

PUBLIC DISCLOSURE COPY

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

2021Open to Public
Inspection**A For the 2021 calendar year, or tax year beginning and ending****B** Check if applicable:

- ☐ Address change
☐ Name change
☐ Initial return
☐ Final return/terminated
☐ Amended return
☐ Application pending

C Name of organization**METHODIST HEALTHCARE - OLIVE BRANCH HOSPITAL**

Doing business as

Number and street (or P.O. box if mail is not delivered to street address) Room/suite
4250 BETHEL RD.City or town, state or province, country, and ZIP or foreign postal code
OLIVE BRANCH, MS 38654**F** Name and address of principal officer: **DAVID BAYTOS**
SAME AS C ABOVE**D** Employer identification number**64-0889822****E** Telephone number**901-516-0563****G** Gross receipts \$ **102,530,869.****H(a)** Is this a group returnfor 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: ▶ **WWW.METHODISTHEALTH.ORG****K** Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶**L** Year of formation: **1998** **M** State of legal domicile: **MS****Part I Summary**

Activities & Governance	1	Briefly describe the organization's mission or most significant activities:	100 BED HOSPITAL PROVIDING HEALTHCARE SERVICES TO DESOTO COUNTY AND THE SURROUNDING AREAS	
	2	Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	3	Number of voting members of the governing body (Part VI, line 1a)	3	9
	4	Number of independent voting members of the governing body (Part VI, line 1b)	4	8
	5	Total number of individuals employed in calendar year 2021 (Part V, line 2a)	5	631
	6	Total number of volunteers (estimate if necessary)	6	5
	7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	0.
7b	Net unrelated business taxable income from Form 990-T, Part I, line 11	7b	0.	
Revenue	8	Contributions and grants (Part VIII, line 1h)	Prior Year 2,307,299.	Current Year 0.
	9	Program service revenue (Part VIII, line 2g)	84,876,829.	102,162,531.
	10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	0.	0.
	11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	292,117.	368,338.
	12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	87,476,245.	102,530,869.
	Expenses	13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	0.
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)	32,677,609.	37,789,257.
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)	53,965,316.	58,966,076.
18		Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	86,642,925.	96,755,333.
19	Revenue less expenses. Subtract line 18 from line 12	833,320.	5,775,536.	
Net Assets or Fund Balances	20	Total assets (Part X, line 16)	Beginning of Current Year 91,306,725.	End of Year 89,122,547.
	21	Total liabilities (Part X, line 26)	14,146,492.	3,845,361.
	22	Net assets or fund balances. Subtract line 21 from line 20	77,160,233.	85,277,186.

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			
	CHUCK LANE, CFO Type or print name and title				
Paid Preparer Use Only	Print/Type preparer's name AMY BIBBY	Preparer's signature AMY BIBBY	Date 11/16/22	Check <input type="checkbox"/> if self-employed	PTIN P00445891
	Firm's name ▶ FORVIS, LLP	Firm's EIN ▶ 44-0160260	Phone no. (828) 254-2254		
Firm's address ▶ 500 RIDGEFIELD COURT ASHEVILLE, NC 28806					

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

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Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:

METHODIST LE BONHEUR HEALTHCARE, IN PARTNERSHIP WITH ITS MEDICAL STAFFS, WILL COLLABORATE WITH PATIENTS AND THEIR FAMILIES TO BE THE LEADER IN PROVIDING HIGH QUALITY, COST-EFFECTIVE PATIENT-AND FAMILY-CENTERED CARE. SERVICES WILL BE PROVIDED IN A MANNER WHICH

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

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

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

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

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

4a (Code:) (Expenses \$ 89,297,893. including grants of \$) (Revenue \$ 102,162,531.)

METHODIST HEALTHCARE - OLIVE BRANCH HOSPITAL (OBH) IS THE NEWEST HOSPITAL IN THE METHODIST LE BONHEUR HEALTHCARE SYSTEM, DESIGNED TO CARE FOR THE COMMUNITY OF NORTH MISSISSIPPI. THE FIVE-STORY, 100-BED HOSPITAL OPENED IN 2013 AND FEATURES AN INNOVATIVE, ENVIRONMENTALLY FRIENDLY DESIGN.

PLEASE SEE OUR EXPANDED STATEMENT OF PROGRAM SERVICE ACCOMPLISHMENTS ON SCHEDULE O.

4b (Code:) (Expenses \$ including grants of \$) (Revenue \$)

4c (Code:) (Expenses \$ including grants of \$) (Revenue \$)

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

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

4e Total program service expenses **89,297,893.**

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Part IV Checklist of Required Schedules

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

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Part IV Checklist of Required Schedules (continued)

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

	Yes	No
1a Enter the number reported in box 3 of Form 1096. Enter -0- if not applicable	1a	50
b Enter the number of Forms W-2G included on 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	X

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

		Yes	No
2a Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a 631		
b If at least one is reported on line 2a, did the organization file all required federal employment tax returns?		X	
Note: If the sum of lines 1a and 2a is greater than 250, you may be required to e-file. See instructions.			
3a Did the organization have unrelated business gross income of \$1,000 or more during the year?			X
b If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation on Schedule O			
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)?			X
b If "Yes," enter the name of the foreign country			
See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).			
5a Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?			X
b Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?			X
c If "Yes" to line 5a or 5b, did the organization file Form 8886-T?			
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?			X
b If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?			
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?			X
b If "Yes," did the organization notify the donor of the value of the goods or services provided?			
c Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?			X
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?			X
f Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?			X
g If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?			
h If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?			
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?			
9 Sponsoring organizations maintaining donor advised funds.			
a Did the sponsoring organization make any taxable distributions under section 4966?			
b Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?			
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?			
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.			
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?			X
b If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation on Schedule O			
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?			X
If "Yes," see the instructions and file Form 4720, Schedule N.			
16 Is the organization an educational institution subject to the section 4968 excise tax on net investment income?			X
If "Yes," complete Form 4720, Schedule O.			
17 Section 501(c)(21) organizations. Did the trust, any disqualified person, or mine operator engage in any activities that would result in the imposition of an excise tax under section 4951, 4952 or 4953?			
If "Yes," complete Form 6069.			

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

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

Section A. Governing Body and Management

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

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

		Yes	No	
10a Did the organization have local chapters, branches, or affiliates?	10a		X	
b If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?	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	X		
b Describe on 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	X		
b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	X		
c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe on Schedule O how this was done	12c	X		
13 Did the organization have a written whistleblower policy?	13	X		
14 Did the organization have a written document retention and destruction policy?	14	X		
15 Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?				
a The organization's CEO, Executive Director, or top management official	15a		X	
b Other officers or key employees of the organization	15b		X	
If "Yes" to line 15a or 15b, describe the process on 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		X	
b If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?	16b			

Section C. Disclosure

17 List the states with which a copy of this Form 990 is required to be filed ► **NONE**

18 Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A, if applicable), 990, and 990-T (section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
☒ Own website ☐ Another's website ☒ Upon request ☐ Other (explain on Schedule O)

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

20 State the name, address, and telephone number of the person who possesses the organization's books and records ►
RICK HETHERINGTON - 901-478-1040
1211 UNION AVENUE, SUITE 600, MEMPHIS, TN 38104

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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 the 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, Form 1099-MISC, and/or box 1 of Form 1099-NEC) of more than \$100,000 from the organization and any related organizations.
 - List all of the organization's **former** officers, key employees, and highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
 - List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.
- See the 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 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/1099-NEC)	(E) Reportable compensation from related organizations (W-2/1099-MISC/1099-NEC)	(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) DAVID BAYTOS PRESIDENT/CEO	46.00 4.00	X		X				0.	621,567.	22,701.
(2) KRIS SANDERS TREASURER	40.00			X				243,578.	0.	59,829.
(3) ANNELEISE JENSEN VP/CNO	40.00			X				237,533.	0.	45,798.
(4) JENNIFER WEAVER PHARMACIST	40.00					X		176,139.	0.	36,116.
(5) REGINA STEVENS PATIENT CARE COORD/FIXED	40.00					X		175,125.	0.	20,922.
(6) ALLISON MEREDITH PHARMACIST	40.00					X		151,442.	0.	30,320.
(7) MUSA CEESAY CLINICAL PHARMACIST	40.00					X		154,482.	0.	14,781.
(8) MARGARET WALLACE PHARMACIST	40.00					X		142,210.	0.	14,657.
(9) MERLE FLOWERS CHAIR	1.00	X		X				0.	0.	0.
(10) SAMUEL P. RIKARD SECRETARY	1.00	X		X				0.	0.	0.
(11) MICHAEL BELLIPANNI BOARD MEMBER	1.00	X						0.	0.	0.
(12) REV. KEITH MASON BOARD MEMBER	1.00	X						0.	0.	0.
(13) PATT DORR BOARD MEMBER	1.00	X						0.	0.	0.
(14) TIM DONOVAN BOARD MEMBER	1.00	X						0.	0.	0.
(15) LEE SMART BOARD MEMBER	1.00	X						0.	0.	0.
(16) JAMIE STEEN BOARD MEMBER	1.00	X						0.	0.	0.

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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 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/1099-NEC)	(E) Reportable compensation from related organizations (W-2/1099-MISC/1099-NEC)	(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 Subtotal								1,280,509.	621,567.	245,124.
c Total from continuation sheets to Part VII, Section A								0.	0.	0.
d Total (add lines 1b and 1c)								1,280,509.	621,567.	245,124.

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 50

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
MEDICAL ANESTHESIA GROUP PA, 1755 KIRBY PKWY STE 330, MEMPHIS, TN 38120-4398	PHYSICIAN SERVICES	913,717.
MEMPHIS NEUROLOGY PLLC, 7645 WOLF RIVER CIR # 100, GERMANTOWN, TN 38138	PHYSICIAN SERVICES	571,500.
PEDIATRIX MEDICAL GROUP INC PO BOX 281034, ATLANTA, GA 30384-1034	MEDICAL CALL SERVICES	512,295.
MID-SOUTH PULMONARY SPECIALISTS P C 5050 POPLAR, MEMPHIS, TN 38157-0800	PHYSICIAN SERVICES	438,300.
GASTROENTEROLOGY CENTER OF THE, 8000 WOLF RIVER BLVD STE 20, GERMANTOWN, TN 38138	PHYSICIAN SERVICES	363,177.

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 7

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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	1 a Federated campaigns	1a					
	b Membership dues	1b					
	c Fundraising events	1c					
	d Related organizations	1d					
	e Government grants (contributions)	1e					
	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						
Program Service Revenue	2 a NET PATIENT REVENUE	Business Code	623000	99,602,945.	99602945.		
	b PROVIDER RELIEF FUNDS		623000	1,852,425.	1,852,425.		
	c 340B REVENUE		900099	707,161.	707,161.		
	d						
	e						
	f All other program service revenue						
	g Total. Add lines 2a-2f				102162531.		
	Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)					
4 Income from investment of tax-exempt bond proceeds							
5 Royalties							
6 a Gross rents		6a	(i) Real 9,622.	(ii) Personal			
b Less: rental expenses ...		6b	0.				
c Rental income or (loss)		6c	9,622.				
d Net rental income or (loss)				9,622.			
7 a Gross amount from sales of assets other than inventory		7a	(i) Securities	(ii) Other			
b Less: cost or other basis and sales expenses		7b					
c Gain or (loss)		7c					
d Net gain or (loss)							
8 a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18		8a					
b Less: direct expenses		8b					
c Net income or (loss) from fundraising events							
9 a Gross income from gaming activities. See Part IV, line 19		9a					
b Less: direct expenses	9b						
c Net income or (loss) from gaming activities							
10 a Gross sales of inventory, less returns and allowances	10a						
b Less: cost of goods sold	10b						
c Net income or (loss) from sales of inventory							
Miscellaneous Revenue	11 a MISCELLANEOUS REVENUE	Business Code	900099	358,716.			358,716.
	b						
	c						
	d All other revenue						
	e Total. Add lines 11a-11d				358,716.		
	12 Total revenue. See instructions				102530869.	102162531.	0.

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Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 ...				
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	481,111.	481,111.		
6 Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	31,051,331.	29,421,745.	1,629,586.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	1,169,434.	1,108,998.	60,436.	
9 Other employee benefits	3,019,072.	2,863,047.	156,025.	
10 Payroll taxes	2,068,309.	1,961,419.	106,890.	
11 Fees for services (nonemployees):				
a Management				
b Legal				
c Accounting	-10,000.		-10,000.	
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other. (If line 11g amount exceeds 10% of line 25, column (A), amount, list line 11g expenses on Sch O.)	14,637,375.	12,694,890.	1,942,485.	
12 Advertising and promotion	41,411.	27,411.	14,000.	
13 Office expenses	4,181,888.	1,998,451.	2,183,437.	
14 Information technology	76,259.	67,074.	9,185.	
15 Royalties				
16 Occupancy	558,127.	558,127.		
17 Travel	5,480.	2,666.	2,814.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials ...				
19 Conferences, conventions, and meetings	7,489.		7,489.	
20 Interest	9,192.	9,192.		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	6,642,839.	6,642,839.		
23 Insurance	1,355,093.		1,355,093.	
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses on line 24e. If line 24e amount exceeds 10% of line 25, column (A), amount, list line 24e expenses on Schedule O.)				
a BAD DEBT EXPENSE	18,424,140.	18,424,140.		
b MEDICAL SUPPLIES	10,249,769.	10,249,769.		
c OVERHEAD & ADMINISTRATI	2,474,844.	2,474,844.		
d FOOD	312,146.	312,146.		
e All other expenses	24.	24.		
25 Total functional expenses. Add lines 1 through 24e	96,755,333.	89,297,893.	7,457,440.	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)

**METHODIST HEALTHCARE - OLIVE BRANCH
HOSPITAL**

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Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year	
Assets	1 Cash - non-interest-bearing	-195,422.	1	-449,827.	
	2 Savings and temporary cash investments		2		
	3 Pledges and grants receivable, net		3		
	4 Accounts receivable, net	7,385,719.	4	7,348,144.	
	5 Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons		5		
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)		6		
	7 Notes and loans receivable, net		7		
	8 Inventories for sale or use	1,248,657.	8	1,206,553.	
	9 Prepaid expenses and deferred charges	160,010.	9	190,587.	
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 127,621,331.			
	b Less: accumulated depreciation	10b 53,999,274.	73,322,246.	10c	73,622,057.
	11 Investments - publicly traded securities		11		
	12 Investments - other securities. See Part IV, line 11		12		
	13 Investments - program-related. See Part IV, line 11		13		
	14 Intangible assets	4,791,048.	14	4,791,048.	
	15 Other assets. See Part IV, line 11	4,594,467.	15	2,413,985.	
16 Total assets. Add lines 1 through 15 (must equal line 33)	91,306,725.	16	89,122,547.		
Liabilities	17 Accounts payable and accrued expenses	14,146,492.	17	3,845,361.	
	18 Grants payable		18		
	19 Deferred revenue		19		
	20 Tax-exempt bond liabilities		20		
	21 Escrow or custodial account liability. Complete Part IV of Schedule D		21		
	22 Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons		22		
	23 Secured mortgages and notes payable to unrelated third parties		23		
	24 Unsecured notes and loans payable to unrelated third parties		24		
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D		25		
	26 Total liabilities. Add lines 17 through 25	14,146,492.	26	3,845,361.	
Net Assets or Fund Balances	Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33.				
	27 Net assets without donor restrictions	77,160,233.	27	85,277,186.	
	28 Net assets with donor restrictions		28		
	Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33.				
	29 Capital stock or trust principal, or current funds		29		
	30 Paid-in or capital surplus, or land, building, or equipment fund		30		
	31 Retained earnings, endowment, accumulated income, or other funds		31		
	32 Total net assets or fund balances	77,160,233.	32	85,277,186.	
	33 Total liabilities and net assets/fund balances	91,306,725.	33	89,122,547.	

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**METHODIST HEALTHCARE - OLIVE BRANCH
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Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	102,530,869.
2	Total expenses (must equal Part IX, column (A), line 25)	2	96,755,333.
3	Revenue less expenses. Subtract line 2 from line 1	3	5,775,536.
4	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	4	77,160,233.
5	Net unrealized gains (losses) on investments	5	
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain on Schedule O)	9	2,341,417.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	10	85,277,186.

Part XII Financial Statements and Reporting

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

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

Form **990** (2021)

SCHEDULE A
(Form 990)

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

2021

Open to Public
Inspection

Name of the organization **METHODIST HEALTHCARE - OLIVE BRANCH HOSPITAL**

Employer identification number
64-0889822

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

f Enter the number of supported organizations _____

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

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

**METHODIST HEALTHCARE - OLIVE BRANCH
HOSPITAL**

Schedule A (Form 990) 2021

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

(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2017	(b) 2018	(c) 2019	(d) 2020	(e) 2021	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 Public support. Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2017	(b) 2018	(c) 2019	(d) 2020	(e) 2021	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First 5 years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here						► <input type="checkbox"/>

Section C. Computation of Public Support Percentage

14 Public support percentage for 2021 (line 6, column (f), divided by line 11, column (f))	14	%
15 Public support percentage from 2020 Schedule A, Part II, line 14	15	%
16a 33 1/3% support test - 2021. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization	►	<input type="checkbox"/>
b 33 1/3% support test - 2020. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization	►	<input type="checkbox"/>
17a 10% -facts-and-circumstances test - 2021. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and stop here. Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization	►	<input type="checkbox"/>
b 10% -facts-and-circumstances test - 2020. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the facts-and-circumstances test, check this box and stop here. Explain in Part VI how the organization meets the facts-and-circumstances test. The organization qualifies as a publicly supported organization	►	<input type="checkbox"/>
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions	►	<input type="checkbox"/>

Schedule A (Form 990) 2021

**METHODIST HEALTHCARE - OLIVE BRANCH
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Schedule A (Form 990) 2021

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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) 2017	(b) 2018	(c) 2019	(d) 2020	(e) 2021	(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) 2017	(b) 2018	(c) 2019	(d) 2020	(e) 2021	(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 on line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15 Public support percentage for 2021 (line 8, column (f), divided by line 13, column (f))	15	%
16 Public support percentage from 2020 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2021 (line 10c, column (f), divided by line 13, column (f))	17	%
18 Investment income percentage from 2020 Schedule A, Part III, line 17	18	%

19a 33 1/3% support tests - 2021. 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 - 2020. 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 ► ☐

**METHODIST HEALTHCARE – OLIVE BRANCH
HOSPITAL**

Schedule A (Form 990) 2021

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Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

**METHODIST HEALTHCARE - OLIVE BRANCH
HOSPITAL**

Schedule A (Form 990) 2021

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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 on lines 11b and 11c below, the governing body of a supported organization?		
b A family member of a person described on line 11a above?		
c A 35% controlled entity of a person described on line 11a or 11b above? <i>If "Yes" to line 11a, 11b, or 11c, provide detail in Part VI.</i>		
11c		

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally Integrated Supporting Organizations

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

**METHODIST HEALTHCARE - OLIVE BRANCH
HOSPITAL**

Schedule A (Form 990) 2021

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

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

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

Section B - Minimum Asset Amount		(A) Prior Year	(B) Current Year (optional)
1	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):		
a	Average monthly value of securities	1a	
b	Average monthly cash balances	1b	
c	Fair market value of other non-exempt-use assets	1c	
d	Total (add lines 1a, 1b, and 1c)	1d	
e	Discount claimed for blockage or other factors (<i>explain in detail in Part VI</i>):		
2	Acquisition indebtedness applicable to non-exempt-use assets	2	
3	Subtract line 2 from line 1d.	3	
4	Cash deemed held for exempt use. Enter 0.015 of line 3 (for greater amount, see instructions).	4	
5	Net value of non-exempt-use assets (subtract line 4 from line 3)	5	
6	Multiply line 5 by 0.035.	6	
7	Recoveries of prior-year distributions	7	
8	Minimum Asset Amount (add line 7 to line 6)	8	

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

Schedule A (Form 990) 2021

**METHODIST HEALTHCARE - OLIVE BRANCH
HOSPITAL**

Schedule A (Form 990) 2021

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

Section D - Distributions		Current Year
1 Amounts paid to supported organizations to accomplish exempt purposes	1	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	2	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	3	
4 Amounts paid to acquire exempt-use assets	4	
5 Qualified set-aside amounts (prior IRS approval required - <i>provide details in Part VI</i>)	5	
6 Other distributions (<i>describe in Part VI</i>). See instructions.	6	
7 Total annual distributions. Add lines 1 through 6.	7	
8 Distributions to attentive supported organizations to which the organization is responsive (<i>provide details in Part VI</i>). See instructions.	8	
9 Distributable amount for 2021 from Section C, line 6	9	
10 Line 8 amount divided by line 9 amount	10	

Section E - Distribution Allocations (see instructions)	(i) Excess Distributions	(ii) Underdistributions Pre-2021	(iii) Distributable Amount for 2021
1 Distributable amount for 2021 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2021 (reasonable cause required - <i>explain in Part VI</i>). See instructions.			
3 Excess distributions carryover, if any, to 2021			
a From 2016			
b From 2017			
c From 2018			
d From 2019			
e From 2020			
f Total of lines 3a through 3e			
g Applied to underdistributions of prior years			
h Applied to 2021 distributable amount			
i Carryover from 2016 not applied (see instructions)			
j Remainder. Subtract lines 3g, 3h, and 3i from line 3f.			
4 Distributions for 2021 from Section D, line 7: \$			
a Applied to underdistributions of prior years			
b Applied to 2021 distributable amount			
c Remainder. Subtract lines 4a and 4b from line 4.			
5 Remaining underdistributions for years prior to 2021, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, <i>explain in Part VI</i> . See instructions.			
6 Remaining underdistributions for 2021. Subtract lines 3h and 4b from line 1. For result greater than zero, <i>explain in Part VI</i> . See instructions.			
7 Excess distributions carryover to 2022. Add lines 3j and 4c.			
8 Breakdown of line 7:			
a Excess from 2017			
b Excess from 2018			
c Excess from 2019			
d Excess from 2020			
e Excess from 2021			

Schedule A (Form 990) 2021

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

2021**Open to Public
Inspection****Name of the organization** **METHODIST HEALTHCARE - OLIVE BRANCH
HOSPITAL****Employer identification number**
64-0889822**Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.** Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

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

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

1 Purpose(s) of conservation easements held by the organization (check all that apply).
☐ Preservation of land for public use (for example, recreation or education) ☐ Preservation of a 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 Tax Year
a Total number of conservation easements	2a
b Total acreage restricted by conservation easements	2b
c Number of conservation easements on a certified historic structure included in (a)	2c
d Number of conservation easements included in (c) acquired after 7/25/06, and not on a historic structure listed in the National Register	2d

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

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

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

☐ Yes ☐ No

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

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

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

☐ Yes ☐ No

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

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

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

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

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

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

(ii) Assets included in Form 990, Part X

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

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

b Assets included in Form 990, Part X

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

Schedule D (Form 990) 2021

**METHODIST HEALTHCARE - OLIVE BRANCH
HOSPITAL**

Schedule D (Form 990) 2021

64-0889822 Page **3**

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. (Col. (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. (Col. (b) must equal Form 990, Part X, col. (B) line 13.) ▶		

Part IX Other Assets.

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

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

Part X Other Liabilities.

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

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

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

Schedule D (Form 990) 2021

METHODIST HEALTHCARE - OLIVE BRANCH
HOSPITAL

Schedule D (Form 990) 2021

64-0889822 Page 4

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	86,448,146.
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	0.
3	Subtract line 2e from line 1	3	86,448,146.
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	16,082,723.
c	Add lines 4a and 4b	4c	16,082,723.
5	Total revenue. Add lines 3 and 4c . (This must equal Form 990, Part I, line 12.)	5	102,530,869.

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	78,331,193.
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	0.
3	Subtract line 2e from line 1	3	78,331,193.
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	18,424,140.
c	Add lines 4a and 4b	4c	18,424,140.
5	Total expenses. Add lines 3 and 4c . (This must equal Form 990, Part I, line 18.)	5	96,755,333.

Part XIII Supplemental Information.

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

PART X, LINE 2:

THE ORGANIZATION CONSOLIDATES ITS AUDIT WITH ITS CORPORATE PARENT AND OTHER SUBSIDIARIES OF THE PARENT. THE FOLLOWING STATEMENT REFLECTS THE FIN 48 FOOTNOTE OF THE CONSOLIDATED GROUP.

THE INTERNAL REVENUE SERVICE HAS DETERMINED THAT THE SYSTEM AND ALL OF THE NONPROFIT AFFILIATES FOR WHICH THE SYSTEM OR ITS BOARD OF DIRECTORS IS CONTROLLING MEMBER ARE EXEMPT FROM FEDERAL INCOME TAX UNDER INTERNAL REVENUE CODE (IRC) SECTION 501(A) AS ORGANIZATIONS DESCRIBED IN SECTION 501(C)(3). AS QUALIFIED TAX-EXEMPT ORGANIZATIONS, THE SYSTEM'S NONPROFIT AFFILIATES MUST OPERATE IN CONFORMITY WITH THE IRC TO MAINTAIN THEIR TAX-EXEMPT STATUS. INCOME TAX FROM THE OPERATIONS OF THE SYSTEM'S WHOLLY

Part XIII Supplemental Information (continued)

OWNED FOR-PROFIT SUBSIDIARY, AMBULATORY OPERATIONS, INC., AND ITS
SUBSIDIARIES IS NOT SIGNIFICANT.

THE SYSTEM APPLIES FASB ASC TOPIC 740 (TOPIC 740), ACCOUNTING FOR
UNCERTAINTY IN INCOME TAXES. TOPIC 740 CLARIFIES THE ACCOUNTING FOR
UNCERTAINTY IN INCOME TAX POSITIONS AND PROVIDES GUIDANCE ON WHEN TAX
POSITIONS ARE RECOGNIZED IN AN ENTITY'S FINANCIAL STATEMENTS AND HOW THE
VALUES OF THESE POSITIONS ARE DETERMINED. THERE HAS BEEN NO IMPACT ON THE
SYSTEM'S COMBINED FINANCIAL STATEMENTS AS A RESULT OF TOPIC 740.

PART XI, LINE 4B - OTHER ADJUSTMENTS:

EQUITY TRANSFER TO/FROM AFFILIATE	-2,341,417.
BAD DEBT EXPENSE	18,424,140.
TOTAL TO SCHEDULE D, PART XI, LINE 4B	16,082,723.

PART XII, LINE 4B - OTHER ADJUSTMENTS:

BAD DEBT EXPENSE	18,424,140.
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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/Form990 for instructions and the latest information.**

OMB No. 1545-0047

2021

**Open to Public
Inspection**

Name of the organization **METHODIST HEALTHCARE - OLIVE BRANCH HOSPITAL** **Employer identification number**
64-0889822

Part I Financial Assistance and Certain Other Community Benefits at Cost

	Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	X	
b If "Yes," was it a written policy?	X	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input checked="" type="checkbox"/> 200% <input type="checkbox"/> Other _____ %	X	
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input checked="" type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	X	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	X	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	X	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	X	
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		X
6a Did the organization prepare a community benefit report during the tax year?	X	
b If "Yes," did the organization make it available to the public?	X	

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

	(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
Financial Assistance and Means-Tested Government Programs						
a Financial Assistance at cost (from Worksheet 1)			5692095.		5692095.	7.27%
b Medicaid (from Worksheet 3, column a)			8583331.	15028191.	0.	.00%
c Costs of other means-tested government programs (from Worksheet 3, column b)			5,525.	2,275.	3,250.	.00%
d Total. Financial Assistance and Means-Tested Government Programs			14280951.	15030466.	5695345.	7.27%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)						
f Health professions education (from Worksheet 5)						
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			30,289.		30,289.	.04%
j Total. Other Benefits			30,289.		30,289.	.04%
k Total. Add lines 7d and 7j			14311240.	15030466.	5725634.	7.31%

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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.

10	Total		
Part III	Bad Debt, Medicare, & Collection Practices		

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

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

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

Name of hospital facility or letter of facility reporting group METHODIST HEALTHCARE-OLIVE BRANCH HOSPITLine 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	X
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2	X
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	X
If "Yes," indicate what the CHNA report describes (check all that apply):		
a <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b <input checked="" type="checkbox"/> Demographics of the community		
c <input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d <input checked="" type="checkbox"/> How data was obtained		
e <input checked="" type="checkbox"/> The significant health needs of the community		
f <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j <input type="checkbox"/> Other (describe in Section C)		
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>19</u>		
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	X
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a	X
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b	X
7 Did the hospital facility make its CHNA report widely available to the public?	7	X
If "Yes," indicate how the CHNA report was made widely available (check all that apply):		
a <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>SEE PART V, SECTION C</u>		
b <input type="checkbox"/> Other website (list url):		
c <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d <input type="checkbox"/> Other (describe in Section C)		
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	X
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>21</u>		
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	X
a If "Yes," (list url): <u>SEE PART V, SECTION C</u>		
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	X
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b	
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

**METHODIST HEALTHCARE - OLIVE BRANCH
HOSPITAL**

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Part V Facility Information (continued)

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group **METHODIST HEALTHCARE-OLIVE BRANCH HOSPITAL**

	Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:		
13 Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	X
If "Yes," indicate the eligibility criteria explained in the FAP:		
a <input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>200</u> % and FPG family income limit for eligibility for discounted care of <u>250</u> %		
b <input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c <input type="checkbox"/> Asset level		
d <input checked="" type="checkbox"/> Medical indigency		
e <input type="checkbox"/> Insurance status		
f <input checked="" type="checkbox"/> Underinsurance status		
g <input checked="" type="checkbox"/> Residency		
h <input type="checkbox"/> Other (describe in Section C)		
14 Explained the basis for calculating amounts charged to patients?	14	X
15 Explained the method for applying for financial assistance?	15	X
If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):		
a <input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b <input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c <input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d <input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e <input checked="" type="checkbox"/> Other (describe in Section C)		
16 Was widely publicized within the community served by the hospital facility?	16	X
If "Yes," indicate how the hospital facility publicized the policy (check all that apply):		
a <input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>WWW.METHODISTHEALTH.ORG/FINANCIAL-ASSISTANCE/</u>		
b <input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
c <input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V, PAGE 8</u>		
d <input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e <input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f <input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g <input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h <input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i <input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations		
j <input checked="" type="checkbox"/> Other (describe in Section C)		

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Part V Facility Information (continued)**Billing and Collections**Name of hospital facility or letter of facility reporting group METHODIST HEALTHCARE-OLIVE BRANCH HOSPITAL

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

Policy Relating to Emergency Medical Care

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

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**METHODIST HEALTHCARE - OLIVE BRANCH
HOSPITAL**

Part V Facility Information *(continued)***Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**Name of hospital facility or letter of facility reporting group METHODIST HEALTHCARE-OLIVE BRANCH HOSPITAL**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.

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

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

If "Yes," explain in Section C.

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

If "Yes," explain in Section C.

	Yes	No
23		X
24		X

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HOSPITAL

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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.

METHODIST HEALTHCARE-OLIVE BRANCH HOSPITAL:

PART V, SECTION B, LINE 5: MLH ENGAGED SERVICE-AREA COMMUNITY

ORGANIZATIONS AND LEADERS VIA A COMBINATION OF FOCUS GROUPS AND

STAKEHOLDER INTERVIEWS TO COMPLETE A THOROUGH CHNA. ORGANIZATIONS AND

LEADERS IDENTIFIED ARE STAKEHOLDERS IN THE HEALTH OF THE COMMUNITY. THE

MLH CHNA INCORPORATED DATA AND INPUT FROM THE FOLLOWING: CHRIST

COMMUNITY HEALTH SERVICES, CHURCH HEALTH CENTER, MEMPHIS CHILD ADVOCACY

CENTER, MEMPHIS HEALTH CENTER, PORTER LEATH, SHELBY COUNTY HEALTH

DEPARTMENT, SHELBY COUNTY SCHOOLS, UNITED WAY OF THE MID-SOUTH, THE

UNIVERSITY OF MEMPHIS, THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER,

AS WELL AS LOCAL BUSINESS LEADERS, MLH AND WEST ASSOCIATES, LEADERSHIP,

AND PHYSICIANS AND OUR PATIENT AND FAMILY PARTNERS.

METHODIST HEALTHCARE-OLIVE BRANCH HOSPITAL:

PART V, SECTION B, LINE 6A: METHODIST UNIVERSITY HOSPITAL, METHODIST

SOUTH HOSPITAL, METHODIST NORTH HOSPITAL, METHODIST LE BONHEUR GERMANTOWN

HOSPITAL, LE BONHEUR CHILDREN'S HOSPITAL, AND METHODIST OLIVE BRANCH

HOSPITAL

METHODIST HEALTHCARE-OLIVE BRANCH HOSPITAL:

PART V, SECTION B, LINE 11: MLH DEVELOPED HOSPITAL-SPECIFIC

IMPLEMENTATION PLANS. EACH FACILITY'S IMPLEMENTATION PLAN WAS DESIGNED TO

BE SYSTEM-MINDED AND FOCUSED ON ADDRESSING THE IDENTIFIED COMMUNITY HEALTH

NEEDS (I.E., MATERNAL INFANT & CHILD HEALTH; ACCESS TO HEALTH SERVICES;

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HOSPITAL

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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.

CANCER; AND CARDIOVASCULAR DISEASE & STROKE). PLANS ASSUME ALL HOSPITAL FACILITIES WILL WORK TOGETHER IN ADDRESSING NEEDS, AND DOES NOT INCLUDE AN EXHAUSTIVE LIST OF CURRENT COMMUNITY HEALTH INITIATIVES. THE "SIGNATURE INITIATIVES" ADDRESSED WITHIN THIS PLAN ARE SPECIFIC PROGRAMS OF FOCUS WHICH WILL BE USED TO MEASURE PROGRESS OF HOW THIS SYSTEM IS WORKING TO ADDRESS THE NEEDS OF THE COMMUNITY.

METHODIST HEALTHCARE-OLIVE BRANCH HOSPITAL:

PART V, SECTION B, LINE 13B: THE ORGANIZATION USES TWO DIFFERENT METHODS FOR DETERMINING ELIGIBILITY FOR FREE OR DISCOUNTED CARE BASED ON WHETHER THE PATIENT SUBMITS A FINANCIAL ASSISTANCE POLICY (FAP).

IF THE PATIENT SUBMITS A FAP APPLICATION:

-A TEAM OF FINANCIAL ASSISTANCE REPRESENTATIVES REVIEWS THE APPLICATION TO DETERMINE IF THEY QUALIFY FOR FEDERAL ASSISTANCE SUCH AS FOOD STAMPS OR WELFARE. IF SO, THE PATIENT RECEIVES A 100% WRITE OFF.

- IF THE PATIENT DOES NOT QUALIFY FOR FEDERAL ASSISTANCE, THE TEAM DETERMINES THE AMOUNT OF DISCOUNT BASED ON INCOME WITHIN THE FEDERAL POVERTY GUIDELINES AND THE NUMBER OF DEPENDENTS. THE LEVEL OF DISCOUNT THEN RANGES FROM 80%, OR 90% UP TO 100% DISCOUNT.

IF THE PATIENT DOES NOT SUBMIT A FAP APPLICATION:

THE ORGANIZATION SENDS THE ACCOUNT TO A VENDOR TO DETERMINE IF THE ACCOUNT QUALIFIES FOR FINANCIAL ASSISTANCE AT A 100% WRITE OFF. THE ACCOUNT MUST PASS ALL OF THE FOLLOWING TESTS IN ORDER TO RECEIVE A 100% WRITE OFF. ALL OTHER ACCOUNTS SIMPLY RECEIVE THE 75% DISCOUNT. THE VENDOR USES THE

METHODIST HEALTHCARE - OLIVE BRANCH
HOSPITAL

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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.

FOLLOWING CRITERIA TO DETERMINE IF THE ACCOUNT QUALIFIES FOR FREE CARE:

-NO INSURANCE/THIRD PARTY PAYER ON FILE

-FEDERAL POVERTY SCORE OF 200% OR LESS

METHODIST HEALTHCARE-OLIVE BRANCH HOSPITAL:

PART V, SECTION B, LINE 13H: PATIENTS CAN BE ELIGIBLE FOR 100% CHARITY THROUGH 2 METHODS. ONE IS THROUGH THE AUTOMATED WRITE OFF PROCESS AND ANOTHER IS MANUAL.

AUTOMATED WRITE OFF:

ACCOUNTS WITH NO INSURANCE ARE SENT TO THE VENDOR PERIODICALLY TO SCORE THEM FOR CHARITY. IF THE ACCOUNT FITS IN FOLLOWING CRITERIA IT WILL BE WRITTEN OFF TO 100% CHARITY.

CRITERIA:

IF ACCOUNT IS RETURNED WITH FPG LESS THAN OR EQUAL TO 200%

NO INSURANCE/THIRD PARTY PAYER ON FILE

NO INSURANCE PAYMENTS OR ADJUSTMENTS MADE ON HOSPITAL MAINFRAME SYSTEM (PRIOR TO LIST WITH RAP)

PATIENT RESIDES IN UNITED METHODIST HEALTHCARE CATCHMENT AREAS (ALL OTHERS RECEIVE AUTOMATIC 75% DISCOUNT)

NOT IN CERTAIN DISPOSITIONS OR PHASES WHERE AGENCY IS REVIEWING FOR ADDITIONAL INFORMATION (I.E., LEGAL, BANKRUPTCY, INSURANCE, TPL, DECEASED OR PAYMENT DISPOSITION, ETC.)

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.

ACCOUNT STATUS IS NOT "MED ASSIST" (BEING REVIEWED FOR
MEDICAID/MEDICARE) ACCOUNTS WITH NO INSURANCE ARE SENT TO THE VENDOR
PERIODICALLY TO SCORE THEM FOR CHARITY. IF THE ACCOUNT FITS IN FOLLOWING
CRITERIA IT WILL BE WRITTEN OFF TO 100% CHARITY.
CRITERIA:

MANUAL WRITE OFF:

PFS RECEIVES FINANCIAL ASSISTANCE APPLICATIONS/REQUESTS IN SEVERAL WAYS:
COMPLETED FORMS FROM FACILITIES/HOSPITALS AFTER ADMISSION
PRE-SCREEN PROCESS VIA PHONE CONTACT BY PFS TEAM
PATIENTS RECEIVE A FINANCIAL ASSISTANCE APPLICATION ATTACHED TO FIRST
NOTICE STATEMENT IF THEY'RE UNINSURED
ALL FIRST NOTICE STATEMENTS CONTAIN VERBIAGE REGARDING ELIGIBILITY FOR
FINANCIAL ASSISTANCE IF UNDERINSURED (PATIENTS WILL CONTACT US IF THEY
FALL INTO THIS CATEGORY)
FINANCIAL ASSISTANCE REPS REVIEW APPLICATIONS WHICH CONTAINS (INCOME
STATUS, NUMBER OF DEPENDENTS, SSN, IF THEY QUALIFY FOR FEDERAL ASSISTANCE)
IF THEY QUALIFY FOR FEDERAL ASSISTANCE (FOOD STAMPS, WELFARE) THEY RECEIVE
100% WRITE OFF
IF NOT, FINANCIAL ASSISTANCE REPS REVIEW INCOME, TAX RETURNS AND NUMBER OF
DEPENDENTS AND ANNUAL FPG SPREADSHEETS TO ASSESS WRITE OFF LEVELS ABOVE
75% (80, 90 UP TO 100%)
*THESE ITEMS ARE SUBJECT TO CHANGE DUE TO ACQUIRING NEW AUTOMATED WRITE
OFF SYSTEM

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.

METHODIST HEALTHCARE-OLIVE BRANCH HOSPITAL:

PART V, SECTION B, LINE 15E: IN ADDITION, THE ORGANIZATION EXPLAINS THE METHOD FOR APPLYING FOR FINANCIAL ASSISTANCE DURING ADMISSION AND DURING THE PRE-SCREENING PROCESS AFTER DISCHARGE.

METHODIST HEALTHCARE-OLIVE BRANCH HOSPIT

PART V, LINE 16B, FAP APPLICATION WEBSITE:

WWW.METHODISTHEALTH.ORG/FINANCIAL-ASSISTANCE/

METHODIST HEALTHCARE-OLIVE BRANCH HOSPIT

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

WWW.METHODISTHEALTH.ORG/FINANCIAL-ASSISTANCE/

METHODIST HEALTHCARE-OLIVE BRANCH HOSPITAL:

PART V, SECTION B, LINE 16J: IN ADDITION, THE ORGANIZATION ATTACHES THE FINANCIAL ASSISTANCE POLICY TO FIRST NOTICE LETTERS FOR ALL UNINSURED PATIENTS. A LINK IS INCLUDED ON THE NOTICE INSTRUCTING APPLICANTS ON HOW TO APPLY FOR FINANCIAL ASSISTANCE OR HOW TO RECEIVE THE APPLICATION.

SCHEDULE H, PART V, SECTION B, LINE 7A

THE CHNA CAN BE FOUND USING THE FOLLOWING URL:

[HTTPS://WWW.METHODISTHEALTH.ORG/ABOUT-US/COMMUNITY-HEALTH/](https://www.methodisthealth.org/about-us/community-health/)

SCHEDULE H, PART V, SECTION B, LINE 10A

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? 12

Name and address	Type of Facility (describe)
1 UT METHODIST PHYSICIANS CARDIOLOGY 4250 BETHEL ROAD, 5TH FLOOR OLIVE BRANCH, MS 38654	SPECIALISTS
2 METHODIST DIAGNOSTIC CENTER - SOUTHAV 7400 AIRWAYS BLVD. SOUTHAVEN, MS 38671	IMAGING & DIAGNOSTIC CENTER
3 METHODIST MEDICAL GROUP 7235 HACKS CROSS RD. OLIVE BRANCH, MS 38654	PRIMARY CARE
4 SOUTHCREST WOMEN'S HEALTHCARE 5480 GOODMAN RD, SUITE 2 OLIVE BRANCH, MS 38654	SPECIALISTS
5 OLIVE BRANCH WOMEN'S CENTER 4250 BETHEL ROAD, 5TH FLOOR OLIVE BRANCH, MS 38654	SPECIALISTS
6 METHODIST MEDICAL GROUP - GENERAL SUR 5480 GOODMAN RD. SUITE 3 OLIVE BRANCH, MS 38654	SPECIALISTS
7 METHODIST MEDICAL GROUP 7163 GOODMAN RD. OLIVE BRANCH, MS 38654	PRIMARY CARE
8 UT METHODIST PHYSICIANS GENERAL & MIN 4250 BETHEL ROAD, 5TH FLOOR OLIVE BRANCH, MS 38654	SPECIALISTS
9 SUTHERLAND CARDIOLOGY CLINIC 4250 BETHEL ROAD, 5TH FLOOR OLIVE BRANCH, MS 38654	SPECIALISTS
10 METHODIST MEDICAL GROUP - CARNAHAN 5908 GETWELL RD SOUTHAVEN, MS 38672	SPECIALISTS

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Part VI Supplemental Information

Provide the following information.

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

PART I, LINE 3C:

ALL SELF PAY PATIENTS RECEIVE A 75% DISCOUNT WHICH IS NOT BASED ON INCOME LEVELS.

THE ORGANIZATION USES TWO DIFFERENT METHODS FOR DETERMINING ELIGIBILITY FOR FREE OR DISCOUNTED CARE BASED ON WHETHER THE PATIENT SUBMITS A FINANCIAL ASSISTANCE POLICY (FAP).

IF THE PATIENT SUBMITS A FAP APPLICATION:

-A TEAM OF FINANCIAL ASSISTANCE REPRESENTATIVES REVIEWS THE APPLICATION TO DETERMINE IF THEY QUALIFY FOR FEDERAL ASSISTANCE SUCH AS FOOD STAMPS OR WELFARE. IF SO, THE PATIENT RECEIVES A 100% DISCOUNT.

- IF THE PATIENT DOES NOT QUALIFY FOR FEDERAL ASSISTANCE, THE TEAM DETERMINES THE AMOUNT OF DISCOUNT BASED ON INCOME ACCORDING TO FEDERAL POVERTY GUIDELINES AND THE NUMBER OF DEPENDENTS. THE LEVEL OF DISCOUNT THEN RANGES FROM 80%, OR 90% UP TO 100% DISCOUNT.

IF THE PATIENT DOES NOT SUBMIT A FAP APPLICATION:

Part VI Supplemental Information (Continuation)

THE ORGANIZATION SENDS THE ACCOUNT TO A VENDOR TO DETERMINE IF THE ACCOUNT QUALIFIES FOR FINANCIAL ASSISTANCE AT A 100% DISCOUNT. THE ACCOUNT MUST PASS ALL OF THE FOLLOWING TESTS IN ORDER TO RECEIVE A 100% DISCOUNT. ALL OTHER ACCOUNTS RECEIVE ONLY THE 75% DISCOUNT. THE VENDOR USES THE FOLLOWING CRITERIA TO DETERMINE IF THE ACCOUNT QUALIFIES FOR FREE CARE:

-NO INSURANCE/THIRD PARTY PAYER ON FILE

-FEDERAL POVERTY SCORE OF 200% OR LESS

PART I, LINE 6A:

METHODIST HEALTHCARE-OLIVE BRANCH HOSPITAL'S COMMUNITY BENEFIT REPORT IS PREPARED PRIMARILY BY THE COMMUNICATIONS AND MARKETING DEPARTMENT, WITH SUPPORT FROM THE ACCOUNTING AND FINANCE DEPARTMENTS OF METHODIST LE BONHEUR HEALTHCARE, THE HOME OFFICE/CORPORATE PARENT ENTITY OF THE HOSPITAL. THE HOSPITAL'S COMMUNITY BENEFIT REPORT CAN BE FOUND ON THE COMPANY'S WEBSITE AT WWW.METHODISTHEALTH.ORG UNDER THE "ABOUT US" SECTION.

PART I, LINE 7:

WORKSHEET 2 OF THE 2021 SCHEDULE H INSTRUCTIONS WAS USED TO COMPUTE A COST-TO-CHARGES RATIO THAT WAS USED TO CALCULATE CHARITY CARE, UNREIMBURSED MEDICAID, AND SHORTFALLS FROM OTHER MEANS-TESTED GOVERNMENT PROGRAMS AT COST.

PART I, LN 7 COL(F):

THE AMOUNT ON FORM 990, PART IX, LINE 25 CONTAINS A BAD DEBT EXPENSE OF \$18,424,140 THAT HAS BEEN REMOVED FOR PURPOSES OF CALCULATING PERCENT OF TOTAL EXPENSE ON SCHEDULE H, PART I, LINE 7, COLUMN (F).

METHODIST HEALTHCARE - OLIVE BRANCH
HOSPITAL

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Part VI Supplemental Information (Continuation)

PART III, LINE 4:

THE ORGANIZATION'S FINANCIAL STATEMENTS DO NOT INCLUDE A FOOTNOTE ON BAD DEBTS, ACCOUNTS RECEIVABLE, OR ALLOWANCE FOR UNCOLLECTABLE ACCOUNTS.

WORKSHEET 2 OF THE 2021 SCHEDULE H INSTRUCTIONS WAS USED TO COMPUTE A COST-TO-CHARGES RATIO THAT WAS USED TO CALCULATE BAD DEBT AT COST.

WHEN A PORTION OF PATIENT CHARGES BECOME THE PATIENT'S RESPONSIBILITY, THE AMOUNT IS WRITTEN OFF TO BAD DEBTS AND THEN SENT TO OUR EARLY-OUT GROUP, ANY PAYMENTS RECOUPED BY OUR EARLY-OUT GROUP ARE THEN APPLIED AGAINST THE BAD DEBT EXPENSE. IT IS OUR ESTIMATION BASED ON HISTORICAL EXPERIENCE THAT ABOUT 50% OF THE REMAINING PORTION OF BAD DEBTS (AFTER RECOVERIES) COULD BE APPLICABLE TO PATIENTS WHO, ON ADDITIONAL REVIEW AND PROVIDING ALL RELEVANT INFORMATION, WOULD QUALIFY FOR FINANCIAL ASSISTANCE.

PART III, LINE 9B:

METHODIST LE BONHEUR HEALTHCARE'S COLLECTION PROCESS BEGINS WITH THE ORGANIZATION'S REVENUE CYCLE TEAM MAKING INITIAL COLLECTION EFFORTS TO RECOUP ALL MONIES DUE FROM THE PATIENT'S INSURANCE PROVIDERS. WHEN THE AMOUNT IS SOLELY THE PATIENT'S PORTION, THE ACCOUNT IS TRANSFERRED TO ANOTHER TEAM THAT SPECIALIZES IN PATIENT PORTION ACCOUNTS (EARLY-OUT PROGRAM). IT IS THIS PROGRAM THAT INITIALLY DETERMINES IF A PATIENT QUALIFIES FOR CHARITY CARE UNDER THE ORGANIZATION'S POLICY. IF QUALIFICATION IS UNCLEAR, THIS PROGRAM ATTENDS TO THE ACCOUNT FOR A PREDETERMINED TIME THROUGH LETTERS AND PHONE CALLS. THE DURATION IS DEPENDENT ON VARIOUS SCENARIOS THAT AFFECT ITS LENGTH, SUCH AS PAYMENT ARRANGEMENTS, DISPUTES, ETC. ONCE ALL COLLECTION EFFORTS HAVE BEEN

Schedule H (Form 990)

Part VI Supplemental Information (Continuation)

EXHAUSTED AND IT IS DETERMINED THAT THE REMAINING BALANCE WILL NOT BE COLLECTED, THE ACCOUNT IS REEVALUATED ON THE CRITERIA USED TO DETERMINE FINANCIAL AID ELIGIBILITY.

PART VI, LINE 2:

MLH FORMED A MULTIDISCIPLINARY TEAM TO CONDUCT THE 2019 CHNA. THIS TEAM USED A VARIETY OF DATA TO ENSURE THE ASSESSMENT PROCESS WAS AS ACCURATE AND COMPREHENSIVE AS POSSIBLE. THIS INCLUDED PRIMARY DATA, LIKE FOCUS GROUPS AND INFORMAL INTERVIEWS WITH COMMUNITY MEMBERS AND KEY STAKEHOLDERS, AS WELL AS SECONDARY DATA, SUCH AS PUBLIC HEALTH INFORMATION AND OUR OWN INTERNAL FIGURES. THE PRIMARY DATA WAS ASSESSED FOR THEMES, WHILE THE SECONDARY DATA WAS ANALYZED TO DETERMINE HOW OUR COMMUNITY COMPARED TO PEER COUNTIES (I.E., SIMILAR OUTCOMES IN MORBIDITY AND MORTALITY, AND SIMILAR DRIVERS OF HEALTH, SUCH AS SOCIAL/ECONOMIC FACTORS, PHYSICAL ENVIRONMENT, HEALTH BEHAVIORS, AND CLINICAL ACCESS).

USING HEALTHY PEOPLE 2020 AS A FRAMEWORK, WE SOUGHT TO ANSWER THE QUESTION: WHAT ARE THE HEALTH NEEDS OF OUR COMMUNITY?

A HEALTH NEED WAS IDENTIFIED WHERE THESE TWO CRITERIA WERE MET:

1) IT WAS A THEME AMONG THE PRIMARY DATA, AND
2) RELATED SECONDARY DATA COMPARED UNFAVORABLY TO OTHER COMMUNITIES. ADDITIONAL INFORMATION, LIKE HEALTH DISPARITY, SEVERITY, AND NUMBER AFFECTED, WAS ALSO INCORPORATED WHERE AVAILABLE.

ADDITIONALLY, WE CONSIDERED WHETHER OUR SYSTEM HAD THE ABILITY TO IMPACT THE IDENTIFIED NEED, WHICH FURTHER ENABLED US TO PRIORITIZE OUR RESULTS.

Part VI Supplemental Information (Continuation)

TO DO THIS, WE TOOK INTO ACCOUNT MANY FACTORS, SUCH AS WHETHER WE ALREADY
OFFER SERVICES TO ADDRESS THE NEED, OUR ABILITY TO BUILD UPON EXISTING
INITIATIVES, AND ANY PARTNERS WITH WHOM COLLABORATION WOULD BE POSSIBLE.

USING THIS METHODOLOGY MEANT THE PRIORITIZED NEEDS HAVE THE FOLLOWING
CHARACTERISTICS:

1. IT'S CONSIDERED BY OUR COMMUNITY TO BE A SIGNIFICANT HEALTH NEED.
2. IT'S A HEALTH NEED IN WHICH, BASED ON A COLLECTION OF KEY INDICATORS
IDENTIFIED BY PUBLIC HEALTH EXPERTS, OUR COMMUNITY COMPARES UNFAVORABLY TO
SIMILAR COMMUNITIES AS WELL AS NATIONAL AND STATE BENCHMARKS.
3. HEALTH DISPARITIES, PARTICULARLY RACIAL DISPARITIES, EXIST WITHIN THIS
HEALTH NEED.
4. COMPARED TO OTHER HEALTH NEEDS, MORE PEOPLE ARE AFFECTED BY THIS HEALTH
NEED (E.G. PREVALENCE), AND/OR THEY ARE AFFECTED MORE SEVERELY (E.G.,
MORTALITY).
5. MLH HAS THE ABILITY TO IMPACT THE HEALTH NEED.

PART VI, LINE 3:

METHODIST HEALTHCARE - MEMPHIS HOSPITALS UTILIZES THE FEDERAL POVERTY
GUIDELINES (FPG) TO DETERMINE THE LEVEL OF DISCOUNT UNINSURED PATIENTS MAY
RECEIVE. THE LEVEL BY WHICH ASSISTANCE IS DETERMINED IS THROUGH THE SCALE
SET BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS), WHICH INCLUDES
FACTORS SUCH AS RESIDENTS PER HOUSEHOLD AND INCOME.

MHMH COMMUNICATES AND PROVIDES ASSISTANCE CONCERNING ELIGIBILITY FOR
FINANCIAL ASSISTANCE IN SEVERAL WAYS. CHARITY CARE POLICIES ARE POSTED
AND UPDATED AS PART OF THE ORGANIZATION'S SYSTEM POLICIES AND ARE

Part VI Supplemental Information (Continuation)

AVAILABLE TO ALL STAFF THROUGH THE COMPANY INTRANET CONNECTIONS.

IN ADDITION, PATIENT-FRIENDLY SUMMARIES OF THESE POLICIES ARE POSTED IN
VISIBLE LOCATIONS THROUGHOUT ALL PUBLIC AREAS OF THE FACILITY. AT THE
TIME OF PATIENT REGISTRATION, MHMH PROVIDES FINANCIAL COUNSELING BASED ON
THE AVAILABLE INSURANCE AND "ABILITY TO PAY" INFORMATION PROVIDED. MHMH
ALSO SUPPLIES CHARITY CARE APPLICATIONS AND OFFERS ASSISTANCE IN THE
COMPLETION OF FORMS IN ALL INSTANCES WHERE THE "FINANCIAL PICTURE AS
PRESENTED TO US" APPEARS TO WARRANT THAT SERVICE.

FINALLY, THE HOSPITAL DISCUSSES WITH THE PATIENT THE AVAILABILITY OF
VARIOUS GOVERNMENTAL BENEFITS, SUCH AS MEDICAID OR OTHER STATE PROGRAMS,
AND ASSISTS THE PATIENT WITH QUALIFICATION FOR SUCH PROGRAMS, AS
APPLICABLE. LANGUAGE BARRIERS ARE TAKEN INTO ACCOUNT WITH ALL PATIENT
COMMUNICATION. ALL STAFF WITH PATIENT CONTACT, INCLUDING ADMISSION AND
BILLING CLERKS, NURSES AND THE MEDICAL STAFF, SOCIAL WORKERS, CHAPLAINS,
AND PATIENT ADVOCATES, ARE KNOWLEDGEABLE ABOUT THE CHARITY CARE POLICY AND
ASSIST PATIENTS WHEN NECESSARY.

PART VI, LINE 4:

METHODIST HEALTHCARE MEMPHIS HOSPITALS (MHMH) WAS FOUNDED BY THE MEMPHIS,
ARKANSAS, AND MISSISSIPPI CONFERENCES OF THE UNITED METHODIST CHURCH TO
SERVE A POPULATION OF ABOUT 1.25 MILLION PEOPLE. WE SERVE A BROAD CROSS
SECTION OF OUR COMMUNITY, REACHING MANY DISADVANTAGED AREAS. PATIENTS FROM
AROUND THE COUNTRY AND ALL OVER THE WORLD FIND THEIR WAY TO US FOR CARE,
BUT FOR THE PURPOSES OF THE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) WHICH
OUR ORGANIZATION CONDUCTS EVERY THREE YEARS, WE IDENTIFY SHELBY COUNTY,
TENNESSEE AND DESOTO COUNTY, MISSISSIPPI AS OUR PRIMARY SERVICE AREA.

Part VI Supplemental Information (Continuation)

THESE TWO COUNTIES COMPRISE MORE THAN 75 PERCENT OF INPATIENT DISCHARGES
ACROSS OUR SYSTEM AND IS A REPRESENTATIVE SAMPLE OF OUR PATIENT
POPULATION.

THE SERVICE AREA IS COMPRISED OF:

-FORTY-EIGHT PERCENT MALES AND TWENTY-ONE PERCENT FEMALES OF CHILD-BEARING
AGE

-FORTY-EIGHT PERCENT AFRICAN AMERICANS, FORTY-TWO PERCENT WHITES, SIX
PERCENT HISPANICS, AND FOUR PERCENT OTHER RACES/ETHNICITIES

-THE AVERAGE HOUSEHOLD INCOME IS \$66,530

-59.3 PERCENT OF THE POPULATION HAS AT LEAST SOME COLLEGE EDUCATION

MHMH IS THE LARGEST TENNCARE/MEDICAID HEALTHCARE PROVIDER IN THE AREA,
WITH APPROXIMATELY 13,000 INPATIENTS SERVED EACH YEAR. LE BONHEUR
CHILDREN'S HOSPITAL IS THE ONLY PEDIATRIC HOSPITAL IN THE REGION,
PROVIDING A FULL CONTINUUM OF SERVICES MEETING CHILDREN'S PRIMARY
THROUGH AND QUATERNARY NEEDS. AS AN ACADEMIC MEDICAL CENTER, MHMH TRAINS
HEALTH PROFESSIONALS AND FURNISHES SPECIALIZED HEALTHCARE SERVICES NOT
OTHERWISE AVAILABLE IN THE REGION. MHMH IS THE PRIMARY TEACHING SITE FOR
THE UNIVERSITY OF TENNESSEE SCHOOL OF MEDICINE. THIS DISTINCTION, ALONG
WITH THE ACCOMPANYING RESEARCH, BENEFITS THE ENTIRE METROPOLITAN
COMMUNITY.

PART VI, LINE 5:

METHODIST LE BONHEUR HEALTHCARE WORKS DILIGENTLY THROUGHOUT OUR LOCAL
COMMUNITIES TO INCREASE HEALTH AWARENESS AMONGST THE GENERAL PUBLIC. AS
STATED IN OUR ORGANIZATON'S MISSION AND VALUES; IT IS OUR DEDICATION TO
COMMUNITY SERVICE THAT DRIVES OUR CALL TO ACTION.

METHODIST HEALTHCARE - OLIVE BRANCH
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Part VI Supplemental Information (Continuation)

OUR GOAL IS TO PROVIDE OUR NEIGHBORS WITH RESOURCES AND EDUCATION
NECESSARY TO EFFECTIVELY COMBAT THE RISK FACTORS AND BEHAVIORS THAT POSE
A CHALLENGE TO LIFE EXPECTANCY RATES WITHIN OUR REGION. OUR DEDICATION TO
GIVING BACK INVOLVES A NUMBER OF MEASUREABLE PROGRAMS AND EVENTS THAT ARE
ALL ALIGNED WITH OUR PRIMARY GOAL OF ALLOWING PEOPLE OF THE MID SOUTH TO
LIVE THEIR BEST LIVES. OUR HOSPITALS ARE PART OF A SYSTEM THAT IS THE
LARGEST PROVIDER OF TENNCARE SERVICES IN THE STATE, AND OUR FACILITIES
PROVIDE FULL ACCESS TO ALL INDIVIDUALS IN OUR SERVICE AREA. OUR LOCATIONS
ARE PLACED IN ALL QUADRANTS OF OUR GEOGRAPHIC SERVICE AREAS ALLOWING US TO
PROVIDE ACCESS TO HEALTHCARE FOR ALL OF THE COMMUNITY.

OTHER ELEMENTS OF OUR COMMITMENT TO GIVING INCLUDE; OUR EDUCATIONAL
SEMINARS THAT FOCUS ON TOPICS SUCH AS DIABETES PREVENTION AND MANAGEMENT,
STROKE PREVENTION AND CARE, PEDIATRIC ASTHMA TRAINING, FIRST AID/ HANDS
ONLY CPR TRAINING, AND MENTAL HEALTH AWARENESS; WHICH ARE OFFERED AT
VARIOUS METHODIST HOSPITAL LOCATIONS. IN ADDITION TO THAT, OUR FACILITIES
SERVE AS HOST TO A NUMBER OF SUPPORT GROUPS SUCH AS "MOMS", "DYNAMIC
DADS", "GRIEF", AND SOCIAL SKILL DEVELOPMENT GROUPS. ALL OF WHICH SHARE A
COMMON OBJECTIVE; TO SUPPLY THE PEOPLE OF OUR COMMUNITY WITH THE EMOTIONAL
SUPPORT AND RESOURCES NEEDED TO OVERCOME LIFE STRESSORS.

HEALTH FAIRS ARE HELD AT EACH OF OUR NORTH, SOUTH, GERMANTOWN, AND OLIVE
BRANCH HOSPITALS ON AN ANNUAL BASIS PROVIDING HEALTH SCREENINGS TO THE
PUBLIC AND FOLLOW UP REFERRELS ARE PROVIDED AS NEEDED. ALL OF THESE
SERVICES ARE PROVIDED AT NO COST TO THE COMMUNITY.

IN ADDITION TO THAT, OUR ORGANIZATION ABSORBS COST ASSOCIATED WITH
PROVIDING EDUCATIONS, DURABLE MEDICAL EQUIPMENT AND HOME HEALTH VISITS

Schedule H (Form 990)

Part VI Supplemental Information (Continuation)

FOR MANY OF OUR INDIGENT PATIENTS ALL IN EFFORTS OF ALLOWING THEM TO
CONTINUE THEIR RECOVERY PROCESS POST DISCHARGE. OUR FACILITIES ABSORB THE
COST OF TRANSPORTATION FOR MANY OF OUR PATIENTS BY CAB, BUS, OR AMBULANCE
TO GET HOME AFTER DISCHARGE.

MEDICAL EDUCATION AND RESEARCH-METHODIST SUPPORTS VIA DIRECT SALARY AND
BENEFIT CONTRIBUTIONS TO THE UNIVERSITY OF TENNESSEE HEALTH SCIENCE
CENTER (UTHSC) FOR GRADUATE MEDICAL TRAINING POSITIONS (GME) AT METHODIST
UNIVERSITY HOSPITAL, LE BONHEUR CHILDREN'S HOSPITAL, AND METHODIST LE
BONHEUR GERMANTOWN HOSPITAL. THESE GME RESIDENTS AND FELLOWS ARE EMPLOYEES
AND TRAINEES AT THE UNIVERSITY OF TENNESSEE, BUT THEIR FINANCIAL SUPPORT
FOR SALARIES AND BENEFITS COMES VIA METHODIST. THESE TRAINEES SPEND TIME
AT A METHODIST HOSPITAL DURING THE PERIODS OF METHODIST SUPPORT AND ARE
INVOLVED IN PATIENT CARE IN ADDITION TO EDUCATIONAL ACTIVITIES.

CHURCH HEALTH CENTER: AS AN EARLY SUPPORTER OF THE CHURCH HEALTH CENTER,
METHODIST LE BONHEUR HEALTHCARE STRONGLY BELIEVES IN ITS MISSION TO SERVE
THE WORKING POOR. FROM ITS BEGINNINGS AS A PROJECT OF ST. JOHN'S UNITED
METHODIST CHURCH AND OF DR. SCOTT MORRIS TO THE COMPREHENSIVE COMMUNITY
RESOURCE IT IS TODAY, THE CHURCH HEALTH CENTER PROVIDES AFFORDABLE HEALTH
CARE, DENTISTRY, OPTOMETRY, PASTORAL COUNSELING, AND HEALTH EDUCATION TO
THOSE WHO NEED THESE SERVICES IN MEMPHIS. METHODIST HEALTHCARE - MEMPHIS
HOSPITALS IS PROUD TO SUPPORT THIS WORTHY ENDEAVOR. MHM HELPS SUPPORT THE
CHURCH HEALTH CENTER BY PROVIDING PATIENT CARE FREE OF CHARGE.

LE BONHEUR COMMUNITY HEALTH & WELL-BEING LE BONHEUR CHILDREN'S HOSPITAL'S
COMMUNITY OUTREACH DIVISION WORKS TO EXTEND THE WORK OF THE HOSPITAL
BEYOND ITS WALLS. THROUGH A VARIETY OF PROGRAMS, WE MAKE A DIFFERENCE IN

Part VI Supplemental Information (Continuation)

THE EVERYDAY LIVES OF CHILDREN IN COMMUNITIES THROUGHOUT THE REGION. A SPIRIT OF FAITH AND HEALING PERVADES METHODIST LE BONHEUR HEALTHCARE.

AS A FAITH-BASED INSTITUTION, WE ARE WORKING TO DEFINE HOW WE CAN BETTER UTILIZE OUR FAITH RESOURCES AND OTHER ASSETS IN THE COMMUNITY TO IMPROVE HEALTH. THAT MISSION HAS RESULTED IN A STRATEGY AROUND CONGREGATIONS AND OUR CONNECTION WITH THEM. WE BELIEVE THAT CONGREGATIONS CAN PLAY A SIGNIFICANT ROLE IN HEALTHCARE WHEN THEY ARE STRATEGIC PARTNERS IN THEIR MEMBERS' HEALTH JOURNEYS. TO THAT END, WE HAVE ENTERED INTO COVENANT RELATIONSHIPS WITH 500+ CONGREGATIONS TO IMPROVE THE ACCESS TO COMPREHENSIVE HEALTH SERVICES FOR ALL CITIZENS AND TO IMPROVE THE HEALTH STATUS OF THESE PATIENTS.

THE CENTER OF EXCELLENCE IN FAITH AND HEALTH (COE) IS HOUSED IN RENOVATED SPACE AT METHODIST UNIVERSITY HOSPITAL. THE COE ADVANCES HEALTH BY BRINGING FAITH AND HEALTH TOGETHER FOR THE IMPROVED WELLBEING OF THOUSANDS OF PATIENTS. THE CENTER'S GOAL IS TO DRAMATICALLY ENHANCE QUALITY OF CARE AND SUPPORT FOR OUR PATIENTS AND THEIR FAMILIES. WE BELIEVE THAT THE COUPLING OF FAITH AND HEALTH CAN NOT ONLY ELEVATE THE LEVEL OF CARE WE DELIVER TO OUR PATIENTS, BUT ALSO IMPROVE THE QUALITY OF LIFE FOR OUR COMMUNITY AND BEYOND.

THE ACTUAL CENTER OF EXCELLENCE SPACE TRANSFORMED THE PREVIOUSLY EXISTING INTENSIVE CARE WAITING ROOM INTO A STATE-OF-THE-ART FAMILY-CENTERED HEALING ENVIRONMENT WITH A QUIET AREA, RESOURCE ROOM, EDUCATION SPACES, MOVEABLE FURNITURE, AS WELL AS SPACE FOR LOCAL CLERGY TO COUNSEL THEIR MEMBERS. IT ALSO HOUSES CREATIVE MEETING SPACE FOR ACADEMIC PARTNERS LOCALLY AND ACROSS THE GLOBE TO WORK WITH EACH OTHER, AS WELL AS PROVIDE

Part VI Supplemental Information (Continuation)

TRAINING AND EDUCATION TO OUR ASSOCIATES, LOCAL CLERGY AND COMMUNITY
HEALTH PARTNERS.

METHODIST PLACES A STRONG VALUE ON EDUCATION. THROUGH THE SHELBY COUNTY
SCHOOLS ADOPT-A-SCHOOL PROGRAM, MLH ASSOCIATES WORKED TO:

- TUTOR AND MENTOR STUDENTS
- PROVIDE SPEAKERS FOR A NUMBER OF EVENTS INCLUDING CAREER DAYS
- JUDGE EVENTS SUCH AS SCIENCE PROJECTS
- PROCTOR TESTS
- PROVIDE FINANCIAL SUPPORT FOR SPECIAL NEEDS AND PROGRAMS

IN-KIND GOODS AND SERVICES

MHMH ASSOCIATES DONATED THOUSANDS OF HOURS TO MANY COMMUNITY GROUPS BY
SERVING ON NUMEROUS BOARDS AND COMMITTEES, INCLUDING:

HEALTHY SHELBY COUNTY, COMMONTABLE HEALTH ALLIANCE, CHRIST COMMUNITY
HEALTH SERVICES, CHURCH HEALTH CENTER, ITN MEMPHIS, METRO CARE, HEALTH
CHOICE, TN CARE MEDICAL CARE ADVISORY, ISCT, CONCORD NURSING PROGRAM
ADVISORY BOARD, SC COLLEGE OF NURSING ADVISORY COMMITTEE, NATIONAL
ARTHRITIS FOUNDATION, GIFT OF LIFE MIDSOUTH, TENNESSEE NURSES ASSOCIATION,
NWTN HEAD START HEALTH HEALTHY ADVISORY COMMITTEE, SHELBY COUNTY
BREASTFEEDING COALITION, PROMISE OF NURSING FOR TN, TN PUBLIC HEALTH
ASSOCIATION, AMERICAN LIVER FOUNDATION, CYNTHIA MILK FUND, YMCA, OVERTON
PARK CONSERVANCY, TENNESSEE BUSINESS ROUNDTABLE, COMMUNITY ALLIANCE FOR
THE HOMELESS, CENTER OF YOUTH MINISTRY TRAINING, UNITED METHODIST
NEIGHBORHOOD CENTERS, BOYS&GIRLS CLUB, GREATER MEMPHIS CHAMBER OF
COMMERCE, SOULSVILLE FOUNDATION, AMERICAN HEART ASSOCIATION, MARCH OF

METHODIST HEALTHCARE - OLIVE BRANCH
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Part VI Supplemental Information (Continuation)

DIMES, CARL PERKINS CENTER FOR THE PREVENTION OF CHILD ABUSE, SAFE KIDS,
BLUFF CITY MEDICAL SOCIETY, MEMPHIS AND MIDSOUTH PEDIATRIC ASSOCIATION,
CYSTIC FIBROSIS FOUNDATION, MAKE A WISH FOUNDATION MIDSOUTH, MELANOMA
RESEARCH FOUNDATION, RED CROSS, NATIONAL CIVIL RIGHTS MUSEUM, JUVENILE
DIABETES FOUNDATION, NEW MEMPHIS INSTITUTE, MID SOUTH MINORITY BUSINESS
COUNCIL, APRIL 4 FOUNDATION, GIRLS INC. , WOMEN'S FOUNDATION FOR GREATER
MEMPHIS, MEMPHIS MUSEUMS INC. MEMPHIS BRANCH NAACP, 100 BLACK MEN OF
MEMPHIS INC., MEMPHIS COMMITTEE FOR ECONOMIC DEVELOPMENT, MEMPHIS
THEOLOGICAL SEMINARY, MEMPHIS TOMORROW, MEMPHIS CHILD ADVOCACY CENTER,
EXCHANGE CLUB CARL PERKINS CENTER, NATIONAL KIDNEY FOUNDATION, GIFT OF
LIFE MID SOUTH, PEOPLE FIRST OF TN, CITY OF MEMPHIS IT STEERING,
CHILDREN'S HOSPITAL ASSOCIATION, NEW LEADERS ADVISORY BOARD, IDLEWILD
CHILDREN'S CENTER, FIRE MUSEUM OF MEMPHIS, REGIONAL INTERFAITH SOUP
KITCHEN,

A MAJORITY OF THE ORGANIZATION'S GOVERNING BODY IS COMPRISED OF PERSONS
WHO RESIDE IN THE PRIMARY SERVICE AREA AND WHO ARE NEITHER EMPLOYEES OF
NOR INDEPENDENT CONTRACTORS OF THE ORGANIZATION. THE HOSPITAL EXTENDS
MEDICAL STAFF PRIVILEGES TO ALL QUALIFIED PHYSICIANS IN ITS COMMUNITY.

PART VI, LINE 6:

METHODIST HEALTHCARE-OLIVE BRANCH HOSPITAL, THE FILING ORGANIZATION, IS A
SUBSIDIARY OF METHODIST LE BONHEUR HEALTHCARE (MLH). ALTHOUGH THIS FORM
990 ONLY INCLUDES THE CHARITY CARE AND COMMUNITY BENEFIT OF THIS
ORGANIZATION, MLH INCLUDES THE FOLLOWING ENTITIES THAT ALSO PROVIDE
CHARITY CARE AND COMMUNITY BENEFIT:

- METHODIST HEALTHCARE - MEMPHIS HOSPITALS

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Part VI Supplemental Information (Continuation)

- ALLIANCE HEALTH SERVICES, INC.
- METHODIST HEALTHCARE COMMUNITY CARE ASSOCIATES

IN ADDITION, METHODIST HEALTHCARE FOUNDATION AND LE BONHEUR CHILDREN'S HOSPITAL FOUNDATION PROVIDE VALUABLE FINANCIAL SUPPORT TO THE OPERATIONS OF THE GROUP, ALLOWING IT TO PURSUE RESEARCH AND CONSTRUCTION PROJECTS TO PROVIDE ADDITIONAL BENEFITS TO THE COMMUNITY. METHODIST HEALTHCARE - MEMPHIS HOSPITALS ALSO HAS A TEACHING AND RESEARCH AFFILIATION WITH THE UNIVERSITY OF TENNESSEE. THE UNIVERSITY HAS A CLINICAL REACH THAT EXTENDS BEYOND THE LOCAL SERVICE AREA, PROVIDING HIGHLY SPECIALIZED SERVICES THAT ATTRACT PATIENTS FROM A MULTI-STATE SERVICE AREA. MHMH HAD OVER 225 RESIDENTS, PLUS FELLOWS, NURSES, AND ALLIED HEALTH PROFESSIONALS THAT TRAINED IN OUR FACILITIES DURING 2021.

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

TN,MS

**SCHEDULE J
(Form 990)**

Department of the Treasury
Internal Revenue Service

Compensation Information

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

OMB No. 1545-0047

2021

Open to Public
Inspection

Name of the organization **METHODIST HEALTHCARE - OLIVE BRANCH HOSPITAL** Employer identification number **64-0889822**

Part I Questions Regarding Compensation

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

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

Schedule J (Form 990) 2021

**METHODIST HEALTHCARE - OLIVE BRANCH
HOSPITAL**

Schedule J (Form 990) 2021

64-0889822

Page **2**

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

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC and/or 1099-NEC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) DAVID BAYTOS PRESIDENT/CEO	(i)	0.	0.	0.	0.	0.	0.	0.
	(ii)	359,678.	176,718.	85,171.	8,700.	14,001.	644,268.	46,928.
(2) KRIS SANDERS TREASURER	(i)	186,169.	45,306.	12,103.	41,189.	18,640.	303,407.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(3) ANNELISE JENSEN VP/CNO	(i)	190,912.	45,038.	1,583.	39,247.	6,551.	283,331.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(4) JENNIFER WEAVER PHARMACIST	(i)	160,266.	15,873.	0.	10,073.	26,043.	212,255.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(5) REGINA STEVENS PATIENT CARE COORD/FIXED	(i)	160,556.	14,000.	569.	9,988.	10,934.	196,047.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(6) ALLISON MEREDITH PHARMACIST	(i)	136,866.	14,000.	576.	8,708.	21,612.	181,762.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(7) MUSA CEESAY CLINICAL PHARMACIST	(i)	153,911.	0.	571.	7,945.	6,836.	169,263.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
(8) MARGARET WALLACE PHARMACIST	(i)	141,541.	0.	669.	8,606.	6,051.	156,867.	0.
	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

Schedule J (Form 990) 2021

Part III Supplemental Information

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

PART I, LINE 3:

THE BOARD OF METHODIST LE BONHEUR HEALTHCARE, A RELATED ORGANIZATION AND
CORPORATE OVERSIGHT ENTITY, CONDUCTS THE FOLLOWING METHODS TO ESTABLISH
COMPENSATION FOR ITS OFFICERS AND KEY EMPLOYEES:

- COMPENSATION COMMITTEE
- INDEPENDENT COMPENSATION CONSULTANT
- FORM 990 OF OTHER ORGANIZATIONS
- WRITTEN EMPLOYMENT CONTRACT
- COMPENSATION STUDY / SURVEY
- APPROVAL BY THE BOARD / COMPENSATION COMMITTEE

PART I, LINE 4B:

THE PURPOSE OF THE METHODIST LE BONHEUR HEALTHCARE CONSOLIDATED EXECUTIVE
DEFERRED COMPENSATION PLAN IS TO PROVIDE RETIREMENT BENEFITS FOR CERTAIN
EXECUTIVE LEVEL EMPLOYEES IN ADDITION TO THE BENEFITS PROVIDED THROUGH THE
OTHER RETIREMENT PLANS THAT ARE SPONSORED BY THE COMPANY. IT IS INTENDED
THAT THIS PLAN COMPLY WITH INTERNAL REVENUE CODE SECTION 457(F) AND QUALIFY

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.

FOR THE SHORT TERM DEFERRAL EXCEPTION TO CODE SECTION 409A. UNDER THE
PLAN, CORPORATE EXECUTIVES AT OR ABOVE THE VICE PRESIDENT LEVEL ARE
ELIGIBLE TO RECEIVE EXECUTIVE DEFERRED COMPENSATION CREDITS DEPENDING ON
THEIR POSITION CLASSIFICATION [6%, 8%, 10%, 12%, 15%, 25% OF BASE SALARY].
EACH PLAN YEAR, THE EXECUTIVE MUST ELECT A DEFERRED VESTING DATE TO BE
APPLIED TO THE DEFERRED COMPENSATION CREDIT THAT WILL BE EARNED IN THAT
PLAN YEAR. THE DEFERRED VESTING DATE IS SUBJECT TO A VESTING SCHEDULE THAT
REQUIRES A MINIMUM DEFERRAL OF 5 YEARS TO BECOME VESTED. UPON REACHING AGE
55, THE MINIMUM DEFERRAL IS REDUCED TO 3 YRS. UPON REACHING AGE 60, THE
MINIMUM DEFERRAL IS REDUCED TO 2 YRS. AT AGE 64, A CASH EQUIVALENT IS
PROVIDED TO THE EXECUTIVE AND NO ADDITIONAL DEFERRALS ARE MADE UNDER THIS
PLAN.

RESTORATION BENEFIT PARTICIPANTS THAT WERE NEGATIVELY IMPACTED BY FREEZING
THE RESTORATION PLAN WERE PROVIDED WITH AN ADDITIONAL ANNUAL EDCP
CONTRIBUTION UNTIL AGE 65 DESIGNED TO KEEP THEM WHOLE.

THE PLAN IS UNFUNDED WITH ALL BENEFITS PAID FROM THE COMPANY'S GENERAL
ASSETS. HOWEVER, THE EXECUTIVE IS ALLOWED TO DIRECT THE INVESTMENTS OF HIS

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.

DEFERRED COMPENSATION CREDIT IN A MENU OF INVESTMENT ALTERNATIVES MADE AVAILABLE BY THE COMPANY. UPON VESTING, A DISTRIBUTION IS PROVIDED LESS APPLICABLE TAX. IN THE CASE OF A VOLUNTARY TERMINATION OF EMPLOYMENT BY THE EXECUTIVE OR INVOLUNTARY TERMINATION OF EMPLOYMENT FOR CAUSE BY THE COMPANY, THE NON-VESTED FUNDS ARE FORFEITED. ACCELERATED VESTING (100%) IS ALLOWED UPON DEATH, DISABILITY OR AN INVOLUNTARY TERMINATION BY THE COMPANY WITHOUT CAUSE.

ALLOCATIONS TO THE 457(F) PLAN FOR THE YEAR INCLUDE THE FOLLOWING:

\$11,539 - ANNE LISE JENSEN

\$12,064 - KRIS SANDERS

IN ADDITION, THE FOLLOWING INDIVIDUALS RECEIVED 457(F) PAYOUTS. THIS AMOUNT REPRESENTS THE FULLY VESTED PORTION PURSUANT TO THE 457(F) PLAN. THIS AMOUNT WAS REFLECTED IN COLUMN (C) ON THE PRIOR YEARS FORM 990 AS REQUIRED.

PAYOUTS FROM THE PLAN FOR THE YEAR INCLUDE THE FOLLOWING:

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.

\$46,928 DAVID BAYTOS

IN ADDITION, THE FOLLOWING INDIVIDUALS RECEIVED AN EXECUTIVE RETIREMENT
LUMP SUM PAYOUT. ONCE AN EXECUTIVE REACHES THE AGE OF 64 THEN THEY ARE NO
LONGER ELIGIBLE TO PARTICIPATE IN THE 457(F) PLAN. A LUMP SUM IS PAID
ANNUALLY ON THE LAST PAY PERIOD OF THE YEAR, EQUIVALENT TO THE CONTRIBUTION
THAT WOULD HAVE BEEN MADE TO THE 457(F) PLAN. THIS AMOUNT REPRESENTS THE
FULLY VESTED PORTION PURSUANT TO THE 457(F) PLAN. THIS AMOUNT WAS REFLECTED
IN COLUMN (C) ON THE PRIOR YEAR'S FORM 990 AS REQUIRED.

PAYOUTS FROM THE EXECUTIVE RETIREMENT PLAN FOR THE YEAR:

NO PAYMENTS MADE DURING TAX YEAR.

SCHEDULE O
(Form 990)

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 Form 990-EZ.

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

OMB No. 1545-0047

2021

Open to Public
Inspection

Name of the organization

METHODIST HEALTHCARE - OLIVE BRANCH
HOSPITAL

Employer identification number
64-0889822

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

SUPPORTS THE HEALTH MINISTRIES AND SOCIAL PRINCIPLES OF THE UNITED
METHODIST CHURCH TO BENEFIT THE COMMUNITIES WE SERVE.

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

SERVICES OFFERED AT OBH INCLUDE:

24-HOUR EMERGENCY ROOM

CARDIOLOGY

ENT

GASTROENTEROLOGY

FULL SERVICE ACUTE CARE

NEPHROLOGY

NEUROLOGY

OBSTETRICS AND MATERNITY

ONCOLOGY

MAMMOGRAPHY

OUTPATIENT NUTRITION THERAPY

RADIOLOGY, INCLUDING MRI, CT, NUCLEAR MEDICINE, AND ULTRASOUND

REHABILITATION SERVICES: PHYSICAL, SPEECH, AND OCCUPATIONAL THERAPY

SURGICAL SERVICES: GENERAL, SAME DAY, MINIMALLY INVASIVE

UROLOGY

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

METHODIST HEALTHCARE - OLIVE BRANCH HOSPITAL IS A SUBSIDIARY OF METHODIST
LE BONHEUR HEALTHCARE (MLH, 58-1454711), WITH THE PERSONS SITTING ON THE

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

Schedule O (Form 990) 2021

132211 11-11-21

Name of the organization	METHODIST HEALTHCARE - OLIVE BRANCH HOSPITAL	Employer identification number 64-0889822
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MLH BOARD OF DIRECTORS SERVING AS THE MEMBERS OF THE ORGANIZATION.

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

AS THE MEMBERS OF THE ORGANIZATION, THE MLH BOARD OF DIRECTORS ELECTS ALL MEMBERS OF THE GOVERNING BODY FOR THE ORGANIZATION.

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

THE MEMBERS SHALL FROM TIME TO TIME ADOPT AND PROMULGATE SUCH AMENDMENTS AS THEY SHALL DEEM APPROPRIATE TO THE GENERAL POLICIES AND GUIDELINES OF THE CORPORATION, ALL OF WHICH SHALL NOT BE INCONSISTENT WITH THE PURPOSES OF METHODIST LE BONHEUR HEALTHCARE. UPON REQUEST BY THE BOARD OF DIRECTORS OF THE CORPORATION AND AT SUCH OTHER TIMES AS THE MEMBERS MAY SELECT, THE MEMBERS SHALL REVIEW THE AFFAIRS OF THE CORPORATION AND TAKE SUCH ACTION AS IT MAY DEEM APPROPRIATE IN ACCORDANCE WITH THESE BYLAWS. THE "CORPORATE LIMIT" REFERRED TO IN THE FOLLOWING ITEMS SHALL BE THE SUM OF FIVE HUNDRED THOUSAND DOLLARS (\$500,000.00) OR SUCH OTHER SUMS AS MAY FROM TIME TO TIME BE DESIGNATED BY ACTION OF THE MEMBERS; AND FOR PURPOSES OF THESE BYLAWS THE WORDS "THE CORPORATION" SHALL MEAN METHODIST HEALTHCARE - OLIVE BRANCH HOSPITAL. THE FOLLOWING ITEMS, AFTER BEING REVIEWED AND ADOPTED BY THE BOARD OF DIRECTORS, SHALL BE SUBMITTED TO THE MEMBERS FOR APPROVAL.

- IN DECEMBER OF EACH YEAR, A STRATEGIC PLAN AND A ONE (1) YEAR OPERATING BUDGET OF THE CORPORATION'S ENSUING FISCAL YEAR, AND, THEREAFTER, ANY ACTION WHICH WILL RESULT IN A SUBSTANTIAL CHANGE IN THE EXPENDITURES OR REVENUE FORECAST IN ANY SUCH PLAN OR BUDGET;

- ANY CREATION OR SUBSTANTIVE AMENDMENT OF A CONTRACT, LEASE OR OTHER AGREEMENT OF WHICH THE CORPORATION IS A PARTY WHICH INVOLVES AN OBLIGATION,

Name of the organization	METHODIST HEALTHCARE - OLIVE BRANCH HOSPITAL	Employer identification number 64-0889822
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OR A POTENTIAL OBLIGATION, ON THE PART OF THE CORPORATION IN EXCESS OF THE CORPORATE LIMIT, UNLESS SUCH TRANSACTION HAS BEEN PREVIOUSLY APPROVED WITHIN THE CAPITAL OR OPERATING BUDGETS;

- ANY SALE, EXCHANGE, GIFT, MORTGAGE, OPTION, LEASE WITH A TERM IN EXCESS OF ONE YEAR (EXCEPT TO DOCTORS FOR OFFICE SPACE), OR OTHER DISPOSITION OF:

(1) ANY REAL PROPERTY OR INTEREST THEREIN OWNED BY THE CORPORATION, OR

(2) ANY OTHER ASSET OWNED BY THE CORPORATION WITH A VALUE IN EXCESS OF THE CORPORATE LIMIT, EXCEPT WITH RESPECT TO TRANSACTIONS SPECIFIED AND PREVIOUSLY APPROVED WITHIN THE CAPITAL OR OPERATING BUDGETS.

- ANY RELEASE OR CANCELLATION BY THE CORPORATION OF A CLAIM OR RIGHT OF ACTION AGAINST ANOTHER PARTY IN AN AMOUNT IN EXCESS OF THE CORPORATE LIMIT;

- ANY APPLICATION FOR A GOVERNMENT GRANT;

- ANY AMENDMENT OR RESTATEMENT OF THE CORPORATE CHARTER OR ANY PLAN OF MERGER, CONSOLIDATION OR DISSOLUTION OF THE CORPORATION;

- ANY ACTION OR INACTION AT VARIANCE WITH THE STATED POLICIES OF THE CORPORATION WHICH POLICIES HAVE BEEN APPROVED BY THE MEMBERS;

- THE SELECTION OF ANY BANKING INSTITUTION AS A DEPOSITORY OF CORPORATE FUNDS; AND

- ANY OTHER MATTERS AS MAY BE REQUIRED BY LAW TO BE SUBMITTED TO THE

Name of the organization	METHODIST HEALTHCARE - OLIVE BRANCH HOSPITAL	Employer identification number	64-0889822
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MEMBERS OF A NOT-FOR-PROFIT CORPORATION.

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

THE FORM 990 IS PREPARED BY AN INDEPENDENT ACCOUNTING FIRM WITH INPUT FROM HUMAN RESOURCES, LEGAL, COMPLIANCE, AND FINANCE DEPARTMENTS AND EXTERNAL FINANCIAL CONSULTANTS. FINANCIAL INFORMATION IS RECONCILED TO AUDITED FINANCIAL STATEMENTS AS APPROPRIATE. THE INFORMATION TO BE DISCLOSED REGARDING COMPENSATION IS REVIEWED WITH THE COMPENSATION COMMITTEE OF THE BOARD. THE RETURN IS REVIEWED BY THE CHIEF FINANCIAL OFFICER OF MLH AND MANAGEMENT OF THE ORGANIZATION AS APPROPRIATE. A COPY OF THE RETURN IS PROVIDED TO EACH BOARD MEMBER VIA E-MAIL PRIOR TO FILING THE RETURN.

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

METHODIST LE BONHEUR HEALTHCARE, THE PARENT ORGANIZATION, EMPLOYS A COMPLIANCE OFFICER WHO MONITORS AND ENFORCES COMPLIANCE WITH THE CONFLICT OF INTEREST POLICY FOR ALL VOTING BOARD MEMBERS AND APPLICABLE OFFICERS.

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

COMPENSATION FOR OFFICERS AND KEY EMPLOYEES OF THE ORGANIZATION IS DETERMINED BY THE BOARD OF DIRECTORS OF METHODIST LE BONHEUR HEALTHCARE, THE PARENT ORGANIZATION. AN EXTERNAL INDEPENDENT CONSULTANT ADVISES THE BOARD COMPENSATION COMMITTEE ON EXECUTIVE SALARY AND INCENTIVE COMPENSATION. BENEFITS ARE PERIODICALLY BENCHMARKED BY A SEPARATE EXTERNAL CONSULTANT AND ANY CHANGES ARE APPROVED BY THE BOARD OF DIRECTORS COMPENSATION COMMITTEE.

THE COMPENSATION COMMITTEE IS COMPRISED OF INDEPENDENT MEMBERS AND IS A SUBGROUP OF THE FULL BOARD OF DIRECTORS. THE COMPENSATION CONSULTANT

Name of the organization	METHODIST HEALTHCARE - OLIVE BRANCH HOSPITAL	Employer identification number 64-0889822
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ANNUALLY DEVELOPS TOTAL CASH COMPENSATION COMPARISONS OF PEER NON-PROFIT SYSTEMS ESTABLISHED BY THE COMPENSATION COMMITTEE. THE COMPENSATION CONSULTANT INTERPRETS THE INFORMATION AND PROVIDES AN OPINION OF REASONABLENESS ON THE TOTAL CASH COMPENSATION PACKAGE. THE COMPENSATION COMMITTEE APPROVES ANY CHANGES TO THE COMPENSATION AND EXECUTIVE BENEFIT STRUCTURE OF THE CEO AND OTHER TOP EXECUTIVES, OTHERWISE KNOWN AS DISQUALIFIED CANDIDATES. ALL OTHER COMPENSATION DECISIONS ARE DETERMINED BY ARRANGEMENT AS DELEGATED BY THE BOARD OF DIRECTORS. THE COMMITTEE DOCUMENTS ALL DETERMINATIONS.

FORM 990, PART VI, SECTION C, LINE 18:

PHOTOCOPIES OF THE FORM 990 ARE AVAILABLE UPON REQUEST AT THE ORGANIZATION'S ADMINISTRATIVE OFFICE. IN ADDITION, RECENT FILINGS OF THE FORM 990 ARE AVAILABLE ONLINE AT OUR WEBSITE IN THE "ABOUT US" SECTION.

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

METHODIST LE BONHEUR HEALTHCARE, AND RELATED SUBSIDIARIES. INFORMATION ON FINANCIAL STATEMENTS IS AVAILABLE BY CONTACTING THE ORGANIZATION'S CORPORATE OFFICE. PLEASE SEE FORM 990, PART VI, LINE 20 FOR DETAILS. CONFLICT OF INTEREST POLICY AND GOVERNING DOCUMENTS FOR ALL AFFILIATES OF METHODIST LE BONHEUR HEALTHCARE ARE ALSO AVAILABLE BY REQUEST.

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

PURCHASED SERVICES:

PROGRAM SERVICE EXPENSES	12,655,804.
MANAGEMENT AND GENERAL EXPENSES	1,898,985.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	14,554,789.

Name of the organization **METHODIST HEALTHCARE - OLIVE BRANCH
HOSPITAL**

Employer identification number
64-0889822

CONSULTING:

PROGRAM SERVICE EXPENSES 39,086.

MANAGEMENT AND GENERAL EXPENSES 43,500.

FUNDRAISING EXPENSES 0.

TOTAL EXPENSES 82,586.

TOTAL OTHER FEES ON FORM 990, PART IX, LINE 11G, COL A 14,637,375.

FORM 990, PART XI, LINE 9, CHANGES IN NET ASSETS:

TRANSFER FROM AFFILIATES 2,341,417.

FORM 990, PART XII, LINE 2C:

THE PROCESS HAS NOT CHANGED FROM THE PRIOR YEAR.

**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

2021

**Open to Public
Inspection**

Name of the organization **METHODIST HEALTHCARE - OLIVE BRANCH HOSPITAL** Employer identification number **64-0889822**

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
ALLIANCE HEALTH SERVICES INC. - 62-0841121 6400 SHELBY VIEW SUITE 101 MEMPHIS, TN 38134	HEALTHCARE	TENNESSEE	501(C)(3)	LINE 10	METHODIST LE BONHEUR HEALTHCARE		X
CHILDREN'S FOUNDATION RESEARCH INSTITUTE - 83-4329511, 850 POPLAR AVENUE BLDG 2, MEMPHIS, TN 38105	HEALTHCARE	TENNESSEE	501(C)(3)	LINE 10	LE BONHEUR CHILDREN'S FOUNDATION		X
LE BONHEUR CHILDREN'S HOSPITAL FOUNDATION - 62-1872938, 850 POPLAR AVENUE BLDG 2, MEMPHIS, TN 38105	FOUNDATION	TENNESSEE	501(C)(3)	LINE 12A, I	METHODIST LE BONHEUR HEALTHCARE		X
METHODIST HEALTHCARE - MEMPHIS HOSPITALS - 62-0479367, 1265 UNION AVENUE, MEMPHIS, TN 38104	HOSPITALS	TENNESSEE	501(C)(3)	LINE 3	METHODIST LE BONHEUR HEALTHCARE		X

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

Schedule R (Form 990) 2021

**METHODIST HEALTHCARE - OLIVE BRANCH
HOSPITAL**

Schedule R (Form 990)

64-0889822

Part II Continuation of Identification of Related Tax-Exempt Organizations

(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 organization?	
						Yes	No
METHODIST HEALTHCARE CENTRAL MS MEDICAL ASSOCIATES - 64-0884720, 1211 UNION AVENUE SUITE 657, MEMPHIS, TN 38104	PHYSICIAN PRACTICES	MISSISSIPPI	501(C)(3)	LINE 3	METHODIST LE BONHEUR HEALTHCARE		X
METHODIST HEALTHCARE COMMUNITY CARE ASSOCIATES - 62-1403517, 6400 SHELBY VIEW SUITE 101, MEMPHIS, TN 38134	OUTPATIENT HEALTHCARE	MISSISSIPPI	501(C)(3)	LINE 10	METHODIST LE BONHEUR HEALTHCARE		X
METHODIST HEALTHCARE FOUNDATION - 23-7320638 1211 UNION AVENUE SUITE 450 MEMPHIS, TN 38104	FOUNDATION	TENNESSEE	501(C)(3)	LINE 12A, I	METHODIST LE BONHEUR HEALTHCARE		X
METHODIST HEALTHCARE PRIMARY CARE ASSOCIATES - 58-2078931, 1211 UNION AVENUE SUITE 657, MEMPHIS, TN 38104	PHYSICIAN PRACTICES	TENNESSEE	501(C)(3)	LINE 10	METHODIST LE BONHEUR HEALTHCARE		X
METHODIST HEALTHCARE-DYERSBURG HOSPITAL - 62-1155084, 1211 UNION AVENUE SUITE 657, MEMPHIS, TN 38104	INACTIVE HOSPITAL	TENNESSEE	501(C)(3)	LINE 3	METHODIST LE BONHEUR HEALTHCARE		X
METHODIST HEALTHCARE-JACKSON HOSPITAL - 64-0794199, 1211 UNION AVENUE SUITE 657, MEMPHIS, TN 38104	INACTIVE HOSPITAL	MISSISSIPPI	501(C)(3)	LINE 3	METHODIST LE BONHEUR HEALTHCARE		X
METHODIST HEALTHCARE-JONESBORO HOSPITAL - 71-0499625, 1211 UNION AVENUE SUITE 657, MEMPHIS, TN 38104	INACTIVE HOSPITAL	ARKANSAS	501(C)(3)	LINE 3	METHODIST LE BONHEUR HEALTHCARE		X
METHODIST HEALTHCARE-MIDDLE MISSISSIPPI HOSPITAL - 64-0698911, 1211 UNION AVENUE SUITE 657, MEMPHIS, TN 38104	INACTIVE HOSPITAL	MISSISSIPPI	501(C)(3)	LINE 3	METHODIST LE BONHEUR HEALTHCARE		X
METHODIST LE BONHEUR COMMUNITY OUTREACH - 62-1251288, 1211 UNION AVENUE SUITE 700, MEMPHIS, TN 38104	FOUNDATION	TENNESSEE	501(C)(3)	LINE 7	LE BONHEUR CHILDREN'S FOUNDATION		X
METHODIST LE BONHEUR HEALTHCARE - 58-1454711 1211 UNION AVENUE SUITE 700 MEMPHIS, TN 38104	SUPPORTING ORGANIZATION	TENNESSEE	501(C)(3)	LINE 12B, II	N/A		X

**METHODIST HEALTHCARE - OLIVE BRANCH
HOSPITAL**

Schedule R (Form 990) 2021

64-0889822 Page 2

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
NORTH SURGERY CENTER, LP - 62-1685756, 3960 NEW COVINGTON PIKE, MEMPHIS, TN 38128	SURGERY CENTER	TN	N/A	N/A	N/A	N/A			N/A			N/A
METHODIST SURGERY CENTER-GERMANTOWN, LP - 62-1659904, 1363 S GERMANTOWN ROAD, GERMANTOWN, TN 38138												
HAMILTON EYE INSTITUTE SURGERY CENTER, LP - 20-2873438, 930 MADISON AVE. 3RD FLOOR, MEMPHIS, TN 38103												
LE BONHEUR EAST SURGERY CENTER II, LP - 80-0247391, 786 ESTATE PLACE, MEMPHIS, TN 38120												
	SURGERY CENTER	TN	N/A	N/A	N/A	N/A	X		N/A	X		N/A

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
AMBULATORY OPERATIONS INC. - 62-1157166 1211 UNION AVENUE SUITE 600 MEMPHIS, TN 38104	MEDICAL AND MANAGEMENT SERVICES	TN	N/A	C CORP	N/A	N/A	N/A		X
SOLUS MANAGEMENT SERVICES INC. - 62-1361349 6400 SHELBY VIEW SUITE 101 MEMPHIS, TN 38134									X
MEMPHIS PROFESSIONAL BUILDING INC. - 62-1847544, 1211 UNION AVENUE SUITE 600, MEMPHIS, TN 38104									X
	INVESTMENTS	TN	N/A	C CORP	N/A	N/A	N/A		X

**METHODIST HEALTHCARE - OLIVE BRANCH
HOSPITAL**

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Part V Transactions With Related Organizations. Complete if the organization answered "Yes" on Form 990, Part IV, line 34, 35b, or 36.

Note: Complete line 1 if any entity is listed in Parts II, III, or IV of this schedule.

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

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)			
(2)			
(3)			
(4)			
(5)			
(6)			

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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.

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