANCING THE PHYSICAL, MENTAL, AND EMOTIONAL AND SPIRITUAL WELL-BEING OF THE COMMUNITIES WE SERVE AS THE COMMUNITY'S PROVIDER OF OUSTANDING QUALITY, SUPERIOR VALUE AND COMPREHENSIVE HEALTH CARE SERVICES.

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

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

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

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

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

4a	(Code: See Additional Data)	(Expenses $	118,638,257	including grants of $	0) (Revenue $	313,182,649)
4b	(Code: See Additional Data)	(Expenses $	113,510,284	including grants of $	0) (Revenue $	149,324,294)
4c	(Code: See Additional Data)	(Expenses $	61,283,199	including grants of $	0) (Revenue $	129,553,731)
4d	Other program services (Describe in Schedule O.)	(Expenses $	185,922,223	including grants of $	2,269,667) (Revenue $	0)
4e	**Total program service expenses ▶**		479,353,963			

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules *(continued)*

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	280		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		Yes	

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

2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	**2a**	4,150		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? **Note.** If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)			**2b**	Yes
3a	Did the organization have unrelated business gross income of $1,000 or more during the year? . . .			**3a**	Yes
b	If "Yes," has it filed a Form 990-T for this year? *If "No" to line 3b, provide an explanation in Schedule O* . . .			**3b**	Yes
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)? . .			**4a**	No
b	If "Yes," enter the name of the foreign country: ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year? . .			**5a**	No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?			**5b**	No
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?			**5c**	
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions? . . .			**6a**	No
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?			**6b**	
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?			**7a**	No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?			**7b**	
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?			**7c**	No
d	If "Yes," indicate the number of Forms 8282 filed during the year	**7d**			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?			**7e**	No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract? . .			**7f**	No
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?			**7g**	
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?			**7h**	
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?			**8**	
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the sponsoring organization make any taxable distributions under section 4966?			**9a**	
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person? . . .			**9b**	
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12 . . .	**10a**			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	**10b**			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	**11a**			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	**11b**			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?			**12a**	
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year.	**12b**			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? . . . . . **Note.** See the instructions for additional information the organization must report on Schedule O.			**13a**	
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	**13b**			
c	Enter the amount of reserves on hand	**13c**			
14a	Did the organization receive any payments for indoor tanning services during the tax year?			**14a**	No
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* . .			**14b**	
15	Is the organization subject to the section 4960 tax on payment(s) of more than $1,000,000 in remuneration or excess parachute payment(s) during the year? . . . . . If "Yes," see instructions and file Form 4720, Schedule N.			**15**	No
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? . . If "Yes," complete Form 4720, Schedule O.			**16**	No

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

Section A. Governing Body and Management

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

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

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

Section C. Disclosure

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

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

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

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

20 State the name, address, and telephone number of the person who possesses the organization's books and records:
▶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, or highest compensated employees who received more than $100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than $10,000 of reportable compensation from the organization and any related organizations.

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

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

(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) Kreg Gruber CEO	2.0 48.0			X				0	1,670,567	203,973
(2) Jeffrey P Costello CFO	2.0 48.0			X				0	1,208,925	131,675
(3) BRYAN BOYER Trustee/Employed Physician	2.0 40.0	X						0	851,880	34,035
(4) Larry Tracy President	40.0 0.0			X				596,664	0	113,993
(5) BRANT SANDERS EMPLOYED PHYSICIAN	0.0 40.0					X		577,575	0	11,596
(6) Dale A Patterson Employed Physician	40.0 0.0					X		453,066	0	34,356
(7) JAMES LOWE EMPLOYED PHYSICIAN	0.0 40.0					X		436,896	0	32,138
(8) RANDELL COULTER EMPLOYED PHYSICIAN	0.0 40.0					X		454,630	0	11,596
(9) Cheryl Wibbens-Lesh MD Asst. Secr./VP	0.0 40.0						X	0	400,443	35,716
(10) KRISTEN JENNINGS DIR OF MED RESIDENCY PROGRAM	40.0 0.0					X		313,744	0	34,405
(11) Peter Baranay Chair	2.0 0.0	X		X				1,308	0	0
(12) BRAD TOOTHAKER Vice Chair	2.0 0.0	X		X				1,248	0	0
(13) HUGH HEDMAN MD TRUSTEE	2.0 0.0	X						948	0	0
(14) KAREN BARNETT CHAIR	2.0 0.0	X		X				0	0	0
(15) TIM DURHAM Trustee	2.0 0.0	X						0	0	0
(16) MARK HARMAN Trustee	2.0 0.0	X						0	0	0
(17) THOMAS HAUCH MD SECRETARY	2.0 0.0	X		X				0	0	0

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			
1b Sub-Total ▶										
c Total from continuation sheets to Part VII, Section A ▶										
d Total (add lines 1b and 1c) ▶								2,836,079	4,131,815	643,483

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 ▶ 150

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
SOUTH BEND EMERGENCY PHYSICIANS, 615 N MICHIGAN SOUTH BEND, IN 46601	PHYSICIAN SERVICES	3,721,955
SOUTH BEND MEDICAL FOUNDATION, 530 N LAFAYETTE BLVD SOUTH BEND, IN 46601	LAB SERVICES	4,979,581
GIBSON LEWIS LLC, 1001 W 11TH STREET MISHAWAKA, IN 46544	CONSTRUCTION	3,615,287
METRO AVIATION INC, 1214 HAWN AVENUE SHREVEPORT, LA 71107	MEDICAL FLIGHTS	2,025,547
PANZICA2 A JOINT VENTURE, 416 EAST MONROE ST SUITE 320 SOUTH BEND, IN 46601	CONSTRUCTION	13,521,072

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 142

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	1,321,013			
e Government grants (contributions)	1e	2,303,901			
f All other contributions, gifts, grants, and similar amounts not included above	1f				
g Noncash contributions included in lines 1a - 1f: $	1g				
h **Total.** Add lines 1a-1f		3,624,914			
Program Service Revenue	Business Code				
2a NET PATIENT REVENUE	622110	576,998,736	576,998,736		
b AFFILIATE RENTAL REVENUE	532000	2,094,658	2,094,658		
c JOINT VENTURE ACTIVITY	561499	918,679	918,679		
d AMBULANCE SUPPLY	621910	107,274	107,274		
e CASH DISCOUNTS	611710	52,541	52,541		
f All other program service revenue.		32,514	32,514		
g **Total.** Add lines 2a–2f	580,204,402				
3 Investment income (including dividends, interest, and other similar amounts)		147,467			147,467
4 Income from investment of tax-exempt bond proceeds		31			31
5 Royalties		0			
	(i) Real	(ii) Personal			
6a Gross rents 6a	1,293,944				
b Less: rental expenses 6b	14,075				
c Rental income or (loss) 6c	1,279,869	0			
d Net rental income or (loss)			1,279,869		1,279,869
	(i) Securities	(ii) Other			
7a Gross amount from sales of assets other than inventory 7a	0	130,289			
b Less: cost or other basis and sales expenses 7b	7,531	33,348			
c Gain or (loss) 7c	-7,531	96,941			
d Net gain or (loss)			89,410		89,410
Other Revenue 8a Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18	8a	264,276			
b Less: direct expenses	8b	355,386			
c Net income or (loss) from fundraising events			-91,110		-91,110
9a Gross income from gaming activities. See Part IV, line 19	9a	0			
b Less: direct expenses	9b	0			
c Net income or (loss) from gaming activities			0		
10a Gross sales of inventory, less returns and allowances	10a	0			
b Less: cost of goods sold	10b	0			
c Net income or (loss) from sales of inventory			0		
Miscellaneous Revenue	Business Code				
11a HLC ATHLETIC CLUB	713940	5,999,920	5,966,319		33,601
b OUTPATIENT PHARMACY	561499	5,933,335			5,933,335
c VENDOR REBATES	713940	1,591,732	1,591,732		
d All other revenue		6,649,625	4,298,221	184,425	2,166,979
e **Total.** Add lines 11a–11d		20,174,612			
12 **Total revenue.** See instructions		605,429,595	592,060,674	184,425	9,559,582

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	2,269,667	2,269,667		
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	714,161		714,161	
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	164,575,771	149,434,800	15,140,971	
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	5,479,564	4,975,444	504,120	
9 Other employee benefits	25,341,807	23,010,361	2,331,446	
10 Payroll taxes	10,785,112	9,792,882	992,230	
11 Fees for services (non-employees):				
a Management	245,013	222,472	22,541	
b Legal	131,382		131,382	
c Accounting	277,553		277,553	
d Lobbying	17,044	15,476	1,568	
e Professional fundraising services. See Part IV, line 17	0			
f Investment management fees	21,924		21,924	
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	41,209,528	39,378,987	1,830,541	
12 Advertising and promotion	203,681	184,942	18,739	
13 Office expenses	4,420,908	4,014,184	406,724	
14 Information technology	61,086	55,466	5,620	
15 Royalties	0			
16 Occupancy	6,125,181	5,561,664	563,517	
17 Travel	793,748	720,723	73,025	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19 Conferences, conventions, and meetings	62,061	56,351	5,710	
20 Interest	5,185,562	4,708,490	477,072	
21 Payments to affiliates	0			
22 Depreciation, depletion, and amortization	30,322,914	27,533,206	2,789,708	
23 Insurance	3,218,888	2,922,750	296,138	
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	103,400,803	103,400,803		
b BAD DEBT EXPENSE	37,156,745	37,156,745		
c CORPORATE ALLOCATION	41,723,640	37,885,065	3,838,575	
d HOSPITAL ASSESSMENT FEE	23,793,725	23,793,725		
e All other expenses	2,488,723	2,259,760	228,963	
25 **Total functional expenses.** Add lines 1 through 24e	510,026,191	479,353,963	30,672,228	0
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720).				

Part X Balance Sheet

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

				(A) Beginning of year		(B) End of year
Assets	1	Cash–non-interest-bearing		20,401	1	19,526
	2	Savings and temporary cash investments		-3,714,006	2	11,957,914
	3	Pledges and grants receivable, net		596,814	3	422,142
	4	Accounts receivable, net		98,674,931	4	107,763,356
	5	Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons		0	5	0
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)		0	6	0
	7	Notes and loans receivable, net		0	7	0
	8	Inventories for sale or use		17,813,996	8	17,209,333
	9	Prepaid expenses and deferred charges		1,773,700	9	2,015,306
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 864,871,820			
	b	Less: accumulated depreciation	10b 489,636,532	364,408,738	10c	375,235,288
	11	Investments—publicly traded securities		2,718,128	11	2,824,030
	12	Investments—other securities. See Part IV, line 11		0	12	0
	13	Investments—program-related. See Part IV, line 11		261,355	13	270,034
	14	Intangible assets		1,171,474	14	1,171,474
	15	Other assets. See Part IV, line 11		55,232,265	15	36,057,617
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		538,957,796	16	554,946,020
Liabilities	17	Accounts payable and accrued expenses		44,212,885	17	41,553,003
	18	Grants payable		0	18	0
	19	Deferred revenue		144,305	19	21,288
	20	Tax-exempt bond liabilities		148,972,182	20	143,661,411
	21	Escrow or custodial account liability. Complete Part IV of Schedule D		0	21	0
	22	Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons		0	22	0
	23	Secured mortgages and notes payable to unrelated third parties		296,473	23	107,637
	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		27,200,134	25	29,610,601
	26	**Total liabilities.** Add lines 17 through 25		220,825,979	26	214,953,940
Net Assets or Fund Balances		**Organizations that follow FASB ASC 958, check here ▶ ☑ and complete lines 27, 28, 32, and 33.**				
	27	Net assets without donor restrictions		312,373,852	27	333,014,441
	28	Net assets with donor restrictions		5,757,965	28	6,977,639
		Organizations that do not follow FASB ASC 958, check here ▶ ☐ and complete lines 29 through 33.				
	29	Capital stock or trust principal, or current funds			29	
	30	Paid-in or capital surplus, or land, building or equipment fund			30	
	31	Retained earnings, endowment, accumulated income, or other funds			31	
	32	Total net assets or fund balances		318,131,817	32	339,992,080
	33	Total liabilities and net assets/fund balances		538,957,796	33	554,946,020

Part XI Reconcilliation 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	605,429,595
2	Total expenses (must equal Part IX, column (A), line 25)	2	510,026,191
3	Revenue less expenses. Subtract line 2 from line 1	3	95,403,404
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	318,131,817
5	Net unrealized gains (losses) on investments	5	394,943
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	-73,938,084
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	339,992,080

Part XII Financial Statements and Reporting

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

			Yes	No
1	Accounting method used to prepare the Form 990: ☐ 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?	2a		No
	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?	2b	Yes	
	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?	2c	Yes	
	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?	3a	Yes	
b	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits.	3b	Yes	

Additional Data

Software ID:

Software Version:

EIN: 35-0868132

Name: Memorial Hospital of South Bend Inc

Form 990 (2019)

Form 990, Part III, Line 4a:

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. 2019 STATISTICS FOR THIS SERVICE UNIT INCLUDE: - 567,311 INPATIENT PROCEDURES - 472,019 OUTPATIENT PROCEDURES - 1,158 INPATIENT CATHS - 1,667 OUTPATIENT CATHS.

Form 990, Part III, Line 4b:

Patient Care Unit Services provides a wide variety of hospital services including: - Inpatient rehabilitation CARF (Commission on Accreditation of Rehabilitation Facilities) 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. 2019 STATISTICS FOR THIS SERVICE UNIT INCLUDE: - 94,418 PATIENT DAYS - 11,194 INPATIENT ER VISITS - 52,957 OUTPATIENT ER VISITS - 2,360 BIRTHS - 18,879 OBSERVATION STAYS.

Form 990, Part III, Line 4c:

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. 2018 STATISTICS FOR THIS SERVICE UNIT INCLUDE: - 9,382 INPATIENT PROCEDURES - 402 OPEN HEART PROCEDURES - 20,286 OUTPATIENT PROCEDURES.

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SCHEDULE A (Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

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

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
Memorial Hospital of South Bend Inc

Employer identification number
35-0868132

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

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

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

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

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

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

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

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

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

8 ☐ A community trust described in **section 170(b)(1)(A)(vi)**. (Complete Part II.)

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

10 ☐ An organization that normally receives: (1) more than 331/3% 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 331/3% 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? Yes	(iv) No	(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
Total						

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grant.") . .						
2 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) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(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** . . . . . ▶ ☐

Section C. Computation of Public Support Percentage

14 Public support percentage for 2019 (line 6, column (f) divided by line 11, column (f)) **14**

15 Public support percentage for 2018 Schedule A, Part II, line 14 . . . . . **15**

16a **33 1/3% support test—2019.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **33 1/3% support test—2018.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

17a **10%-facts-and-circumstances test—2019.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

b **10%-facts-and-circumstances test—2018.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization . . . . . ▶ ☐

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 . . . . . ▶ ☐

Part III **Support Schedule for Organizations Described in Section 509(a)(2)**
(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . .						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year.						
c Add lines 7a and 7b. .						
8 **Public support.** (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
9 Amounts from line 6. . .						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. .						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975.						
c Add lines 10a and 10b.						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on.						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) . .						
13 **Total support.** (Add lines 9, 10c, 11, and 12.). .						

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

Section C. Computation of Public Support Percentage

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

Section D. Computation of Investment Income Percentage

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

19a **33 1/3% support tests—2019.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . . ▶ ☐

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

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

			Yes	No
1	Did the directors, trustees, or membership of one or more supported organizations have the power to regularly appoint or elect at least a majority of the organization's directors or trustees at all times during the tax year? *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.*	**1**		
2	Did the organization operate for the benefit of any supported organization other than the supported organization(s) that operated, supervised, or controlled the supporting organization? *If "Yes," explain in* ***Part VI*** *how providing such benefit carried out the purposes of the supported organization(s) that operated, supervised or controlled the supporting organization.*	**2**		

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year **(see instructions)**:

- **a** ☐ The organization satisfied the Activities Test. Complete **line 2** below.
- **b** ☐ The organization is the parent of each of its supported organizations. Complete **line 3** below.
- **c** ☐ 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? *If "Yes," then in* ***Part VI identify those supported organizations and explain*** *how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.*	**2a**		
b	Did the activities described in (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? *If "Yes," explain in* ***Part VI*** *the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.*	**2b**		

3 Parent of Supported Organizations. **Answer (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? *Provide details in* ***Part VI.***	**3a**		
b	Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? *If "Yes," describe in* ***Part VI.*** *the role played by the organization in this regard.*	**3b**		

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

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

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

	Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):	1		
a	Average monthly value of securities	1a		
b	Average monthly cash balances	1b		
c	Fair market value of other non-exempt-use assets	1c		
d	**Total** (add lines 1a, 1b, and 1c)	1d		
e	**Discount** claimed for blockage or other factors (explain in detail in Part VI):			
2	Acquisition indebtedness applicable to non-exempt use assets	2		
3	Subtract line 2 from line 1d	3		
4	Cash deemed held for exempt use. Enter 1-1/2% of line 3 (for greater amount, see instructions).	4		
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5		
6	Multiply line 5 by .035	6		
7	Recoveries of prior-year distributions	7		
8	**Minimum Asset Amount** (add line 7 to line 6)	8		

	Section C - Distributable Amount			Current Year
1	Adjusted net income for prior year (from Section A, line 8, Column A)	1		
2	Enter 85% of line 1	2		
3	Minimum asset amount for prior year (from Section B, line 8, Column A)	3		
4	Enter greater of line 2 or line 3	4		
5	Income tax imposed in prior year	5		
6	**Distributable Amount.** Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	6		

7 ☐ Check here if the current year is the organization's first as a non-functionally-integrated Type III supporting organization (see instructions)

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

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

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

Additional Data

Software ID:

Software Version:

EIN: 35-0868132

Name: Memorial Hospital of South Bend Inc

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

Facts And Circumstances Test

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SCHEDULE C (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶**Complete if the organization is described below.** ▶**Attach to Form 990 or Form 990-EZ.**
▶**Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No. 1545-0047

2019

Open to Public Inspection

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

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

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

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

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

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

Name of the organization	Employer identification number
Memorial Hospital of South Bend Inc	35-0868132

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

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV (see instructions for definition of "political campaign activities")

2 Political campaign activity expenditures (see instructions) ▶ $

3 Volunteer hours for political campaign activities (see instructions)

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

1 Enter the amount of any excise tax incurred by the organization under section 4955 ▶ $

2 Enter the amount of any excise tax incurred by organization managers under section 4955 ▶ $

3 If the organization incurred a section 4955 tax, did it file Form 4720 for this year? ☐ Yes ☐ No

4a Was a correction made? ☐ Yes ☐ No

b If "Yes," describe in Part IV.

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

1 Enter the amount directly expended by the filing organization for section 527 exempt function activities ▶ $

2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities ▶ $

3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b ▶ $

4 Did the filing organization file **Form 1120-POL** for this year? ☐ Yes ☐ No

5 Enter the names, addresses and employer identification number (EIN) of all section 527 political organizations to which the filing organization made payments. For each organization listed, enter the amount paid from the filing organization's funds. Also enter the amount of political contributions received that were promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC). If additional space is needed, provide information in Part IV.

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

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

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

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

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	**(a)** Filing organization's totals	**(b)** Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
Not over $500,000	20% of the amount on line 1e.
Over $500,000 but not over $1,000,000	$100,000 plus 15% of the excess over $500,000.
Over $1,000,000 but not over $1,500,000	$175,000 plus 10% of the excess over $1,000,000.
Over $1,500,000 but not over $17,000,000	$225,000 plus 5% of the excess over $1,500,000.
Over $17,000,000	$1,000,000.

g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a. If zero or less, enter -0-.		
i Subtract line 1f from line 1c. If zero or less, enter -0-.		

j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? ☐ **Yes** ☐ **No**

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

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	**(a)** 2016	**(b)** 2017	**(c)** 2018	**(d)** 2019	**(e)** Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.		(a) Yes	(a) No	(b) Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a	Volunteers?		No	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		No	
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?		No	
e	Publications, or published or broadcast statements?		No	
f	Grants to other organizations for lobbying purposes?		No	
g	Direct contact with legislators, their staffs, government officials, or a legislative body?		No	
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?	Yes		17,044
j	Total. Add lines 1c through 1i			17,044
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?		No	

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

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

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

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

Part IV Supplemental Information

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

Return Reference	Explanation
SCHED 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) - 8% AMA (American Medical Association) - 60% APTA (American Physical Therapy Association) - 23% ANFP (Association of Nutrition & Foodservice Professionals) - 1% ACHE (American College of Healthcare Executives) - 1% ASHP (American Society of Health-System Pharmacists) - 19% CAP (College of American Pathologists) - 35% ACS (American College of Surgeons) - 4% AND (Academy of Nutrition and Dietetics) - 13% NACH (National Association of Children's Hospitals) - 25% APA (American Psychiatry Association) - 14% Memorial Hospital of South Bend, Inc. pays dues to some additional organizations not listed above, which do not specify a percentage for lobbying, for these organizations that we are unable to ascertain allocation of dues attributed to Lobbying a conservative estimate of 20% is applied.

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SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes," on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990.
▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
Memorial Hospital of South Bend Inc

Employer identification number
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.

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

5 Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

6 Did the organization inform all grantees, donors, and donor advisors in writing that grant funds can be used only for charitable purposes and not for the benefit of the donor or donor advisor, or for any other purpose conferring impermissible private benefit? ☐ Yes ☐ No

Part II Conservation Easements.

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

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

☐ Preservation of land for public use (e.g., recreation or education)
☐ Preservation of an historically important land area
☐ Protection of natural habitat
☐ Preservation of a certified historic structure
☐ Preservation of open space

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

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

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

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

5 Does the organization have a written policy regarding the periodic monitoring, inspection, handling of violations, and enforcement of the conservation easements it holds? ☐ Yes ☐ No

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

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

8 Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and section 170(h)(4)(B)(ii)? ☐ Yes ☐ No

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

Part III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets.

Complete if the organization answered "Yes" on Form 990, Part IV, line 8.

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

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

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

(ii) Assets included in Form 990, Part X ▶ $ _____

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

a Revenue included on Form 990, Part VIII, line 1 ▶ $ _____

b Assets included in Form 990, Part X ▶ $ _____

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

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

- a ☐ Public exhibition
- b ☐ Scholarly research
- c ☐ Preservation for future generations
- d ☐ Loan or exchange programs
- e ☐ Other .....

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

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

Part IV Escrow and Custodial Arrangements.

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

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

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

		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 in Part XIII . . . . ☐

Part V Endowment Funds.

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	30,834,712	34,205,140	33,854,961	26,556,022	29,619,029
b Contributions	2,588,247	1,352,757	2,155,261	9,605,449	4,093,832
c Net investment earnings, gains, and losses	3,242,314	-2,479,196	2,479,263	339,397	-1,367,472
d Grants or scholarships	1,740,359	2,243,989	4,284,345	2,645,907	5,789,367
e Other expenditures for facilities and programs					
f Administrative expenses					
g End of year balance	34,924,914	30,834,712	34,205,140	33,854,961	26,556,022

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

- a Board designated or quasi-endowment ▶ 80.030 %
- b Permanent endowment ▶ 0.210 %
- c Temporarily restricted endowment ▶ 19.760 %

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:

	Yes	No
3a(i) (i) unrelated organizations		No
3a(ii) (ii) related organizations	Yes	
3b If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R?	Yes	

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

Part VI Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		21,501,410		21,501,410
b Buildings		528,305,464	223,563,929	304,741,535
c Leasehold improvements		851,999	851,999	0
d Equipment		309,524,546	263,996,152	45,528,394
e Other		4,688,401	1,224,452	3,463,949
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10(c).)* ▶				375,235,288

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	20,000,382
(2)INT IN NET ASSETS OF REC ORG	6,977,639
(3)INTEREST RECEIVABLE - SWAP	129,936
(4)OTHER RECEIVABLES	5,591,860
(5)2016 BOND FUND	11,573
(6)AFFILIATE INTERCO	770,228
(7)RIGHT OF USE FINANCING ASSET	2,253,391
(8)SWAP MTM RECEIVABLE	322,608
(9)	
Total. *(Column (b) must equal Form 990, Part X, col.(B) line 15.)* ▶	36,057,617

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	0
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col.(B) line 25.)* ▶	29,610,601

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

Part XI Reconciliation of Revenue per Audited Financial Statements With Revenue per Return.
Complete if the organization answered 'Yes' on Form 990, Part IV, line 12a.

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

Part XII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return.
Complete if the organization answered 'Yes' on Form 990, Part IV, line 12a.

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

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

Additional Data

Software ID:

Software Version:

EIN: 35-0868132

Name: Memorial Hospital of South Bend Inc

Form 990, Schedule D, Part IX, - Other Assets

(a) Description	(b) Book value
DUE FROM 3RD PARTY PAYORS	20,000,382
INT IN NET ASSETS OF REC ORG	6,977,639
INTEREST RECEIVABLE - SWAP	129,936
OTHER RECEIVABLES	5,591,860
2016 BOND FUND	11,573
AFFILIATE INTERCO	770,228
RIGHT OF USE FINANCING ASSET	2,253,391
SWAP MTM RECEIVABLE	322,608

Supplemental Information

Return Reference	Explanation
PART V, LINE 4	Net assets with donor restrictions consist of assets whose use is limited by donor imposed , time and/or purpose restrictions. Some net assets have been restricted by donors to be m aintained by the Corporation in perpetuity. In accordance with the restriction, a majority of the investment income and investment gains or losses from these net assets are restric ted by the donor for a specific purpose. A specified portion of income earned by the net a ssets is released from restriction and used for operations each year and, therefore, is in cluded in the consolidated statements of operations and changes in net assets as other rev enue. THE BOARD HAS DISCRETION TO UTILIZE EACH YEAR THE INCOMES, REVENUES AND PROFITS ARIS ING AND ACCRUING FROM THE ENDOWMENTS IN DEFRAYING COSTS ASSOCIATED WITH THE TRUST AND THE REMAINDER FOR SUPPORT, BETTERMENT, IMPROVEMENT, UPKEEP, EXPANSION AND REPLACEMENT OF BEACO N HEALTH SYSTEM, INC. AND ITS CORPORATE AFFILIATES.

Supplemental Information

Return Reference	Explanation
PART X, LINE 2	ASC 740, Income Taxes, requires that realization of an uncertain income tax position is mo re 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 conventio ns. This interpretation also clarifies the financial statement classification of tax-relat ed penalties and interest and sets forth new disclosures regarding unrecognized tax benefi ts. No amount was recorded for the years ended December 31, 2019 or 2018.

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SCHEDULE G (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding Fundraising or Gaming Activities

Complete if the organization answered "Yes" on Form 990, Part IV, lines 17, 18, or 19, or if the organization entered more than $15,000 on Form 990-EZ, line 6a.

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

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
Memorial Hospital of South Bend Inc

Employer identification number
35-0868132

Part I **Fundraising Activities.** Complete if the organization answered "Yes" on Form 990, Part IV, line 17. Form 990-EZ filers are not required to complete this part.

1 Indicate whether the organization raised funds through any of the following activities. Check all that apply.

a ☐ Mail solicitations
b ☐ Internet and email solicitations
c ☐ Phone solicitations
d ☐ In-person solicitations
e ☐ Solicitation of non-government grants
f ☐ Solicitation of government grants
g ☐ Special fundraising events

2a Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising services? ☐ **Yes** ☐ **No**

b If "Yes," list the 10 highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least $5,000 by the organization.

(i) Name and address of individual or entity (fundraiser)	**(ii)** Activity	**(iii)** Did fundraiser have custody or control of contributions? **Yes**	**No**	**(iv)** Gross receipts from activity	**(v)** Amount paid to (or retained by) fundraiser listed in col. **(i)**	**(vi)** Amount paid to (or retained by) organization
Total . . . . . ▶						

3 List all states in which the organization is registered or licensed to solicit contributions or has been notified it is exempt from registration or licensing.

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

		(a) Event #1 MARATHON (event type)	(b) Event #2 (event type)	(c) Other events 0 (total number)	(d) Total events (add col. (a) through col. (c))
Revenue	1 Gross receipts	264,276			264,276
	2 Less: Contributions				
	3 Gross income (line 1 minus line 2)	264,276			264,276
Direct Expenses	4 Cash prizes	2,700			2,700
	5 Noncash prizes	584			584
	6 Rent/facility costs				
	7 Food and beverages	5,558			5,558
	8 Entertainment				
	9 Other direct expenses	346,544			346,544
	10 Direct expense summary. Add lines 4 through 9 in column (d) ▶				355,386
	11 Net income summary. Subtract line 10 from line 3, column (d) ▶				-91,110

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	☐ Yes % ☐ No	☐ Yes % ☐ No	☐ Yes % ☐ 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 ▶ ----------

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

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

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

Name ▶ ----------

Address ▶ ----------

16 Gaming manager information:

Name ▶ ----------

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

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

Return Reference	Explanation
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.

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SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
Memorial 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	1a	Yes	
b	If "Yes," was it a written policy?	1b	Yes	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year.			
	☑ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ 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: ☐ 100% ☐ 150% ☑ 200% ☐ Other _____ %	3a	Yes	
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: ☐ 200% ☐ 250% ☐ 300% ☑ 350% ☐ 400% ☐ Other _____ %	3b	Yes	
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"?	4	Yes	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	Yes	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		No
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligibile for free or discounted care?	5c		
6a	Did the organization prepare a community benefit report during the tax year?	6a	Yes	
b	If "Yes," did the organization make it available to the public?	6b	Yes	
	Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.			

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			2,696,536		2,696,536	0.570 %
b Medicaid (from Worksheet 3, column a)			106,185,824	81,793,284	24,392,540	5.160 %
c Costs of other means-tested government programs (from Worksheet 3, column b)			0	0	0	0 %
d **Total** Financial Assistance and Means-Tested Government Programs			108,882,360	81,793,284	27,089,076	5.730 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4).			4,628,220	2,131,693	2,496,527	0.530 %
f Health professions education (from Worksheet 5)			7,907,296	1,680,788	6,226,508	1.320 %
g Subsidized health services (from Worksheet 6)			0	0	0	0 %
h Research (from Worksheet 7)			507,617	391,730	115,887	0.020 %
i Cash and in-kind contributions for community benefit (from Worksheet 8)			332,128	0	332,128	0.070 %
j **Total.** Other Benefits			13,375,261	4,204,211	9,171,050	1.940 %
k **Total.** Add lines 7d and 7j			122,257,621	85,997,495	36,260,126	7.670 %

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						
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building			27,851	142	27,709	0.010 %
7 Community health improvement advocacy						
8 Workforce development						
9 Other						
10 Total			27,851	142	27,709	0.010 %

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

				Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?		1	Yes	
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	2	9,107,118		
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	4,553,559		
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	85,892,296		
6	Enter Medicare allowable costs of care relating to payments on line 5	6	119,798,847		
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-33,906,551		
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:				

☐ Cost accounting system ☐ Cost to charge ratio ☑ Other

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures

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

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

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

			Yes	No
Community Health Needs Assessment				
1	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		No
2	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C.	2		No
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12.	3	Yes	
	If "Yes," indicate what the CHNA report describes (check all that apply):			
a	☑ A definition of the community served by the hospital facility			
b	☑ Demographics of the community			
c	☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d	☑ How data was obtained			
e	☑ The significant health needs of the community			
f	☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g	☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h	☑ The process for consulting with persons representing the community's interests			
i	☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j	☐ Other (describe in Section C)			
4	Indicate the tax year the hospital facility last conducted a CHNA: 20 18			
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	Yes	
6 a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	Yes	
b	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C.	6b	Yes	
7	Did the hospital facility make its CHNA report widely available to the public?	7	Yes	
	If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	☑ Hospital facility's website (list url): www.beaconhealthsystem.org/chna			
b	☐ Other website (list url):			
c	☑ Made a paper copy available for public inspection without charge at the hospital facility			
d	☑ Other (describe in Section C)			
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11.	8	Yes	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 19			
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	Yes	
a	If "Yes" (list url): www.beaconhealthsystem.org/chna			
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		No
b	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c	If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

MEMORIAL HOSPITAL OF SOUTH BEND INC

Name of hospital facility or letter of facility reporting group

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	**13**	Yes	
If "Yes," indicate the eligibility criteria explained in the FAP:			
a ☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200. % and FPG family income limit for eligibility for discounted care of 350. %			
b ☐ Income level other than FPG (describe in Section C)			
c ☑ Asset level			
d ☑ Medical indigency			
e ☐ Insurance status			
f ☐ Underinsurance discount			
g ☐ Residency			
h ☑ Other (describe in Section C)			
14 Explained the basis for calculating amounts charged to patients?	**14**	Yes	
15 Explained the method for applying for financial assistance?	**15**	Yes	
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a ☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b ☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c ☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d ☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e ☐ Other (describe in Section C)			
16 Was widely publicized within the community served by the hospital facility?	**16**	Yes	
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a ☑ The FAP was widely available on a website (list url): See Section C for full URL			
b ☑ The FAP application form was widely available on a website (list url): See Section C for full URL			
c ☑ A plain language summary of the FAP was widely available on a website (list url): See Section C for full URL			
d ☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e ☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f ☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g ☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h ☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i ☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j ☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

MEMORIAL HOSPITAL OF SOUTH BEND INC

Name of hospital facility or letter of facility reporting group

		Yes	No
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	**17**	Yes	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:			
a ☐ Reporting to credit agency(ies)			
b ☐ Selling an individual's debt to another party			
c ☐ 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 ☐ Actions that require a legal or judicial process			
e ☐ Other similar actions (describe in Section C)			
f ☑ None of these actions or other similar actions were permitted			
19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	**19**		No
If "Yes," check all actions in which the hospital facility or a third party engaged:			
a ☐ Reporting to credit agency(ies)			
b ☐ Selling an individual's debt to another party			
c ☐ 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 ☐ Actions that require a legal or judicial process			
e ☐ 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 ☑ Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)			
b ☑ Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)			
c ☑ Processed incomplete and complete FAP applications (if not, describe in Section C)			
d ☑ Made presumptive eligibility determinations (if not, describe in Section C)			
e ☐ Other (describe in Section C)			
f ☐ None of these efforts were made			

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

MEMORIAL HOSPITAL OF SOUTH BEND INC

Name of hospital facility or letter of facility reporting group

		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 ☐	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b ☑	The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
c ☐	The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period		
d ☐	The hospital facility used a prospective Medicare or Medicaid method		
23	During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care? **23**		No
	If "Yes," explain in Section C.		
24	During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual? **24**		No
	If "Yes," explain in Section C.		

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

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

Form and Line Reference	Explanation
See Add'l Data	

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.

Form and Line Reference	Explanation
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 t hey 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 (unemp loyment income) 2. Last 3 pay stubs or a letter or printout from employer(s) providing ver ification of gross income if currently employed. This documentation should not be more tha n 30 days old from date of issue and include year-to-date information. 3. Last 3 bank stat ements (including explanations of regular deposits not explained by pay stubs) 4. Social S ecurity award or entitlement letter or other proof of gross monthly award. 5. Retirement i ncome. 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 sche dules). 10. Other financial obligations. 11. Amount and frequency of hospital/medical bill s. 12. Other financial resources that produce income. 13. If Self-Employed, Gross Income l ess Cost of Goods sold and employee salaries. Financial Capacity 1. Individuals with the f inancial capacity to purchase health insurance coverage through the Health Insurance Marke tplace may be required to purchase and will be provided access to meet with an Indiana Cer tified Navigator as a means of assuring access to healthcare services, for their overall p ersonal health, and for the protection of their individual assets. 2. Individuals have bee n found they are ineligible for Medicaid or other affordable health care coverage must pro vide proof of denial. 3. Food Stamps or Supplemental Nutrition Assistance Program (SNAP) w ill not be counted as income. 4. Cosmetic Services are not eligible for any type of assist ance and cannot be included in the amount of hospital/medical bills owed. Part VI, Descrip tions for Part I, Line 6a Beacon Health System, Inc, EIN 45-3864076, prepares the annual c ommunity 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 $37,156,745 Par t VI, Descriptions for Part I, Line 7 COSTING METHODOLOGY The costing method used to calcu late 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 calcul ated using direct costs. PART VI, Descriptions for Part II, Line 6 In 2017 The Executive D irector of Beacon Community Impact was asked to represent Beacon Health System as one of s ix anchor organizations. She currently maintains this seat. This group, now recognized as the St. Joseph County Health Improvement Alliance Group, has met several times since the o riginal 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 focus on our stak eholders top priorities in order to increase public health infrastructure and ultimately i mprove 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. The Director of Community Impact participa tes on the executive team of the St. Joseph County System of Care. This group is a network of services and supports that identify and meet the needs of families, youth, and childre n so they may define and reach their potential. Part VI, Descriptions for Part III, Line 2 THE CORPORATION EVALUATES THE COLLECTABILITY OF ITS ACCOUNTS RECEIVABLE BASED ON THE LENG TH OF TIME THE RECEIVABLE IS OUTSTANDING, PAYOR CLASS, AND THE ANTICIPATED FUTURE UNCOLLEC TIBLE AMOUNTS BASED ON HISTORICAL EXPERIENCE. ACCOUNTS RECEIVABLE ARE CHARGED TO THE ALLOW ANCE 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 AD JUSTED 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 determ ined by Worksheet 2, to total bad debt expense per the audited financial statements. 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 wou ld fall under the FAP. We have applied the historical estimate to the total bad debt expen se to determine the amount attributable to the FAP. Part VI, Descriptions for Part III, Li ne 4 THE PROVISION FOR BAD DEBTS IS BASED UPON MAN

Form and Line Reference	Explanation
Part VI, Descriptions for Part I, Line 3c	AGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS TAKING INTO CONSIDERATION THE TRENDS IN HEALTH CARE COVERAGE, HISTORICAL ECONOMIC TRENDS, AND OTHER COLLECTION INDIC ATORS. 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 RE VIEW ARE THEN UTILIZED TO MAKE MODIFICATIONS, AS NECESSARY, TO THE PROVISION FOR BAD DEBTS TO PROVIDE FOR AN APPROPRIATE ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS. A SIGNIFICANT PORTION OF THE CORPORATION'S UNINSURED PATIENTS WILL BE UNABLE OR UNWILLING TO PAY FOR THE SERVIC ES PROVIDED. THUS, THE CORPORATION RECORDS A SIGNIFICANT PROVISION FOR BAD DEBTS RELATED T O UNINSURED PATIENTS IN THE PERIOD THE SERVICES ARE PROVIDED. Part VI, Descriptions for Pa rt III, Line 8 RATIONALE FOR INCLUSION OF THE MEDICARE SHORTFALL AS A COMMUNITY BENEFIT PA RTICIPATION IN THE GOVERNMENTAL MEDICARE PROGRAM DOES NOT PROVIDE THE OPPORTUNITY FOR A HO SPITAL TO NEGOTIATE A REIMBURSEMENT RATE OR STRUCTURE THAT WOULD ALLOW THE HOSPITAL TO COV ER THE COST OF THE MEDICAL SERVICE RENDERED TO THE PROGRAM PARTICIPANT, AS WOULD BE THE CA SE IN CONTRACTUAL NEGOTIATIONS WITH COMMERCIAL INSURANCE COMPANIES. NOR IS THE HOSPITAL AL LOWED 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 PROGRA M. THE MEDICAID PROGRAM IS RECOGNIZED AS A COMMUNITY BENEFIT ON SCHEDULE H AND ON COMMUNIT Y BENEFIT REPORTS FOR MOST STATES. THE QUALITY AND COST OF THE PATIENT CARE IS THE SAME RE GARDLESS OF PAYOR SOURCE. HENCE THE ACCEPTANCE OF MEDICARE REIMBURSEMENT REPRESENTS A REDU CTION OR RELIEF OF THE GOVERNMENT BURDEN TO PAY THE FULL COST OF CARE PROVIDED. Part VI, D escriptions for Part III, Line 9b Collections Practices Patients known to qualify for fina ncial assistance follow the same collection policy as all individuals with balances remain ing after application of financial assistance. Credit and Collections Policy: Memorial Hos pital of South Bend relies on timely payment of patient accounts receivable to allow the H ospital to continue to provide high-quality medical care and to secure the latest in healt h care technology for its patients. Memorial Hospital, recognizing the burden that unexpec ted 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 adjudic ate patient's insurance claims and by providing alternative payment plans for patients. Th e Hospital also provides subsidized care for those patients who qualify. However, with the exception of some Government and contracted care plans, ultimate responsibility for resol ution or payment of accounts rests with the patient. Patients are expected to work with Ho spital personnel to resolve accounts with their insurance companies and/or employers as ap propriate. Where there is an estimated self-pay balance due, Memorial Hospital will ask no n-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 l ater determined to qualify under the FAP, Memorial Hospital would issue a refund to the pa tient for any amount that has been determined to exceed their newly determined financial r esponsibility. 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 inpati ent admissions, same day surgery patients, and patients scheduled for high-dollar outpatie nt procedures prior to or at the time of admission or registration. In the event that a re quest for payment is not made prior to o

Additional Data

Software ID:

Software Version:

EIN: 35-0868132

Name: Memorial Hospital of South Bend Inc

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

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? **1** Name, address, primary website address, and state license number		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	**Other (Describe)**	**Facility reporting group**
1	MEMORIAL HOSPITAL OF SOUTH BEND INC 615 N MICHIGAN STREET SOUTH BEND, IN 46545 www.BeaconHealthSystem.org 16-005053-1	X	X	X	X		X	X			

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

Form and Line Reference	Explanation
PART V, Section B, Line 5	The data collection and analysis process started in February and concluded on September 20 18. The key findings were consolidated in two reports: the first provided a snapshot of th e three-county overall health status, and the second focused on the health needs of childr en in Elkhart, St. Joseph and Marshall counties. The Key Informant Survey collected inform ation from March 28th to August 20th, 2018. The Community Survey was launched on May 7th a nd was closed on August 20th, 2018. The methodology followed for the needs assessment was based on three steps: 1) Identify needs; 2) Analyze the links between the needs and the in formation required to make decisions; 3) Make recommendations that guide decision-making. Since community engagement and feedback are essential to the integrity and validity of the CHNA process, input was actively solicited and secured from three sources (elaborated bel ow) to understand community health needs. To ensure a representative sample of the communi ty completed the community survey, a special effort was made to get feedback from hard to reach and minority populations. In addition to the survey being pushed out through digital platforms and listservs in both English and Spanish, the Beacon Community Impact/enFocus team (which is an organization that assisted with the community health needs assessment) p artnered with 35 different organizations to collect feedback and attended 8 community even ts (listed below) to directly target individuals who typically do not complete community s urveys. Beacon Community Impact's partner organizations provided recommendations and restr ictions for creating a variety of strategies to engage these harder-to reach samples withi n the tri-county population. For the purpose of the Community Health Needs Assessment (CHN A), the community served is defined as those persons residing in Elkhart and St Joseph Cou nties, who were program participants. Beacon Community Impact makes a special effort to fo cus on 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 p opulation and/or the uninsured. Stakeholders in the community participated and represented a broad knowledge of interests, including public health, and minority, cultural, and unde rserved populations. Through the following organizations Beacon along with enFocus also en sured that under-represented populations (Medically Underserved, Low-Income, and Minority Populations) were engaged in the consultation process, actively reaching out to them, ensu ring that needs and perceptions from a wide range of demographic and socioeconomic groups were taken into consideration in the definition of top community health issues. The follow ing organizations helped increase the reach of the survey, hence solicited in order for Be acon to take into account input received from persons who represent the broad interests of the community it serves: St.

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

Form and Line Reference	Explanation
PART V, Section B, Line 5	Joseph County: - 100 Black Men of SJC - Center for the Homeless - Community Foundation of St. Joseph County - Goodwill Industries - Hope Ministries - Imani Unidad - IUSB Division o f Health Sciences - IUSB School of Nursing - Ivy Tech Community College - La Casa de Amist ad - The LGBTQ Center - Notre Dame - South Bend Community School Corporation - South Bend- Elkhart Regional Partnership - South Bend Heritage Foundation - South Bend Veterans Center - St. Joseph County Public Library - St. Margaret's House - TREES, Inc - United Church of Christ - United Religious Community - United Way of St. Joseph County - Youth Service Bur eau South Bend. Elkhart County: - Community Foundation of Elkhart County - Church Communit y Services - Elkhart County Public Library - Faith Mission of Elkhart - Greater Elkhart Ch amber of Commerce - Heart City Health - Mosaic Health & Healing Arts - Minority Health Coa lition - Northern Indiana Hispanic Health Coalition - RETA: Reason Enough to Act - Ribbon of Hope Cancer Support - United Health Services. Marshall County: -Bowen Center - Marshall County System of Care - United Way of Marshall County (Trustees at Purdue University) - M arshall County. Additional efforts were made to reach the at-risk individuals in the commu nity. Beacon and enFocus solicited and received input from the vulnerable and broader comm unity by attending the following community events. Community Outreach Events: - Faith Miss ion of Elkhart - Elkhart County Public Library - Best Week Ever - St. Joseph County Public Library - Minority Health Coalition - Northern Indiana Hispanic Health Coalition - Center for the Homeless - Heart City Health The assessment process identified four health priori ties that can be streamlined into the essential components of Beacon Health System's missi on. The Healthy Mind, Healthy Body, Healthy Spirit and Healthy Families pillars provide a framework for the alignment of intervention strategies with BHS mission and values that ai m for 1) providing information and enhance skills to patients/practitioners/community; 2) improving equitable access to health and wellness; 3) leveraging incentives for long-term behavioral change; and 4) improving and strengthening the social and healthcare systems in the three-county area. Part V, Section B, Line 6a & 6b Memorial Hospital of South Bend (M HSB) developed the 2018 St. Joseph County CHNA in partnership with Elkhart General Hospita l and Community Hospital of Bremen, Beacon Health System (BHS) Care Partners. Part V, Sect ion B, Line 7D The Community Health Needs Assessment (CHNA) was made widely available to t he community through posting on the MHSB website at BeaconHealthSystem.org/CHNA and throug h email transmission upon request. Hospital staff were also available to discuss the resul ts of the CHNA and implementation strategies in requested community forums.

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

Form and Line Reference	Explanation
Part V, Section B, Line 11	Overall In 2019, Beacon Community Impact provided community resources to 40,168 individual s in the priority areas of Healthy Body, Healthy Families, Healthy Mind, and Healthy Spiri t. Healthy Mind had the largest number of participants, which includes the department's AC E Interface Initiative. Healthy Spirit had the lowest number of participants, but it is al so the department's newest priority. The department plans to see a greater number of parti cipants in subsequent years as programming develops around substance use issues. St. Josep h County had the greatest number of participants served, followed by Elkhart and then Mars hall County. Similar to the Healthy Spirit priority, Marshall County is Beacon Community I mpact's newest service area and has the smallest number of residents. The goal for 2019 wa s to service 55% of participants in St. Joseph County, 40% of participants in Elkhart Coun ty and 5% of participants in Marshall County. Implementation Strategies - As a general rul e, the implementation of any of the four strategies will take into consideration the follo wing approaches: 1) the program should address discrete factors, such as knowledge, belief s and skills, at individual and family levels; and 2) the program should address context f actors such as social support, available resources and services, and access barriers to fi nancial/physical/information resources, at family and community levels. By addressing risk and protective factors in a comprehensive way, BHS acknowledges the fact that comorbiditi es are very likely to happen to chronic disease patients, because different health issues or disorders share the same risk factors, so the interventions addressing such factors are reasonably expected to reduce the prevalence of these multiple conditions. Healthy Body - Obesity/ Overweight The Healthy Body priority is aimed at reducing obesity in youth and a dults through increased physical activity and improved nutrition. In 2019, Beacon Communit y Impact engaged with six programs in this priority, serving a total of 7,228 people. Most participants engaged with the Healthy Body priority through health education and awarenes s activities, while a small percentage of the programs were geared towards Action (behavio r change). Compared to the previous year, Beacon Community Impact saw a 130% increase in H ealthy Body participants. Indicators: Youth leisure time, Adult leisure time, Adult BMI, a nd Youth BMI Programs: Achieve, Dame tu Mano Class, Dame tu Mano Radio, Diabetes Alliance Program Healthy Hearts and Women, Infant and Children Current Gap: - Obesity rates in 2017 for EC (14.5%), MC (15.2%) and SJC (14.3%) are higher than IN. - 1 in 3 children ages 10- 17 are overweight or obese (33.9%), - According to WIC, by 2017, 13.5% of children between 2-5 years of age who were part of the program were obese. Intended Health Outcome: - By t he end of the program cycle, obesity and overweight rates are reduced through the adoption of individual habits of healt

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

Form and Line Reference	Explanation
Part V, Section B, Line 11	hier nutrition and increased physical activity. Behavioral Objective: - By the end of the program cycle, participants are consuming enough healthier food to cover their caloric nee ds and are engaged in regular physical activity, in accordance to attitudes and practices promoted by BHS. Rationale: - Obesity results from a combination of causes and contributin g factors, including individual factors such as behavior and genetics. Behaviors can inclu de dietary patterns, physical activity, inactivity, medication use, and other exposures. - Obesity is often associated with poorer mental health outcomes, reduced quality of life, and the leading causes of death in the U.S. and worldwide, including diabetes, heart disea se, stroke, and some types of cancer. Healthy Mind - Mental Health The Healthy Mind priori ty is aimed at improving the mental and behavioral health of the community. It also houses the department's ACE Interface initiative, which is geared towards breaking the cycle of trauma and supporting safe communities. In 2019, Healthy Mind supported 17 programs in pro viding mental health resources to 18,721 community members. Indicators: Youth who were ele ctronically bullied, Youth with an adult in their lives with whom they can talk to about t heir health, Adults with an adult in their lives with whom they can talk to about their he alth Programs: ACE Interface, ACT-Embrace, ADAP (Adolescent Depression Awareness Program), ATIP-EMD, Digital Citizenship, Draw the Line/Respect the Line, Healthy Boundaries (Stress Happens) - KOHLS BE A HERO, Horizon Education Alliance-PAX Elkhart, County Health Departm ent, Horizon Education Alliance, Elkhart Education Foundation Kindness to Prevent Blindnes s, Leighton Lecture Impact Series, PEERS Project, QPR Suicide Prevention Training, Ribbon of Hope, RiverBend Cancer Services, YWCA Take Charge, United Health Services, Yellow Ribbo n Suicide Prevention Program Current Gap: - The prevalence estimates for the IN North Cent ral Region show that 4.7% of resident adults have suffered from a serious mental illness (diagnoses resulting in serious functional impairment). - EC and SJC averaged 4.2 days of p oor mental in the past 30 days before being surveyed. Intended Health Outcome: - By the en d of the program cycle, participants are better able to cope with mental and emotional dis tress through enhanced community capacities (ability to provide mental health services). B ehavioral Objective: - By the end of the program cycle, participants' socioemotional compe tences to reduce mental and emotional distress are strengthened. Rationale: - Conditions l ike depression, anxiety, bipolar disorder, or schizophrenia, among many others, may occur occasionally or over a long period, affecting people's ability to have a normal social lif e and be functional on a daily basis. - Mental illness, especially depression, increases t he risk for many types of physical health problems, particularly long-lasting conditions l ike stroke, type 2 diabetes, a

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

Form and Line Reference	Explanation
Part V, Section B, Line 11	nd heart disease. Similarly, the presence of chronic conditions can increase the risk for mental illness. - Several factors can contribute to risk for mental illness, such as Adver se Child Experiences (ACEs), experiencing other chronic medical conditions (such as cancer or diabetes), biological factors, use of alcohol or drugs, and being/feeling lonely or is olated. Healthy Spirit - Substance Abuse The Healthy Spirit priority, new as of this curre nt CNHA cycle, aims at reducing substance abuse and tobacco use. In 2019 there were six pr ograms aimed at substance abuse that served a total of 770 community members. Moving forwa rd, Community Impact will focus on increasing resources to address this issue. The Departm ent is laying the foundation for increasing impact by growing the network of partners, inc reasing the number of programs, and securing additional funding through state, federal, an d private grants. Indicators: Adults who use tobacco, Youth who use tobacco, Non-fatal ER visits due to opioid overdose Programs: Opioid Public Health Crisis, SB Heritage Foundatio n- Oliver Apartments, South Bend Group Violence Intervention Call-In, SPA (Spiritual & Per sonal Adjustments) Women's Ministry Homes, This is (Not) About Drugs (TINAD) Current Gap: - Drug overdose mortality rates have increased from 2014 to 2016 in all three counties (SJ C, from 13.5% to 22.3%; EC, from 11.9% to 12.3%; and MC, from 7.8% to 9.3%). - Excessive D rinking rates have increased from 2014 to 2016 in all three counties (SJC, from 15.6% to 1 9.5%; EC, from 15.5% to 15.7%; and MC, from 16.2% to 17.2%). Intended Health Outcome: - By the end of the program cycle, participants are better able to cope with substance use dis order (SUD) by strengthening their socioemotional competencies. Behavioral Objective: - By the end of the program cycle, participants' socioemotional competences to reduce exposure to SUDs are strengthened. Rationale: - Excessive drinking is a risk factor for a number o f adverse health outcomes, such as alcohol poisoning, hypertension, acute myocardial infar ction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudd en infant death syndrome, suicide, interpersonal violence, and motor vehicle crashes. - Dr ug use is also a risk factor for respiratory conditions and cancer. - Substance use disord ers can be fatal to the user or others, by causing drunk driving fatalities and drug overd oses. - Mental illnesses and substance use disorders often occur together (sometimes as a contributing factor to the other, or by making it worse). Healthy Families - Maternal/Infa nt Health The Healthy Family priority services families with the goal of reducing infant m ortality, improving outcomes in maternal health and offering resources for child developme nt. In 2019, Beacon Community Impact served a total of 13,389 participants compared to 11, 667 served in 2018. The bulk of these participants came from the Action (behavior change) category, though in general th

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

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

Form and Line Reference	Explanation
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 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 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.

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

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

Form and Line Reference	Explanation
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

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Schedule I (Form 990)

Department of the Treasury
Internal Revenue Service

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

Complete if the organization answered "Yes," on Form 990, Part IV, line 21 or 22.

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2019

Open to Public Inspection

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.

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

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table . . . . . ▶ 19

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

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

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

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

Return Reference	**Explanation**
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.

Additional Data

Software ID:
Software Version:
EIN: 35-0868132
Name: Memorial Hospital of South Bend Inc

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
THE CENTER FOR THE HOMELESS 813 South Michigan SOUTH BEND, IN 46601	35-1768544	501(C)(3)	16,000				auction sponsor
UNIVERSITY OF NOTRE DAME MAIN BUILDING Notre Dame, IN 46556	35-0868188	501(c)(3)	7,500				Research Donation

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
SOUTH BEND HERITAGE FOUNDATION INC 803 Lincolnway West SOUTH BEND, IN 46616	23-7394320	501(c)(3)	27,500				project sponsor
UNITED WAY OF ST JOSEPH 3517 E Jefferson SOUTH BEND, IN 46660	35-1063368	501(c)(3)	50,000				Corporate Sponsor

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
ENFOCUS INC 506 W South St South Bend, IN 46601	45-5638209	501(C)(3)	10,000				Contribution
INDIANA UNIVERSITY FOUNDATION PO Box 7072 Indianapolis, IN 46207	35-6018940	501(C)(3)	10,000				EVENT Sponsorship

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
RIVERBEND CANCER SERVICES 919 E JEFFERSON BLVD SOUTH BEND, IN 46617	35-0872359	501(C)(3)	20,000				PROGRAM SPONSORSHIP
Beacon Medical Group INC 615 N MICHIGAN STREET SOUTH BEND, IN 46601	35-1536132	501(C)(3)	1,831,850				CONTRIBUTION FOR CLINICS

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
ST JOSEPH COUNTY HEALTH DEPARTMENT 227 W JEFFERSON BLVD SOUTH BEND, IN 46601	35-6000194	501(C)(3)	21,250				project sponsor
YWCA 1102 S FELLOWS ST SOUTH BEND, IN 46617	35-0868226	501(C)(3)	30,500				program sponsor

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
CITY OF SOUTH BEND 321 E WALTER ST SOUTH BEND, IN 46614	27-3843043	501(C)(3)	45,000				EVENT SPONSORSHIP
SOUTH BEND EDUCATION FOUNDATION 215 S ST JOSEPH ST SOUTH BEND, IN 46624	35-1959196	501(C)(3)	30,000				CORPORATE SPONSORSHIP

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
ELKHART EDUCATION FOUNDATION 2746 OLD US 20 WEST STE B ELKHART, IN 46514	46-3429545	501(C)(3)	20,000				PROGRAM SPONSORSHIP
NEAR NORTHWEST NEIGHBORHOOD PO BOX 1132 SOUTH BEND, IN 46624	23-7414729		14,500				PROJECT SPONSORSHIP

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
MICHIANA VEGFEST 125 E POKAGON SOUTH BEND, IN 46617	83-0797029	501(C)(3)	11,000				PROJECT SPONSORSHIP
FOUNDATION FOR THE CENTER FOR HOSPICE 111 SUNNYBROOK CT SOUTH BEND, IN 46637	30-0433147	501(c)(3)	10,000				CAMPAIGN PLEDGE

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

(a) Name and address of organization or government	**(b)** EIN	**(c)** IRC section if applicable	**(d)** Amount of cash grant	**(e)** Amount of non-cash assistance	**(f)** Method of valuation (book, FMV, appraisal, other)	**(g)** Description of non-cash assistance	**(h)** Purpose of grant or assistance
UNITED HEALTH SERVICES 6910 N MAIN STREET BLDG 9 MAIL UNIT 10 GRANGER, IN 46530	35-1118647	501(C)(3)	10,000				EVENT SPONSORSHIP
PLAY LIKE A CHAMPION TODAY EDUCATION SERVICES PO BOX 72 NOTRE DAME, IN 46556	81-3305202	501(C)(3)	7,500				PROGRAM SPONSOR

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
GENTLEMAN AND SCHOLARS INC 1412 W WASHINGTON ST SOUTH BEND, IN 46601	46-5141303	501(C)(3)	6,000				EVENT SPONSORSHIP
GOODWILL INDUSTRIES PO BOX 3846 SOUTH BEND, IN 46619	53-0196588	501(C)(3)	6,000				LITTLE LIBRARY SPONSORSHIP

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Schedule J (Form 990)

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

2019

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
Memorial Hospital of South Bend Inc

Employer identification number
35-0868132

Part I Questions Regarding Compensation

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

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 are not listed on Form 990, Part VII.

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

(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				
See Additional Data Table							

Part III Supplemental Information

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

Return Reference	Explanation
SCHED J, PART I, LINE 1A	MEMORIAL HOSPITAL OF SOUTH BEND, INC. OFFERS COMPLIMENTARY HEALTH CLUB MEMBERSHIP TO BEACON HEALTH SYSTEM'S HEALTH AND LIFESTYLE CENTER, A RELATED PARTY. MEMORIAL HOSPITAL OF SOUTH BEND INC. REIMBURSES DIRECTORS FOR THE TAX EFFECT OF THE 1099 REPORTABLE BENEFITS FOR SPOUSAL TRAVEL. MEMORIAL HOSPITAL OF SOUTH BEND INC. ALSO REIMBURSES FOR DIRECT EXPENSES RELATED TO ANY TRAVEL ON THE ORGANIZATION'S BEHALF. 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. PART I, LINE 3 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. THE FOLLOWING INDIVIDUALS RECEIVED VESTED PAYMENTS IN 2019, REFLECTED IN COLUMN (B)(III): . KREG GRUBER, $106,338 . JEFFREY COSTELLO, $99,427 THE FOLLOWING INDIVIDUALS RECEIVED DEFFERED PAYMENTS IN 2019 THAT WILL VEST IN FUTURE YEARS, WHICH ARE REFLECTED IN COLUMN C: . KREG GRUBER, $161,791 . JEFFREY COSTELLO, $101,390 . LARRY TRACY, $78,667 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% VESTING IS $325,000. THE FOLLOWING INDIVIDUALS EARNED THESE AMOUNTS IN 2019 TOWARDS THE LONGEVITY BONUS PLAN: . KREG GRUBER, $16,250 . JEFFREY COSTELLO, $16,250 THE LONGEVITY BONUS PLAN BECAME FULLY VESTED IN 2019 AND WAS PAID OUT TO THE FOLLOWING INDIVIDUALS, REFLECTED IN COLUMN B(III): . KREG GRUBER, $325,000 . JEFFREY COSTELLO, $325,000 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. 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.

Additional Data

Software ID:
Software Version:
EIN: 35-0868132
Name: Memorial Hospital of South Bend Inc

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1Jeffrey P Costello CFO	(i)	0	0	0	0	0	0	0
	(ii)	536,899	213,297	458,729	112,590	19,085	1,340,600	380,118
1Kreg Gruber CEO	(i)	0	0	0	0	0	0	0
	(ii)	792,493	435,000	443,074	172,991	30,982	1,874,540	377,156
2Cheryl Wibbens-Lesh MD Asst. Secr./VP	(i)	0	0	0	0	0	0	0
	(ii)	328,039	68,750	3,654	11,200	24,516	436,159	0
3Dale A Patterson Employed Physician	(i)	360,191	61,875	31,000	11,200	23,156	487,422	0
	(ii)	0	0	0	0	0	0	0
4BRYAN BOYER Trustee/Employed Physician	(i)	0	0	0	0	0	0	0
	(ii)	824,983	25,229	1,668	11,200	22,835	885,915	0
5Larry Tracy President	(i)	418,010	170,100	8,554	89,867	24,126	710,657	0
	(ii)	0	0	0	0	0	0	0
6BRANT SANDERS EMPLOYED PHYSICIAN	(i)	547,485	1,136	28,954	11,200	396	589,171	0
	(ii)	0	0	0	0	0	0	0
7RANDELL COULTER EMPLOYED PHYSICIAN	(i)	414,967	568	39,095	11,200	396	466,226	0
	(ii)	0	0	0	0	0	0	0
8JAMES LOWE EMPLOYED PHYSICIAN	(i)	411,706	568	24,622	11,200	20,938	469,034	0
	(ii)	0	0	0	0	0	0	0
9KRISTEN JENNINGS DIR OF MED RESIDENCY PROGRAM	(i)	267,559	30,915	15,270	11,200	23,205	348,149	0
	(ii)	0	0	0	0	0	0	0

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

Schedule K (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Information on Tax-Exempt Bonds

▶ Complete if the organization answered "Yes" to Form 990, Part VI, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990.
▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
Memorial 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) Pool financing	
							Yes	No	Yes	No	Yes	No
A	Indiana 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	91-1914363	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	460,000	0	25,101,913	7,121,328
2	Amount of bonds legally defeased	0	0	0	0
3	Total proceeds of issue	37,240,000	45,523,353	96,069,836	7,492,187
4	Gross proceeds in reserve funds	0	0	0	0
5	Capitalized interest from proceeds	0	0	0	0
6	Proceeds in refunding escrows	0	0	0	0
7	Issuance costs from proceeds	0	511,271	764,791	66,925
8	Credit enhancement from proceeds	0	0	0	0
9	Working capital expenditures from proceeds	0	0	0	0
10	Capital expenditures from proceeds	0	0	0	7,425,262
11	Other spent proceeds	37,240,000	45,012,082	95,305,045	0
12	Other unspent proceeds	0	0	0	0
13	Year of substantial completion	2000	2009	2003	2013

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
14	Were the bonds issued as part of a current refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)?	X		X		X			X
15	Were the bonds issued as part of an advance refunding issue of taxable bonds (or, if issued prior to 2018, 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)

		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		
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 ▶	0 %		0 %		0 %		0 %	
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?				X		X		X
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 NA		0		0		0	
c	Term of hedge	2170 %							
d	Was the hedge superintegrated?		X						
e	Was the hedge terminated?		X						

Part IV Arbitrage (Continued)

		A		B		C		D	
		Yes	No	Yes	No	Yes	No	Yes	No
5a	Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X		X		X
b	Name of provider	0		0		0		0	
c	Term of GIC								
d	Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6	Were any gross proceeds invested beyond an available temporary period?		X		X		X		X
7	Has the organization established written procedures to monitor the requirements of section 148?	X		X		X		X	

Part V Procedures To Undertake Corrective Action

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation is not available under applicable regulations?	X		X		X		X	

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

Return Reference	Explanation
PART III, COLUMN A	COLUMN A IS NOT COMPLETED BECAUSE SUCH BONDS WERE ISSUED AFTER 12/31/2002 TO REFUND, THROUGH A SERIES OF 2006 REFUNDINGS, BONDS ISSUED BEFORE 01/01/2003. PART IV, LINE 2C, COLUMN B-D THE DATE THE REBATE COMPUTATION WAS PERFORMED ON THE HOSPITAL AUTHORITY OF SANT JOSEPH COUNTY AND INDIANA FINANCE AUTHORITY WAS 5/18/2018.

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Schedule L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions with Interested Persons

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
Memorial Hospital of South Bend Inc

Employer identification number
35-0868132

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

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

2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958. . . . . ▶ $
3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization . . . . . ▶ $

Part II **Loans to and/or From Interested Persons.**
Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a, or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization? To	From	(e) Original principal amount	(f) Balance due	(g) In default? Yes	No	(h) Approved by board or committee? Yes	No	(i) Written agreement? Yes	No
Total . . . . . ▶ $												

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of assistance	(d) Type of assistance	(e) Purpose of assistance

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) STANZ FOOD	BOARD MEMBER GREATER THAN 35% OWNERSHIP	251,578	PURCHASED SERVICES		No

Part V Supplemental Information

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

Return Reference	Explanation

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SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

Complete to provide information for responses to specific questions on Form 990 or 990-EZ or to provide any additional information.
▶ Attach to Form 990 or 990-EZ.
▶ Go to *www.irs.gov/Form990* for the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
Memorial Hospital of South Bend Inc

Employer identification number

35-0868132

990 Schedule O, Supplemental Information

Return Reference	Explanation
CORE FORM, PART I, LINE 1	BEACON HEALTH SYSTEM, INC. IS COMMITTED TO ENHANCING THE PHYSICAL, MENTAL, AND EMOTIONAL A ND SPIRITUAL WELL-BEING OF THE COMMUNITIES WE SERVE AS THE COMMUNITY'S PROVIDER OF OUSTAND ING QUALITY, SUPERIOR VALUE AND COMPREHENSIVE HEALTH CARE SERVICES. CORE FORM, PART I, LIN E 6 VOLUNTEERS - MEMORIAL HOSPITAL OF SOUTH BEND HAS A DEPARTMENT CALLED AMBASSADOR AND CU STOMER SERVICES. IT IS THE RESPONSIBILITY OF THIS DEPARTMENT TO RECRUIT, ORIENT, PROCESS A ND 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 O F THE AREAS OF SERVICE INCLUDE A MAJOR SURGERY WAITING ROOM, PATIENT ESCORTS, FLOWER DELIV ERY, MAIL DELIVERY, LIVING HISTORY PROGRAM, EMERGENCY DEPARTMENT VOLUNTEERS AND COOKIE BAK ERS. IN 2019, MEMORIAL HAD 441 VOLUNTEERS IN THIS PROGRAM WHO SERVED 34,258 HOURS. CORE FO RM, PART III, LINE 4D OTHER PROGRAM SERVICES OTHER PROGRAM SERVICES INCLUDE PSYCHIATRIC DE PARTMENTS, SOCIAL SERVICES, COMMUNITY OUTREACH PROGRAMS, TITHING, GRANTS, AND SUPPORTING S ERVICES SUCH AS ADMINISTRATION, FINANCE, PAYROLL, PATIENT ACCOUNTING, LAUNDRY SERVICES, HE ALTH AND LIFESTYLE CENTER, AND MEDICAL RECORDS. DUE TO THE NON-REVENUE GENERATING OR COMMU NITY 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 SERV ICES. FORM 990, PART VI, SECTION A, LINE 4 MEMORIAL HOSPITAL OF SOUTH BEND, INC. UPDATED T HEIR CORPORATE BYLAWS IN 2019 TO ALIGN THE AFFILIATE ENTITIES BYLAWS WITH THE PARENT COMPA NY, BEACON HEALTH SYSTEM. CHANGES INCLUDED: 1. THE TREASURER OFFICER POSITION WAS ELIMINAT ED 2. TERM LIMITS FOR DIRECTORS WAS INCREASED FROM TWO TERMS TO THREE CONSECTUIVE TERMS 3. THE ATTENDANCE POLICY WAS UPDATED TO REQUIRE DIRECTORS TO ATTEND AT LEAST 75% OF BOARD ME ETINGS (UPDATED FROM 50%) CORE FORM, PART VI, SECTION A, QUESTION 6 MEMBERS OF THE ORGANIZ ATION - BEACON HEALTH SYSTEM, INC. IS THE SOLE CORPORATE MEMBER OF MEMORIAL HOSPITAL OF SO UTH BEND, INC. CORE FORM, PART VI, SECTION A, QUESTION 7A ELECTION OF BOARD MEMBERS THE CO RPORATE 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 APPROV ED BY THE CORPORATE MEMBER. BEACON HEALTH SYSTEM, THE SOLE MEMBER OF MEMORIAL HOSPITAL OF SOUTH BEND, HAS CONTROL OVER MEMORIAL HOSPITAL OF SOUTH BEND'S OPERATIONS. THE FOLLOWING M ATTERS REQUIRE THE APPROVAL OF BEACON HEALTH SYSTEM'S BOARD: 1. SELECTION AND RETENTION OF AUDITORS, 2. APPROVAL OF ALL CONTRACTS, POLICIES, OR PROGRAMS OF INSURANCE ESTABLISHING T HE TYPES OF INSURANCE COVERAGE REQUIRED AS WELL AS THE COVERAGE LEVELS, 3. NOMINATION AND ELECTION OF BOARD MEMBERS, 4.

990 Schedule O, Supplemental Information

Return Reference	Explanation
CORE FORM, PART I, LINE 1	APPOINTMENT AND EVALUATION OF THE PRESIDENT OF MEMORIAL HOSPITAL OF SOUTH BEND, AND 5. EXE CUTIVE COMPENSATION. CORE FORM, PART VI, SECTION B, LINE 11B FORM 990 REVIEW PROCESS THE O RGANIZATION 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 SC HEDULES. SOME FORMS AND SCHEDULES ARE REVIEWED BY THE CONTROLLER. SUBSEQUENT TO THOSE STEP S, 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 ORGANIZ ATION AND THE CEO CONDUCT A GENERAL OVERVIEW OF THE FORM 990, INCLUDING APPLICABLE COMPENS ATION SCHEDULES. IN 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 T O FILING THE RETURN. CORE FORM, PART VI, SECTION B, LINE 12C CONFLICT OF INTEREST DISCLOSU RE 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 TH EY MAY HAVE. THE STATEMENTS ARE SENT IN JANUARY OF EACH YEAR FOR THE PREVIOUS YEAR ACTIVIT IES AND WE PURSUE THE REPLIES TO GET A 100% RESPONSE RATE. IN THE CURRENT YEAR WE SENT OUT OVER 356 STATEMENTS AND ARE WORKING TO ACHIEVE A 100% RESPONSE RATE. EACH RESPONSE IS REV IEWED 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 O F DIRECTORS. 2. THE SECOND STATEMENT IS THE BOARD DUALITY OF INTEREST STATEMENT THAT IS SE NT TO CURRENT BOARD MEMBERS, FORMER BOARD MEMBERS FROM THE LAST FIVE YEARS, AND OTHER KEY EMPLOYEES. THE DUALITY OF INTEREST STATEMENT IS SENT USING A WEB BASED SURVEY TOOL PROVIDE D BY ERNST & YOUNG. THE REPLIES ARE REVIEWED BY THE DIRECTOR OF INTERNAL AUDIT. THE RESULT S OF THE SURVEYS ARE SUMMARIZED USING THE WEB BASED TOOL, AND ARE REVIEWED BY ERNST & YOUN G 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 REQUIR ES 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. T HIS STATEMENT WAS SENT OUT ON JANUARY 24, 2020 AND THE SIGNED ACKNOWLEDGEMENTS ARE KEPT BY THE DIRECTOR OF INTERNAL AUDIT. IN 2020, 20 DESIGNATED EMPLOYEES WERE REQUESTED TO SIGN T HE FORM AND WE HAD A 100% COMP

990 Schedule O, Supplemental Information

Return Reference	Explanation
CORE FORM, PART I, LINE 1	LIANCE 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 T AKEN TO RESOLVE A TRUE CONFLICT. THE INDIVIDUAL WITH THE POTENTIAL CONFLICT OF INTEREST WO ULD 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 HEALT H SYSTEM, INC. HAS AN EXTENSIVE EXAMINATION THAT IS CONDUCTED, FOR VICE PRESIDENT AND HIGH ER, USING COMPARABLE MARKET DATA THAT IS THEN REVIEWED BY AN INDEPENDENT CONSULTANT HIRED BY, AND REPORTING TO, THE BOARD OF DIRECTORS. HUMAN RESOURCES CONDUCTS THE ANALYSIS AND MA KES 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. RECOMMENDATIO NS 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 IND EPENDENT MEMBERS OF THE BOARD. CORE FORM, PART VI, SECTION C, LINE 19 AVAILABILITY OF ORGA NIZATIONAL DOCUMENTS THE GOVERNING DOCUMENTS AND CONFLICT OF INTEREST POLICY ARE NOT MADE AVAILABLE TO THE PUBLIC. THE FINANCIAL STATEMENTS ARE DISTRIBUTED QUARTERLY TO THE ELECTRO NIC MUNICIPAL MARKET ACCESS (EMMA) WEBSITE AS PART OF THE CONTINUING DISCLOSURES FOR THE B EACON HEALTH SYSTEM, INC. BONDS.

990 Schedule O, Supplemental Information

Return Reference	Explanation
PART XI, LINE 9	Other Changes in the net assets of Fund Balances Write off Inter company, Beacon Health System, Inc. - (75,157,766) Change in interest in recipient org - 1,219,674 Rounding - 7 TOTAL - (73,938,085)

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SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization
Memorial 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

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	(g) No
(1) Beacon Medical Group Inc 615 N Michigan Street South Bend, IN 46601 35-1536132	PHY PRACTICES	IN	501(C)(3)	10	BHS	Yes	
(2) Beacon Health Foundation Inc 615 N Michigan Street South Bend, IN 46601 35-1536129	Financial Sup	IN	501(C)(3)	7	BHS	Yes	
(3) Elkhart General Hospital Inc 600 East Boulevard Elkhart, IN 46514 35-0877574	Hospital	IN	501(C)(3)	3	BHS	Yes	
(4)MEMORIAL ENDOWMENT FUND FOR MEM HOS PO BOX 1602 SOUTH BEND, IN 46634 35-6068581	ENDOWMENT	IN	501(C)(3)	12	MHSB	Yes	
(5)BEACON HEALTH SYSTEM Inc 615 N MICHIGAN STREET SOUTH BEND, IN 46601 45-3864076	Parent Org	IN	501(C)(3)	12A	NA		No
(6)COMMUNITY HOSPITAL OF BREMEN INC 1020 HIGH RD BREMEN, IN 46506 35-0835006	HOSPITAL	IN	501(C)(3)	3	BHS	Yes	
(7)COMMUNITY HOSPITAL OF BREMEN FOUNDATION 1020 HIGH RD BREMEN, IN 46506 35-1813755	FINANCIAL SUP	IN	501(C)(3)	12B, 11	CHB	Yes	

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) Disproprtionate allocations? Yes	(h) No	(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner? Yes	(j) No	(k) Percentage ownership

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	(i) No
(1)BEACON HEALTH VENTURES INC 615 N Michigan Street South Bend, IN 46601 35-1901068	Home Medical	IN	NA	C					
(2)BEACON HEALTH VENTURES MICHIGAN INC 615 N MICHIGAN ST SOUTH BEND, IN 46601 20-8259773	HOME MEDICAL	MI	NA	C					

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

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

See Additional Data Table

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved

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) Disproprtionate 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	

Part VII Supplemental Information

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

Return Reference	Explanation

Additional Data

Software ID:
Software Version:
EIN: 35-0868132
Name: Memorial Hospital of South Bend Inc

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

(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
BEACON MEDICAL GROUP	B	1,831,850	ACTUAL CHARGES
BEACON MEDICAL GROUP	O	1,805,459	ACTUAL CHARGES
BEACON MEDICAL GROUP	P	5,513,688	ACTUAL CHARGES
BEACON MEDICAL GROUP	Q	4,753,267	ACTUAL CHARGES
BEACON MEDICAL GROUP	A	1,498,892	ACTUAL CHARGES
BEACON HEALTH VENTURES	P	530,993	ACTUAL CHARGES
BEACON HEALTH VENTURES	Q	229,818	ACTUAL CHARGES
BEACON HEALTH VENTURES	R	283,347	CASH
ELKHART GENERAL HOSPITAL	P	1,622,500	ACTUAL CHARGES
ELKHART GENERAL HOSPITAL	Q	1,435,722	ACTUAL CHARGES
BEACON HEALTH FOUNDATION	C	1,321,013	ACTUAL CHARGES
COMMUNITY HOSPITAL OF BREMEN	Q	10,720,954	ACTUAL CHARGES
COMMUNITY HOSPITAL OF BREMEN	S	9,862,878	CASH
COMMUNITY HOSPITAL OF BREMEN	A	1,043	ACTUAL CHARGES