

Form **990**
Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)
Do not enter social security numbers on this form as it may be made public
Information about Form 990 and its instructions is at www.irs.gov/form990

OMB No 1545-0047
2017
Open to Public Inspection

A For the 2017 calendar year, or tax year beginning 10-01-2017, and ending 09-30-2018

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

C Name of organization
TALLAHASSEE MEMORIAL HEALTHCARE INC
% WILLIAM A GIUDICE CFO
Doing business as
Number and street (or P O box if mail is not delivered to street address) Room/suite
1300 MICCOSUKEE ROAD
City or town, state or province, country, and ZIP or foreign postal code
TALLAHASSEE, FL 323085054

D Employer identification number
59-1917016

E Telephone number
(850) 431-5238

G Gross receipts \$ 909,364,446

F Name and address of principal officer
WILLIAM GIUDICE CFO
1300 MICCOSUKEE ROAD
TALLAHASSEE, FL 323085054

H(a) Is this a group return for subordinates? Yes No

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

H(c) Group exemption number ▶

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

J Website: ▶ www.tmh.org

K Form of organization Corporation Trust Association Other ▶

L Year of formation 1979

M State of legal domicile FL

Part I Summary

1 Briefly describe the organization's mission or most significant activities
TALLAHASSEE MEMORIAL HEALTHCARE, INC IS A PRIVATE 772-BED, COMMUNITY HEALTH CARE SYSTEM THAT PROVIDES CHARITABLE, COMPASSIONATE, LEADING-EDGE, PATIENT-CENTERED HEALTH CARE

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

3 Number of voting members of the governing body (Part VI, line 1a)	16
4 Number of independent voting members of the governing body (Part VI, line 1b)	13
5 Total number of individuals employed in calendar year 2017 (Part V, line 2a)	5,866
6 Total number of volunteers (estimate if necessary)	575
7a Total unrelated business revenue from Part VIII, column (C), line 12	1,559,739
7b Net unrelated business taxable income from Form 990-T, line 34	1,642,699

	Prior Year	Current Year
8 Contributions and grants (Part VIII, line 1h)	1,171,428	3,724,422
9 Program service revenue (Part VIII, line 2g)	573,405,029	607,338,244
10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	1,062,221	6,889,175
11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	194,191,278	222,696,483
12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	769,829,956	840,648,324
13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	180,008	201,302
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)	301,780,937	316,200,752
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)	420,884,448	473,248,528
18 Total expenses Add lines 13-17 (must equal Part IX, column (A), line 25)	722,845,393	789,650,582
19 Revenue less expenses Subtract line 18 from line 12	46,984,563	50,997,742

	Beginning of Current Year	End of Year
20 Total assets (Part X, line 16)	962,184,865	1,056,902,686
21 Total liabilities (Part X, line 26)	540,413,377	523,704,032
22 Net assets or fund balances Subtract line 21 from line 20	421,771,488	533,198,654

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: 2019-08-14
WILLIAM GIUDICE CFO
Type or print name and title

Paid Preparer Use Only
Print/Type preparer's name: ANTONIO C RUSSO Preparer's signature: ANTONIO C RUSSO Date: _____
Check if self-employed PTIN: P00858539
Firm's name: PricewaterhouseCoopers LLP Firm's EIN: _____
Firm's address: 2001 MARKET ST SUITE 1800 Phone no: (267) 330-3000
PHILADELPHIA, PA 19103

Part III Statement of Program Service Accomplishments

Check if Schedule O contains a response or note to any line in this Part III Yes No

1 Briefly describe the organization's mission

FOUNDED MORE THAN 60 YEARS AGO, TALLAHASSEE MEMORIAL HEALTHCARE INC IS A PRIVATE, NOT-FOR PROFIT, 772-BED, COMMUNITY HEALTH CARE SYSTEM THAT PROVIDES CHARITABLE, COMPASSIONATE, LEADING -EDGE, & PATIENT-CENTERED HEALTH CARE ITS MISSION TRANSFORMING CARE ADVANCING HEALTH IMPROVING LIVES

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 \$ 720,664,181 including grants of \$ 201,302) (Revenue \$ 830,649,835)
See Additional Data

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

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

4d Other program services (Describe in Schedule O)
(Expenses \$ including grants of \$) (Revenue \$)

4e Total program service expenses ▶ 720,664,181

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

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

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

Table with columns for question ID, question text, and Yes/No response boxes. Includes sections for backup withholding, employee reporting, foreign accounts, prohibited tax shelter transactions, deductible contributions, and 501(c)(7), (12), and (29) organizations.

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

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

Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a (16), 1b (13), 2, 3, 4, 5, 6, 7a, 7b, 8a, 8b, 9.

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

Table with 3 columns: Question, Yes, No. Rows include: 10a, 10b, 11a, 11b, 12a, 12b, 12c, 13, 14, 15a, 15b, 16a, 16b.

Section C. Disclosure

Table with 3 columns: Question, Yes, No. Rows include: 17 (FL), 18 (Own website, Another's website, Upon request, Other), 19, 20 (WILLIAM A GIUDICE CFO 1300 MICCOSUKEE ROAD TALLAHASSEE, FL 323085054 (850) 431-5238).

Part VIII Statement of Revenue

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514	
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a					
	b Membership dues	1b					
	c Fundraising events	1c					
	d Related organizations	1d	2,679,772				
	e Government grants (contributions)	1e	809,325				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	235,325				
	g Noncash contributions included in lines 1a-1f \$ <u>48,841</u>						
	h Total. Add lines 1a-1f			3,724,422			
Program Service Revenue		Business Code					
	2a Health Care Services	621500	607,338,244	606,816,164	522,080		
	b _____						
	c _____						
	d _____						
	e _____						
	f All other program service revenue						
g Total. Add lines 2a-2f			607,338,244				
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		5,663,575			5,663,575	
	4 Income from investment of tax-exempt bond proceeds		0				
	5 Royalties		0				
	6a Gross rents	(i) Real	(ii) Personal				
		3,201,448					
		b Less rental expenses	3,816,556				
		c Rental income or (loss)	-615,108	0			
	d Net rental income or (loss)			-615,108	1,037,659	-1,652,767	
	7a Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other				
		13,409,399	1,041,373				
		b Less cost or other basis and sales expenses	13,225,172				
		c Gain or (loss)	184,227	1,041,373			
	d Net gain or (loss)			1,225,600		1,225,600	
	8a Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c) See Part IV, line 18	a	0				
		b Less direct expenses	b	0			
c Net income or (loss) from fundraising events				0			
9a Gross income from gaming activities See Part IV, line 19	a	0					
	b Less direct expenses	b	0				
	c Net income or (loss) from gaming activities			0			
10a Gross sales of inventory, less returns and allowances	a	271,437,742					
	b Less cost of goods sold	b	51,674,394				
	c Net income or (loss) from sales of inventory			219,763,348	219,763,348		
Miscellaneous Revenue		Business Code					
11a VENDOR REBATES		900099	2,276,124	2,276,124			
b PARKING DECK		900099	502,831	502,831			
c CONTRACTUAL LATE FEES		900099	223,046	223,046			
d All other revenue			546,242	546,242			
e Total. Add lines 11a-11d			3,548,243				
12 Total revenue. See Instructions			840,648,324	830,127,755	1,559,739	5,236,408	

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

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.				
1 Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21	201,302	201,302		
2 Grants and other assistance to domestic individuals See Part IV, line 22	0			
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, line 15 and 16	0			
4 Benefits paid to or for members	0			
5 Compensation of current officers, directors, trustees, and key employees	5,343,100	4,785,886	557,214	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	0			
7 Other salaries and wages	266,198,822	240,404,411	25,794,411	
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	3,872,919	3,559,604	313,315	
9 Other employee benefits	22,431,744	20,258,129	2,173,615	
10 Payroll taxes	18,354,167	16,575,665	1,778,502	0
11 Fees for services (non-employees)				
a Management	0			
b Legal	3,129,906	2,924,493	205,413	
c Accounting	966,059		966,059	
d Lobbying	93,548	93,548		
e Professional fundraising services See Part IV, line 17	0			
f Investment management fees	0			
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	79,248,436	73,616,560	5,631,876	
12 Advertising and promotion	1,616,487		1,616,487	
13 Office expenses	25,814,960	23,641,781	2,173,179	
14 Information technology	21,623,849	11,283,922	10,339,927	
15 Royalties	0			
16 Occupancy	7,135,194	5,961,597	1,173,597	
17 Travel	2,763,115	1,639,859	1,123,256	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials	0			
19 Conferences, conventions, and meetings	831,367	407,304	424,063	
20 Interest	6,328,642	6,328,642		
21 Payments to affiliates	0			
22 Depreciation, depletion, and amortization	31,816,813	28,498,950	3,317,863	
23 Insurance	15,268,391	15,035,427	232,964	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a BAD DEBT EXPENSE	133,296,557	133,296,557		
b PATIENT EXPENSE	99,248,440	99,248,440		
c SERVICE/MAINTENANCE	20,817,209	15,557,946	5,259,263	
d INDIGENT CARE ASSESSMENT	7,445,944	7,445,944		
e All other expenses	15,803,611	9,898,214	5,905,397	
25 Total functional expenses. Add lines 1 through 24e	789,650,582	720,664,181	68,986,401	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 <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year
Assets	1 Cash—non-interest-bearing	0	1	0
	2 Savings and temporary cash investments	278,623,043	2	307,702,627
	3 Pledges and grants receivable, net	0	3	0
	4 Accounts receivable, net	85,301,671	4	91,048,606
	5 Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L	0	5	0
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instructions) Complete Part II of Schedule L	0	6	0
	7 Notes and loans receivable, net	0	7	0
	8 Inventories for sale or use	9,995,841	8	10,225,267
	9 Prepaid expenses and deferred charges	15,842,483	9	16,862,080
	10a Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	850,657,915		
	b Less accumulated depreciation	404,399,456		
	11 Investments—publicly traded securities	0	11	0
	12 Investments—other securities See Part IV, line 11	27,300	12	27,300
	13 Investments—program-related See Part IV, line 11	0	13	0
	14 Intangible assets	0	14	0
	15 Other assets See Part IV, line 11	215,832,125	15	184,778,347
16 Total assets. Add lines 1 through 15 (must equal line 34)	962,184,865	16	1,056,902,686	
Liabilities	17 Accounts payable and accrued expenses	73,815,884	17	84,578,616
	18 Grants payable	0	18	0
	19 Deferred revenue	0	19	0
	20 Tax-exempt bond liabilities	374,194,885	20	369,293,175
	21 Escrow or custodial account liability Complete Part IV of Schedule D	0	21	0
	22 Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L	0	22	0
	23 Secured mortgages and notes payable to unrelated third parties	21,131,557	23	20,654,554
	24 Unsecured notes and loans payable to unrelated third parties	0	24	0
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24) Complete Part X of Schedule D	71,271,051	25	49,177,687
	26 Total liabilities. Add lines 17 through 25	540,413,377	26	523,704,032
Net Assets or Fund Balances	27 Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34. Unrestricted net assets	421,771,488	27	533,198,654
	28 Temporarily restricted net assets	0	28	0
	29 Permanently restricted net assets	0	29	0
	30 Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34. Capital stock or trust principal, or current funds		30	
	31 Paid-in or capital surplus, or land, building or equipment fund		31	
	32 Retained earnings, endowment, accumulated income, or other funds		32	
	33 Total net assets or fund balances	421,771,488	33	533,198,654
	34 Total liabilities and net assets/fund balances	962,184,865	34	1,056,902,686

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	840,648,324
2	Total expenses (must equal Part IX, column (A), line 25)	2	789,650,582
3	Revenue less expenses Subtract line 2 from line 1	3	50,997,742
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	421,771,488
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 in Schedule O)	9	60,429,424
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	533,198,654

Part XII Financial Statements and Reporting

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

		Yes	No
<p>1 Accounting method used to prepare the Form 990 <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other _____</p> <p>If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O</p>			
<p>2a Were the organization's financial statements compiled or reviewed by an independent accountant?</p> <p>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</p> <p><input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis</p>	2a		No
<p>b Were the organization's financial statements audited by an independent accountant?</p> <p>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</p> <p><input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis</p>	2b	Yes	
<p>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?</p> <p>If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O</p>	2c	Yes	
<p>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?</p>	3a		No
<p>b If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits</p>	3b		

Additional Data

Software ID:

Software Version:

EIN: 59-1917016

Name: TALLAHASSEE MEMORIAL HEALTHCARE INC

Form 990 (2017)

Form 990, Part III, Line 4a:

DESIGNED TO MEET THE DIVERSE HEALTH CARE NEEDS OF THE BIG BEND REGION, TALLAHASSEE MEMORIAL HEALTHCARE, INC (TMH) IS A COMPREHENSIVE, PRIVATE, NOT-FOR-PROFIT HEALTH CARE SYSTEM THAT SERVES 17 COUNTIES IN NORTH FLORIDA AND SOUTH GEORGIA TMH INCLUDES A 772-BED ACUTE CARE HOSPITAL AND HAS A TIME-HONORED COMMITMENT TO PROVIDING PATIENT-CENTERED, WORLD-CLASS HEALTH CARE TO ITS COMMUNITY WITHOUT REGARD TO A PATIENT'S ABILITY TO PAY TMH HOLDS A NUMBER OF IMPORTANT DISTINCTIONS WITHIN THE REGIONAL HEALTH SECTOR TMH IS HOME TO THE BIG BEND'S ONLY ACCREDITED COMMUNITY HOSPITAL CANCER PROGRAM AND THE REGION'S ONLY STATE-DESIGNATED TRAUMA CENTER TMH IS ALSO THE AREA'S ONLY HOSPITAL RECOGNIZED BY THE SOCIETY OF CHEST PAIN CENTERS AS AN ACCREDITED CHEST PAIN CENTER WITH PCI AND RESUSCITATION AS WELL AS AN ACCREDITED ATRIAL FIBRILLATION PROGRAM WITH EPS, BOTH THE HIGHEST ACCREDITATION LEVELS AVAILABLE BY THE AMERICAN COLLEGE OF CARDIOLOGY TMH IS LICENCED AS NORTH FLORIDA'S ONLY COMPREHENSIVE STROKE CENTER AND IS THE ONLY FACILITY IN THE REGION PERFORMING MINIMAL INVASIVE STROKE INTERVENTIONS TMH MAINTAINS THE AREA'S ONLY PEDIATRIC INTENSIVE CARE UNIT AND THE REGION'S ONLY NEONATAL INTENSIVE CARE UNIT IN ALL, TMH IS THE SEVENTH-LARGEST HOSPITAL IN FLORIDA WITH A MEDICAL STAFF OF 570 + PHYSICIANS REPRESENTING 50+ DIFFERENT SPECIALTIES TMH IS MANAGED BY A TEAM OF COMMUNITY CITIZENS WHO VOLUNTEER THEIR TIME AND EXPERTISE WITHOUT COMPENSATION THE TMH BOARD OF DIRECTORS IS COMMITTED TO ITS COMMUNITY SERVICE MISSION AND MEMBERS SERVE WITHOUT COMPENSATION THE ENERGY RESOURCES COMMITTED BY TMH AND ITS COLLEAGUES ARE PROOF OF THE FULFILLMENT OF ITS MISSION TRANSFORMING CARE ADVANCING HEALTH IMPROVING LIVES SEE SCHEDULE H, PART VI FOR ADDITIONAL DETAILS REGARDING SOME OF THE VARIOUS PROGRAM SERVICE ACCOMPLISHMENTS AND ADDITIONAL COMMUNITY BUILDING ACTIVITIES CONDUCTED BY TMH PART VI FOR ADDITIONAL DETAILS REGARDING SOME OF THE VARIOUS PROGRAM SERVICE ACCOMPLISHMENTS AND ADDITIONAL COMMUNITY BUILDING ACTIVITIES CONDUCTED BY TMH

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
STEVE EVANS CHAIR	2 0 1 0	X		X				0	0	0
CHRISTOPHER RUMANA MD CHAIR-ELECT	2 0 0 0	X		X				0	0	0
MARTHA BARNETT SECRETARY	2 0 0 0	X		X				0	0	0
LEE HINKLE TREASURER	2 0 0 0	X		X				0	0	0
WAYNE BATCHELOR MD DIRECTOR, INDEPENDENT PHYS	1 5 0 0	X						0	0	0
A J BRICKLER MD DIRECTOR, INDEPENDENT PHYS	1 5 0 0	X						0	0	0
BRANT COPELAND DIRECTOR	1 5 0 0	X						0	0	0
AVON DOLL MD DIRECTOR	1 5 0 0	X						0	0	0
KELLY DOZIER DIRECTOR	1 5 0 0	X						0	0	0
WINSTON HOWELL DIRECTOR	1 5 0 0	X						0	0	0

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
AVERY MCKNIGHT DIRECTOR	1 5 0 0	X						0	0	0
ED MURRAY JR DIRECTOR	1 5 0 0	X						0	0	0
MARY PANKOWSKI DIRECTOR	1 5 0 0	X						0	0	0
THOMAS TRUMAN MD DIRECTOR	1 5 0 0	X						0	0	0
GARY WINCHESTER MD DIRECTOR	1 5 0 0	X						0	0	0
ANDREW WONG MD DIRECTOR	1 5 0 0	X						0	0	0
SHELBY BLANK MD EX-OFFICIO DIRECTOR	1 0 0 0	X						0	0	0
GEORGEANN HARTSFIELD EX-OFFICIO DIRECTOR	1 0 0 0	X						0	0	0
SAM LESTER EX-OFFICIO DIRECTOR	1 0 0 0	X						0	0	0
G MARK O'BRYANT EX-OFFICIO DIRECTOR & CEO	53 0 2 0	X		X				1,093,898	0	283,033

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
WILLIAM GIUDICE CHIEF FINANCIAL OFFICER	54 0 1 0			X				571,367	0	86,978
BARBARA ALFORD CHIEF CLINICAL OFFICER/CNO/VP	55 0 0 0			X				371,973	0	62,128
CYNTHIA BLAIR CHIEF IMPROVEMENT/PLNG OFFICER	55 0 0 0			X				251,510	0	15,091
STEPHANIE M DERZYPOLSKI CHIEF COMMUNICATION OFFICER	55 0 0 0			X				210,182	0	33,431
ANDREA K FRIALL MD CHIEF MEDICAL STAFF OFFICER	15 0 0 0			X				175,011	0	0
DONALD LINDSEY CHIEF INFORMATION OFFICER	55 0 0 0			X				260,451	0	36,882
MICKEY S MOORE- THRU 72018 CHIEF ADVANCEMENT OFFICER	0 0 0 0			X				194,229	0	17,921
DEAN WATSON MD CHIEF HEALTH OPS OFFICER	55 0 0 0			X				487,374	0	71,051
YASHICA L WILSON-HEARNS VP/SUPPORT SERVICES	55 0 0 0			X				158,415	0	9,759
JOSEPH L CAMPS MD CHIEF INTEGRATION OFFICER/VP	55 0 0 0			X				114,434	0	0

Form 990, Part VII - Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W- 2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
STEVEN E HAYNES CHIEF HUMAN RESOURCE OFFICER	55 0 0 0			X				210,257	0	10,619
OVIDIU MARINA MD RADIATION ONCOLOGIST	55 0 0 0					X		1,189,734	0	26,068
PHILIP V SHARP MD RADIATION ONCOLOGIST	55 0 0 0					X		1,004,576	0	28,278
ELIOT B SIELOFF MD GENERAL SURGEON	55 0 0 0					X		946,966	0	10,375
WILLIAM DOBAK MD HEMATOLOGIST/ONCOLOGIST	55 0 0 0					X		761,301	0	11,252
DHANANJAY D BENDRE MD RADIATION ONCOLOGIST	55 0 0 0					X		754,837	0	27,884
JASON MOORE FORMER CHIEF OPERATING OFFICER	0 0 0 0						X	208,827	0	18,750
ROBERT L MOORE FORMER CHIEF HR OFFICER	0 0 0 0						X	133,535	0	8,012

SCHEDULE A
(Form 990 or 990EZ)

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.

2017

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

Name of the organization

TALLAHASSEE MEMORIAL HEALTHCARE INC

Employer identification number

59-1917016

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

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

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

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

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

(Complete only if you checked the box on line 5, 7, 8, or 9 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

Section A. Public Support

	Calendar year (or fiscal year beginning in) ▶	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
1	Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant.")	2,325,227	1,892,594	1,602,289	1,171,428	3,724,422	10,715,960
2	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						0
3	The value of services or facilities furnished by a governmental unit to the organization without charge						0
4	Total. Add lines 1 through 3	2,325,227	1,892,594	1,602,289	1,171,428	3,724,422	10,715,960
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)						0
6	Public support. Subtract line 5 from line 4						10,715,960

Section B. Total Support

	Calendar year (or fiscal year beginning in) ▶	(a)2013	(b)2014	(c)2015	(d)2016	(e)2017	(f)Total
7	Amounts from line 4	2,325,227	1,892,594	1,602,289	1,171,428	3,724,422	10,715,960
8	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources	248,809	263,585	105,160	287,579	5,048,467	5,953,600
9	Net income from unrelated business activities, whether or not the business is regularly carried on	1,038,869	1,016,454	1,134,955	1,091,544		4,281,822
10	Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI.)	702,166	779,852	947,112	844,761	1,061,393	4,335,284
11	Total support. Add lines 7 through 10						25,286,666
12	Gross receipts from related activities, etc (see instructions)					12	3,784,356,863

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

Section C. Computation of Public Support Percentage

14	Public support percentage for 2017 (line 6, column (f) divided by line 11, column (f))	14	42.378%
15	Public support percentage for 2016 Schedule A, Part II, line 14	15	46.070%

16a 33 1/3% support test—2017. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization

b 33 1/3% support test—2016. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization

17a 10%-facts-and-circumstances test—2017. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization

b 10%-facts-and-circumstances test—2016. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test The organization qualifies as a publicly supported organization

18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions

Part III Support Schedule for Organizations Described in Section 509(a)(2)

(Complete only if you checked the box on line 10 of Part I or if the organization failed to qualify under Part II. If the organization fails to qualify under the tests listed below, please complete Part II.)

Section A. Public Support

Calendar year (or fiscal year beginning in) ►		(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
1	Gifts, grants, contributions, and membership fees received (Do not include any "unusual grants.")						
2	Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3	Gross receipts from activities that are not an unrelated trade or business under section 513						
4	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5	The value of services or facilities furnished by a governmental unit to the organization without charge						
6	Total. Add lines 1 through 5						
7a	Amounts included on lines 1, 2, and 3 received from disqualified persons						
b	Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of \$5,000 or 1% of the amount on line 13 for the year						
c	Add lines 7a and 7b						
8	Public support. (Subtract line 7c from line 6)						

Section B. Total Support

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

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

Section C. Computation of Public Support Percentage

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

Section D. Computation of Investment Income Percentage

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

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

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

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations (continued)

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

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

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

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

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

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

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

Additional Data

Software ID:

Software Version:

EIN: 59-1917016

Name: TALLAHASSEE MEMORIAL HEALTHCARE INC

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

Facts And Circumstances Test

SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities
For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶Complete if the organization is described below. ▶Attach to Form 990 or Form 990-EZ.
▶Information about Schedule C (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047

2017

Open to Public Inspection

If the organization answered "Yes" on Form 990, Part IV, Line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then
 ● Section 501(c)(3) organizations Complete Parts I-A and B Do not complete Part I-C
 ● Section 501(c) (other than section 501(c)(3)) organizations Complete Parts I-A and C below Do not complete Part I-B
 ● Section 527 organizations Complete Part I-A only
If the organization answered "Yes" on Form 990, Part IV, Line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then
 ● Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)) Complete Part II-A Do not complete Part II-B
 ● Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)) Complete Part II-B Do not complete Part II-A
If the organization answered "Yes" on Form 990, Part IV, Line 5 (Proxy Tax) (see separate instructions) or Form 990-EZ, Part V, line 35c (Proxy Tax) (see separate instructions), then
 ● Section 501(c)(4), (5), or (6) organizations Complete Part III

Name of the organization TALLAHASSEE MEMORIAL HEALTHCARE INC	Employer identification number 59-1917016
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Part I-A Complete if the organization is exempt under section 501(c) or is a section 527 organization.

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

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

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

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

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

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

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

- A** Check if the filing organization belongs to an affiliated group (and list in Part IV each affiliated group member's name, address, EIN, expenses, and share of excess lobbying expenditures)
- B** Check if the filing organization checked box A and "limited control" provisions apply

Limits on Lobbying Expenditures
(The term "expenditures" means amounts paid or incurred.)

	(a) Filing organization's totals	(b) Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)	0	0
b Total lobbying expenditures to influence a legislative body (direct lobbying)	93,548	93,548
c Total lobbying expenditures (add lines 1a and 1b)	93,548	93,548
d Other exempt purpose expenditures	789,557,034	793,193,256
e Total exempt purpose expenditures (add lines 1c and 1d)	789,650,582	793,286,804
f Lobbying nontaxable amount Enter the amount from the following table in both columns	1,000,000	1,000,000

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

- g** Grassroots nontaxable amount (enter 25% of line 1f) 250,000
- h** Subtract line 1g from line 1a If zero or less, enter -0- 250,000
- i** Subtract line 1f from line 1c If zero or less, enter -0-
- j** If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year? Yes No

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

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) Total
2a Lobbying nontaxable amount	1,000,000	1,000,000	1,000,000	1,000,000	4,000,000
b Lobbying ceiling amount (150% of line 2a, column(e))					6,000,000
c Total lobbying expenditures	133,289	97,499	79,152	93,548	403,488
d Grassroots nontaxable amount	250,000	250,000	250,000	250,000	1,000,000
e Grassroots ceiling amount (150% of line 2d, column (e))					1,500,000
f Grassroots lobbying expenditures	0	0	0	0	0

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

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

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

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

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

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

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

Part IV Supplemental Information

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

Return Reference	Explanation
FORM 990, SCHEDULE C, PART II-A, LINE 1	SUPPLEMENTAL INFORMATION REGARDING LOBBYING EXPENSES LOBBYING EXPENSES INCURRED INCLUDE MEETING WITH LOCAL CITY AND COUNTY OFFICIALS AND LEGISLATORS IN ORDER TO SECURE APPROPRIATED FUNDS FOR THE LEVEL II TRAUMA CENTER, AS WELL AS PORTIONS OF VHA AND FLORIDA HOSPITAL ASSOCIATION (FHA) MEMBERSHIP DUES ALLOCATED TO LOBBYING EXPENSES

TY 2017 AffiliatedGroupAttachment

Name: TALLAHASSEE MEMORIAL HEALTHCARE INC

EIN: 59-1917016

Explanation: DIRECT OTHER LOBBYING EXEMPT PURPOSE NAME OF ELECTING ORGANIZATION EXPENDITURES EXPENDITURES

 TALLAHASSEE MEMORIAL HEALTHCARE INC. \$
 93,548 \$789,557,034 THIS ORGANIZATION HAS MADE THE
 LOBBYING ELECTION UNDER I.R.C. SECTION 501(H) FOR THE
 TAX YEAR ENDED SEPTEMBER 30, 2018. THIS ELECTION HAS
 NOT BEEN REVOKED BEFORE THE START OF THE
 ORGANIZATION'S TAX YEAR THAT BEGAN IN 2017. -----
 ----- DIRECT OTHER LOBBYING EXEMPT
 PURPOSE NAME OF NON-ELECTING ORGANIZATION
 EXPENDITURES EXPENDITURES

 SOUTHEAST COMMUNITY HEALTH SRVS, INC. \$
 NONE \$ 158,889 TALLAHASSEE MEMORIAL HEALTHCARE FND.
 NONE 3,477,333 ----- \$ NONE \$ 3,636,222
 TOTALS \$ 93,548 \$793,193,256 =====
 =====

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.
Information about Schedule D (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047
2017
Open to Public Inspection

Name of the organization
TALLAHASSEE MEMORIAL HEALTHCARE INC

Employer identification number
59-1917016

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 (e g , recreation or education) Preservation of an historically important land area

Protection of natural habitat Preservation of a certified historic structure

Preservation of open space

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

	Held at the End of the Year	
a Total number of conservation easements	2a	
b Total acreage restricted by conservation easements	2b	
c Number of conservation easements on a certified historic structure included in (a)	2c	
d Number of conservation easements included in (c) acquired after 8/17/06, and not on a historic structure listed in the National Register	2d	

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part IV Escrow and Custodial Arrangements.

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

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

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance	7,958,119	7,521,314	7,134,085	9,171,531	8,953,457
b Contributions	251,445	256,272	195,126	375,335	23,477
c Net investment earnings, gains, and losses	164,009	181,583	198,103	94,119	194,597
d Grants or scholarships					
e Other expenditures for facilities and programs	3,500	1,050	6,000	2,506,900	
f Administrative expenses					
g End of year balance	8,370,073	7,958,119	7,521,314	7,134,085	9,171,531

- 2** Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as
- a** Board designated or quasi-endowment ▶
 - b** Permanent endowment ▶ 100 000 %
 - c** Temporarily restricted endowment ▶
- The percentages on lines 2a, 2b, and 2c should equal 100%
- 3a** Are there endowment funds not in the possession of the organization that are held and administered for the organization by
- | | | |
|--|------------|-----------|
| (i) unrelated organizations | Yes | No |
| 3a(i) | Yes | |
| (ii) related organizations | | |
| 3a(ii) | | No |
- b** If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R?
- 3b**
- 4** Describe in Part XIII the intended uses of the organization's endowment funds

Part VI Land, Buildings, and Equipment.

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

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		21,958,581		21,958,581
b Buildings		343,445,362	186,750,587	156,694,775
c Leasehold improvements		7,573,242	3,020,479	4,552,763
d Equipment		283,177,631	214,628,390	68,549,241
e Other		194,503,099		194,503,099
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c)) . . . ▶				446,258,459

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

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

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

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

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

(a) Description	(b) Book value
(1) DEBT RESERVE FUND	8,072,328
(2) DEPOSITS AND OTHER ASSETS	62,473,609
(3) OTHER RECEIVABLES	11,243,021
(4) SELF INSURANCE TRUST FUND	5,152,844
(5) UNEXPENDED CONSTRUCTION FUND	97,836,545
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 15.)	184,778,347

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.

(a) Description of liability	(b) Book value
(1) Federal income taxes	0
WORKER'S COMP SELF INSURANCE	1,874,079
PROFESSIONAL LIABILITY SELF IN	23,298,918
OBLIGATION FOR SUPPLEMENTAL EX	3,712,369
DEFERRED COMP ARRANGEMENT	3,328,572
ASSET RETIREMENT OBLIGATION	380,000
AHCA ASSESSMENT	3,833,425
OTHER LIABILITIES	11,448,853
SECURITY DEPOSITS	2,500
DUE TO MEDICARE	1,298,971
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.)	49,177,687

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

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

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

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

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

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

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

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

Additional Data

Software ID:

Software Version:

EIN: 59-1917016

Name: TALLAHASSEE MEMORIAL HEALTHCARE INC

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

1 (a) Description of Liability	(b) Book Value
WORKER'S COMP SELF INSURANCE	1,874,079
PROFESSIONAL LIABILITY SELF IN	23,298,918
OBLIGATION FOR SUPPLEMENTAL EX	3,712,369
DEFFERRED COMP ARRANGEMENT	3,328,572
ASSET RETIREMENT OBLIGATION	380,000
AHCA ASSESSMENT	3,833,425
OTHER LIABILITIES	11,448,853
SECURITY DEPOSITS	2,500
DUE TO MEDICARE	1,298,971

Supplemental Information

Return Reference	Explanation
FORM 990, SCHEDULE D, PART V, LINE 4	INTENDED USE OF ENDOWMENT FUNDS ALL ENDOWMENT FUNDS ARE UTILIZED IN PURSUIT OF THE ORGANIZATION'S TAX EXEMPT PURPOSE -----

**SCHEDULE F
(Form 990)**

Statement of Activities Outside the United States

OMB No 1545-0047

2017

**Open to Public
Inspection**

Department of the Treasury
Internal Revenue Service

- ▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 14b, 15, or 16.
- ▶ Attach to Form 990.
- ▶ Information about Schedule F (Form 990) and its instructions is at www.irs.gov/form990.

Name of the organization
TALLAHASSEE MEMORIAL HEALTHCARE INC

Employer identification number
59-1917016

Part I **General Information on Activities Outside the United States.** Complete if the organization answered "Yes" to Form 990, Part IV, line 14b.

1 For grantmakers. Does the organization maintain records to substantiate the amount of its grants and other assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? Yes No

2 For grantmakers. Describe in Part V the organization's procedures for monitoring the use of its grants and other assistance outside the United States

3 Activities per Region (The following Part I, line 3 table can be duplicated if additional space is needed)

(a) Region	(b) Number of offices in the region	(c) Number of employees, agents, and independent contractors in region	(d) Activities conducted in region (by type) (e.g., fundraising, program services, investments, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for and investments in region
(1) Central America and the Caribbean	0	0	Program Services	Insurance Coverage	453,810
(2)					
(3)					
(4)					
(5)					
3a Sub-total	0	0			453,810
b Total from continuation sheets to Part I					
c Totals (add lines 3a and 3b)	0	0			453,810

Part II Grants and Other Assistance to Organizations or Entities Outside the United States. Complete if the organization answered "Yes" to Form 990, Part IV, line 15, for any recipient who received more than \$5,000. Part II can be duplicated if additional space is needed.

1	(a) Name of organization	(b) IRS code section and EIN (if applicable)	(c) Region	(d) Purpose of grant	(e) Amount of cash grant	(f) Manner of cash disbursement	(g) Amount of non-cash assistance	(h) Description of non-cash assistance	(i) Method of valuation (book, FMV, appraisal, other)
(1)									
(2)									
(3)									
(4)									

2 Enter total number of recipient organizations listed above that are recognized as charities by the foreign country, recognized as tax-exempt by the IRS, or for which the grantee or counsel has provided a section 501(c)(3) equivalency letter ▶ _____

3 Enter total number of other organizations or entities ▶ _____

Part III Grants and Other Assistance to Individuals Outside the United States. Complete if the organization answered "Yes" to Form 990, Part IV, line 16.

Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Region	(c) Number of recipients	(d) Amount of cash grant	(e) Manner of cash disbursement	(f) Amount of non-cash assistance	(g) Description of non-cash assistance	(h) Method of valuation (book, FMV, appraisal, other)
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							
(13)							
(14)							
(15)							
(16)							
(17)							
(18)							

Part IV Foreign Forms

- 1 Was the organization a U S transferor of property to a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 926, Return by a U S Transferor of Property to a Foreign Corporation (see Instructions for Form 926)* Yes No
- 2 Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to separately file Form 3520, Annual Return to Report Transactions with Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U S Owner (see Instructions for Forms 3520 and 3520-A, do not file with Form 990)* Yes No
- 3 Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U S Persons with Respect to Certain Foreign Corporations (see Instructions for Form 5471)* Yes No
- 4 Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund (see Instructions for Form 8621)* Yes No
- 5 Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U S Persons with Respect to Certain Foreign Partnerships (see Instructions for Form 8865)* Yes No
- 6 Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to separately file Form 5713, International Boycott Report (see Instructions for Form 5713, do not file with Form 990)* Yes No

SCHEDULE H (Form 990)
 Department of the Treasury
 Internal Revenue Service
Name of the organization
 TALLAHASSEE MEMORIAL HEALTHCARE INC

Hospitals

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, question 20.**
 ▶ **Attach to Form 990.**
 ▶ **Information about Schedule H (Form 990) and its instructions is at www.irs.gov/form990.**

Employer identification number
 59-1917016

OMB No 1545-0047
2017
Open to Public Inspection

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

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)			24,851,786		24,851,786	3 790 %
b Medicaid (from Worksheet 3, column a)			79,389,612	55,643,082	23,746,530	3 610 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			104,241,398	55,643,082	48,598,316	7 400 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)						
f Health professions education (from Worksheet 5)			22,888,269	3,859,613	19,028,656	2 900 %
g Subsidized health services (from Worksheet 6)			86,545,700	57,216,790	29,328,910	4 470 %
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j Total. Other Benefits			109,433,969	61,076,403	48,357,566	7 370 %
k Total. Add lines 7d and 7j			213,675,367	116,719,485	96,955,882	14 770 %

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing						
2 Economic development						
3 Community support			438,468		438,468	0.070 %
4 Environmental improvements						
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development						
9 Other						
10 Total			438,468		438,468	0.070 %

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

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

Section B. Medicare

5 Enter total revenue received from Medicare (including DSH and IME).	5	111,518,239
6 Enter Medicare allowable costs of care relating to payments on line 5.	6	117,338,312
7 Subtract line 6 from line 5. This is the surplus (or shortfall).	7	-5,820,073
8 Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other		

Section C. Collection Practices

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

Part IV Management Companies and Joint Ventures

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

Part V Facility Information**Section A. Hospital Facilities**

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

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

1

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

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

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)
TALLAHASSEE MEMORIAL HEALTHCARE INC

Name of hospital facility or letter of facility reporting group _____

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): _____ 1

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

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

TALLAHASSEE MEMORIAL HEALTHCARE INC

Name of hospital facility or letter of facility reporting group _____

		Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that		
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP	13 Yes	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>150</u> % and FPG family income limit for eligibility for discounted care of <u>400</u> %		
b	<input checked="" type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input checked="" type="checkbox"/> Asset level		
d	<input type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance discount		
g	<input type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	14 Yes	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)	15 Yes	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply)	16 Yes	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url) <u>SEE SCH H, PART V, SECTION C</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url) <u>SEE SCH H, PART V, SECTION C</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url) <u>SEE SCH H, PART V, SECTION C</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
j	<input type="checkbox"/> Other (describe in Section C)		

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

TALLAHASSEE MEMORIAL HEALTHCARE INC

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

TALLAHASSEE MEMORIAL HEALTHCARE INC

Name of hospital facility or letter of facility reporting group _____

- 22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care
- a** The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
 - b** The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
 - c** The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
 - d** The hospital facility used a prospective Medicare or Medicaid method

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

If "Yes," explain in Section C

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

If "Yes," explain in Section C

	Yes	No
22		
23		No
24		No

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

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

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

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

Part VI Supplemental Information

Provide the following information

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

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7 (BAD DEBT EXPENSE COSTING METHODOLOGY USED)	<p>THE BAD DEBT EXPENSE AMOUNT INCLUDED ON FORM 990, PART IX, COLUMN 25(A) WAS \$133,296,557 FOR THE YEAR ENDED SEPTEMBER 30, 2018 THE COSTING METHODOLOGY USED IN CALCULATING THE AMOUNTS REPORTED ON THE LINE 7 TABLE ARE BASED ON A COST TO CHARGE RATIO THE COST TO CHARGE RATIO WAS DERIVED FROM WORKSHEET 2 ----- PART II (DETAIL OF COMMUNITY BUILDING ACTIVITIES) AS PART OF ITS COMMUNITY BENEFIT PROGRAM, TMH AND ITS COLLEAGUES CONTRIBUTE BOTH TIME AND DOLLARS TO A VARIETY OF LOCAL NONPROFIT ORGANIZATIONS, PARTICULARLY THOSE WHOSE MISSIONS HELP IMPROVE THE HEALTH AND WELFARE OF OUR COMMUNITY DURING THE FISCAL YEAR, TMH CONTRIBUTED SIGNIFICANTLY IN CASH AND IN-KIND DONATIONS, INCLUDING ADMINISTRATIVE SUPPORT, TO MORE THAN 25 DIFFERENT NONPROFIT ORGANIZATIONS SOME OF THE ORGANIZATIONS THAT BENEFITTED FROM THE GENEROSITY OF TMH COLLEAGUES WERE THE FOLLOWING AMERICAN CANCER SOCIETY AMERICAN HEART ASSOCIATION AMERICAN RED CROSS BIG BEND HOSPICE, INC BIG BEND CARES, INC BOY SCOUTS OF AMERICA CAPITAL MEDICAL SOCIETY CHILDREN'S HOME SOCIETY DOWN'S SYNDROME ASSOCIATION ELDER CARE SERVICES, INC FLORIDA A & M UNIVERSITY FOUNDATION, INC FOUNDATION FOR LEON COUNTY SCHOOLS FSU DANCE MARATHON /CHILDREN'S MIRACLE NETWORK FSU RESEARCH FOUNDATION, INC HEALTHY START COALITION MACLAY SCHOOL FOUNDATION, INC MARCH OF DIMES MEALS ON WHEELS RONALD MCDONALD HOUSE ROTARY CLUB SICKLE CELL FOUNDATION TALLAHASSEE CHAMBER OF COMMERCE TALLAHASSEE COMMUNITY COLLEGE FOUNDATION TALLAHASSEE SENIOR CENTER UNITED WAY OF THE BIG BEND WHOLE CHILD LEON, INC -----</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, SECTION A, LINE 1 (BAD DEBT EXPENSE)	TMH REPORTS BAD DEBT EXPENSE IN ACCORDANCE WITH GAAP AND AICPA GUIDELINES HFMA STATEMENT NO 15 HAS NOT BEEN ADOPTED BY THE AICPA ----- PART III, SECTION A, LINE 2 (BAD DEBT EXPENSE METHODOLOGY) THE COSTING METHODOLOGY USED IN DETERMINING THE AMOUNTS REPORTED ON LINES 2 AND 3 ARE BASED ON ACTUAL CHARGES WRITTEN OFF (AMOUNTS THAT ARE DEEMED TO BE UNCOLLECTIBLE) -----

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, SECTION A, LINE 4 (BAD DEBT EXPENSE FOOTNOTE)	THE BAD DEBT EXPENSE FOOTNOTE DISCLOSURE CAN BE FOUND ON PAGE 9 OF THE ELECTRONICALLY ATTACHED FINANCIAL STATEMENTS FOR TALLAHASSEE MEMORIAL HEALTHCARE, INC & SUBSIDIARIES -----

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, SECTION B (COSTING METHODOLOGY, MEDICARE SHORTFALL)	THE COSTING METHODOLOGY USED IN DETERMINING THE AMOUNT REPORTED ON LINE 6 IS BASED ON THE HOSPITAL'S MEDICARE COST REPORT FILING FOR THE YEAR CONSISTENT WITH THE CHARITABLE HEALTHCARE MISSION OF TMH AND THE COMMUNITY BENEFIT STANDARD SET FORTH IN IRS REVENUE RULING 69-545, TMH PROVIDES CARE FOR ALL PATIENTS COVERED BY MEDICARE SEEKING MEDICAL CARE SUCH CARE IS PROVIDED REGARDLESS OF WHETHER THE REIMBURSEMENT PROVIDED FOR SUCH SERVICES MEETS OR EXCEEDS THE COSTS INCURRED BY TMH TO PROVIDE SUCH SERVICES AS A RESULT, TMH VIEWS ANY SHORTFALL REPORTED IN LINE 7 AS AN ADDITIONAL ITEM OF COMMUNITY BENEFIT PROVIDED BY THE ORGANIZATION -----

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, SECTION B, LINE 9B (COLLECTION PRACTICES)	THE HOSPITAL PROVIDES CARE TO PATIENTS WHO MEET CERTAIN CRITERIA UNDER ITS CHARITY CARE POLICY WITHOUT CHARGE OR AT AMOUNTS LESS THAN ITS ESTABLISHED RATES THE HOSPITAL DOES NOT PURSUE COLLECTION OF AMOUNTS DETERMINED TO QUALIFY AS CHARITY CARE -----

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 2 (NEEDS ASSESSMENT)	SEE RESPONSE TO PART V, SECTION B, LINE 5 (INPUT FROM COMMUNITY) AND PART VI, LINE 4 (COMMUNITY INFORMATION) -----

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 3 (PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE)	<p>TMH ATTEMPTS TO EDUCATE ALL PATIENTS, OR THEIR GUARANTORS, ABOUT THEIR FINANCIAL RESPONSIBILITY, AS WELL AS THEIR OPTIONS AND OPPORTUNITIES FOR ASSISTANCE WITH HOSPITAL BILLS ALL PATIENTS ARE GIVEN THE OPPORTUNITY TO RECEIVE A GOOD FAITH ESTIMATE OF SERVICES TO BE PROVIDED ALONG WITH INFORMATION ABOUT FINANCIAL ASSISTANCE SIGNS ARE POSTED IN CENTRAL REGISTRATION, AS WELL AS OTHER ENTRY POINTS IN THE HOSPITAL, PROVIDING PATIENTS WITH A PHONE NUMBER TO CALL FOR THIS INFORMATION THOSE PATIENTS WHO ARE UNINSURED ARE ASKED TO COMPLETE A BRIEF APPLICATION FOR FINANCIAL ASSISTANCE IT IS THROUGH THIS APPLICATION THAT TMH CAN ASSESS THE PATIENT'S NEED FOR FINANCIAL ASSISTANCE OR PROGRAM ELIGIBILITY A PATIENT MAY BE REFERRED TO nTHRIVE, WHICH IS A CONTRACTED COMPANY THAT PROVIDES MEDICAID ELIGIBILITY SERVICES TO THE HOSPITAL FOR THOSE WHO DO NOT SPEAK ENGLISH, TRANSLATION SERVICES ARE AVAILABLE WHEN AN UNINSURED PATIENT PRESENTS IN A NON-EMERGENT SETTING, A FINANCIAL APPLICATION IS COMPLETED AND REVIEWED BY A CUSTOMER SERVICE REPRESENTATIVE VARIOUS OPTIONS, RANGING FROM VOCATIONAL REHAB TO PAYMENT PLANS BASED ON A SLIDING FEE SCHEDULE, TO REFERRAL TO THE WECARE NETWORK, WHICH OFFERS FREE CARE, ARE EXPLORED IN THE EVENT THAT THE PATIENT WOULD QUALIFY FOR MEDICAID, A REFERRAL IS MADE TO NTHRIVE NTHRIVE, THROUGH THE STATE OF FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES SERVICES, ASSISTS PATIENTS IN COMPLETING THE MEDICAID APPLICATION IF THE PATIENT IS DISABLED, OR GOING TO BE DISABLED FOR AT LEAST A YEAR, NTHRIVE WILL ASSIST THE PATIENT IN APPLYING FOR DISABILITY IF A PATIENT PRESENTS TO THE EMERGENCY ROOM, CARE IS PROVIDED PRIOR TO ASCERTAINING THE PATIENT'S COVERAGE AND/OR ABILITY TO PAY ONCE THE PATIENT IS STABILIZED, THE STEPS OUTLINED FOR THE NON-EMERGENT SETTING ARE TAKEN IN THE EVENT THAT A PATIENT DOES NOT QUALIFY FOR ANY STATE/FEDERAL PROGRAMS, AND IS UNINSURED, A CHARITY APPLICATION IS COMPLETED IT IS THROUGH THIS PROCESS THAT A DETERMINATION IS MADE AS TO WHETHER THE PATIENT QUALIFIES FOR CHARITY OR THE SLIDING FEE SCHEDULE THE HOSPITAL SPONSORED FINANCIAL ASSISTANCE PROGRAM (FAP) IS AVAILABLE FOR UNINSURED AND UNDERINSURED PATIENTS FAP IS A CHARITY AND SLIDING SCALE DISCOUNT PROGRAM BASED ON THE PATIENT'S FAMILY INCOME AND HOUSEHOLD SIZE PATIENTS WITH FAMILY INCOMES AT OR BELOW 150% OF THE FEDERAL POVERTY GUIDELINES OR WHOSE CHARGES EXCEED 25% OF THE ANNUAL FAMILY INCOME ARE ELIGIBLE FOR 100 % CHARITY OR FREE CARE PATIENTS WITH FAMILY INCOMES BETWEEN 151% AND 400 % OF THE FEDERAL POVERTY GUIDELINES ARE ELIGIBLE FOR SLIDING SCALE DISCOUNTS THESE UNINSURED PATIENTS WILL BE RESPONSIBLE FOR A PERCENTAGE OF HOSPITAL CHARGES DETERMINED BY INCOME AND FAMILY SIZE THE STATE OF FLORIDA HAS RECOGNIZED THE HIGH LEVEL OF UNCOMPENSATED CARE PROVIDED BY TMH BY DESIGNATING TMH AS A MEDICAID DISPROPORTIONATE SHARE PROVIDER APPROXIMATELY 3% OF TMH'S GROSS REVENUES ARE PROVIDED WITHOUT COMPENSATION TO INDIGENT PATIENTS WITH NO FUNDING SOURCE AND ANOTHER 11 % OF THE GROSS REVENUES ARE GENERATED BY SERVICES TO PATIENTS COVERED UNDER THE MEDICAID PROGRAM AND MEDICAID HMOS A COPY OF OUR FINANCIAL ASSISTANCE POLICY, APPLICATION AND PLAIN LANGUAGE SUMMARY CAN BE ACCESSED AT https //www tmh org/patients-and-visitors/transparency-billing-and-quality -----</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 4 (COMMUNITY INFORMATION)	TMH IS LOCATED IN THE CAPITAL CITY OF TALLAHASSEE, FLORIDA, IN THE HEART OF THE STATE'S PANHANDLE TMH'S PRIMARY SERVICE AREA IS A FOUR-COUNTY REGION (PSA) CONTAINING LEON, GADSDEN, WAKULLA, AND JEFFERSON COUNTIES WITH A POPULATION GREATER THAN 375,000 LEON COUNTY IS THE LARGEST COUNTY IN THE PSA REPRESENTING 75% OF THE FOUR COUNTY POPULATION BASED IN LEON COUNTY, TMH SERVES A TRULY DIVERSE POPULATION WITHIN THE FOUR-COUNTY REGION, THE UNEMPLOYMENT RATE RANGES FROM 3.3% TO 4.6% THE NUMBER OF CHILDREN IN POVERTY RANGES FROM 18% IN LEON COUNTY TO 39% IN GADSDEN COUNTY THE COLLEGE EDUCATION RATE IS STARKLY DIFFERENT IN THE SURROUNDING COUNTIES (AVERAGE OF 18.4%) COMPARED TO LEON COUNTY AT 45.5% THE HOUSEHOLD INCOME IN THESE FOUR COUNTIES RANGES FROM \$39,830 TO \$57,866 (SOURCE FLORIDA OFFICE OF ECONOMIC & DEMOGRAPHIC RESEARCH)

Form and Line Reference	Explanation
PART VI, LINE 5 (INFORMATION REGARDING PROMOTION OF COMMUNITY HEALTH)	<p>AS THE LARGEST SAFETY NET HOSPITAL IN THE SERVICE AREA SPANNING 17 COUNTIES IN NORTH FLORIDA AND SOUTH GEORGIA, TMH HAS A LONG HISTORY OF IMPROVING HEALTH AND QUALITY OF LIFE THROUGHOUT THE REGION. DURING FISCAL YEAR 2018, TMH EXPANDED ACCESS TO CARE BY BRINGING NEW PHYSICIANS FACILITIES AND TECHNOLOGIES TO THE AREA AND REACHED THE COMMUNITY WITH EDUCATIONAL EVENTS AND INITIATIVES. SUBSIDIZED MEDICAL CARE AS A NOT-FOR-PROFIT COMMUNITY HEALTHCARE SYSTEM, TMH OFTEN SUBSIDIZES HEALTH SERVICES THAT DO NOT GENERATE A POSITIVE OPERATING MARGIN BUT ARE NEEDED IN THE COMMUNITY. THE MAJORITY OF THESE SERVICES ARE PROVIDED BY THE METABOLIC HEALTH CENTER, THE TRANSITION CENTER, THE BIXLER TRAUMA & EMERGENCY, THE EMERGENCY CENTER - NORTHEAST AND RURAL CLINICS THROUGHOUT THE BIG BEND THROUGH CLASSES AND INDIVIDUAL OR FAMILY COUNSELING SESSIONS ON TOPICS SUCH AS MANAGING AND TESTING BLOOD SUGAR CHOOSING HEALTHY FOODS, AND STARTING INSULIN AND NUTRITION THERAPY, THE DIABETES CENTER, LOCATED WITHIN THE METABOLIC HEALTH CENTER, HELPS PATIENTS BETTER MANAGE THEIR CONDITION AND AVOID COMPLICATIONS. NEARLY A THIRD OF THE DIABETES CENTER PATIENTS ACCESS CARE THROUGH SUBSIDIZED SERVICES. AN INNOVATIVE FACILITY DESIGNED TO REDUCE EMERGENCY ROOM VISITS AND HOSPITAL READMISSIONS, THE TRANSITION CENTER PROVIDES FOLLOW-UP CARE TO PATIENTS WHO MAY BE AT HIGH RISK FOR READMISSION AFTER LEAVING THE HOSPITAL. TMH'S RURAL CLINICS, INCLUDING FAMILY MEDICINE PRACTICES IN GADSDEN, JEFFERSON, TAYLOR, WAKULLA, AND CALHOUN COUNTIES ENSURE PATIENTS IN TALLAHASSEE'S SURROUNDING COMMUNITIES ARE ABLE TO RECEIVE CARE CLOSE TO HOME. SINCE 2009, THE BIXLER TRAUMA & EMERGENCY CENTER HAS OPERATED AS THE REGION'S ONLY LEVEL II TRAUMA CENTER. IN 2013, TMH ALSO OPENED THE EMERGENCY CENTER - NORTHEAST, EXPANDING EMERGENCY CARE OPTIONS FOR OUR SERVICE AREA. IMPROVING ACCESS TO HEALTHCARE. TMH HAS MADE MANY INVESTMENTS IN ORDER TO OFFER THE COMMUNITY GREATER ACCESS TO NEEDED HEALTHCARE SERVICES. IN ADDITION TO THE ESTABLISHMENT OF THE TRANSITION CENTER AND THE RECENT OPENING OF THE EMERGENCY CENTER - NORTHEAST, TELEMEDICINE TECHNOLOGIES AND THE CONTINUAL DEVELOPMENT OF RESIDENCY PROGRAMS ALLOW MORE PEOPLE TO RECEIVE CARE AT TMH. VIRTUAL HEALTHCARE TOOLS KNOWN AS TELEMEDICINE ALLOW PHYSICIANS AND HEALTHCARE STAFF TO CONNECT WITH PATIENTS AND FELLOW PHYSICIANS FOR ONLINE CONSULTATIONS GREATLY EXPANDING ACCESS TO CARE FOR RESIDENTS OF OUR RURAL COMMUNITIES. RESIDENCY PROGRAMS IN FAMILY MEDICINE, INTERNAL MEDICINE, GENERAL SURGERY, NURSING, AND PHARMACY IMPROVE ACCESS TO CARE AND HELP DEVELOP THE BIG BEND'S MEDICAL COMMUNITY. TALLAHASSEE MEMORIAL HEALTHCARE IS THE REGION'S SAFETY NET HOSPITAL. TRAUMA AND EMERGENCY SERVICES OPERATE AT A FINANCIAL LOSS. HOWEVER, THE PROVISION OF A DESIGNATED LEVEL II TRAUMA CENTER IS AN ESSENTIAL SERVICE FOR TMH'S SERVICE AREA. THE INCREASED COMPLEXITY AND VOLUME OF CARE PROVIDED IN THE EMERGENCY CENTER QUICKLY CAUSED THE FACILITY TO REACH CAPACITY AND RESULTED IN EXTENDED WAIT TIME FOR EMERGENCY PATIENT CARE. BETWEEN THE BIXLER TRAUMA & EMERGENCY CENTER, EMERGENCY CENTER NORTHEAST AND OUR URGENT CARE, OVER 315 PATIENTS ARE SEEN DAILY. TMH'S TRAUMA PROGRAM HAS SEEN A 30 PERCENT INCREASE IN VOLUME SINCE 2014, AND THAT UPWARD TREND CONTINUES. THE MEDIAN PATIENT ARRIVAL TIME TO PATIENT PLACEMENT IN A BED HAS DECREASED TO 15 MINUTES FOR FISCAL YEAR 2018. THE MEDIAN PATIENT ARRIVAL TO PROVIDER EVALUATION TIME IS 36 MINUTES. THE EMERGENCY CENTER NORTHEAST HAS CONTINUED TO EVOLVE AND TAKE ON A LARGER PATIENT POPULATION, INCLUDING THE OPENING OF A CHILDREN'S EMERGENCY CENTER IN AFFILIATION WITH WOLFSON'S CHILDREN'S HOSPITAL. THE AVERAGE DAILY PATIENT COUNT WAS 87 IN 2014 AND THEY NOW SEE AN AVERAGE OF 127 PATIENTS A DAY. THIS HAS GREATLY INCREASED THE COMMUNITY ACCESS TO CARE. THE MEDIAN PATIENT ARRIVAL TIME TO PATIENT PLACEMENT IN A BED IS 18 MINUTES. THE MEDIAN PATIENT ARRIVAL TO PROVIDER EVALUATION TIME IS 36 MINUTES. THE NUMBER OF PATIENTS WHO LEFT BEFORE BEING SEEN HAS REMAINED BELOW THE NATIONAL AVERAGE AT 17 PERCENT FOR FISCAL YEAR 2018. REGIONAL ACCESS TO PHYSICIANS. IN CONTINUATION OF TMH'S COMMITMENT TO IMPROVE ACCESS TO HEALTHCARE IN SURROUNDING RURAL COMMUNITIES, TMH OPERATES FIVE FAMILY MEDICINE PRACTICES THROUGHOUT THE AREA WITH OFFICES LOCATED IN GADSDEN, JEFFERSON, TAYLOR, WAKULLA AND CALHOUN COUNTIES. PHYSICIAN PARTNERS HAS EXPANDED THE REGIONAL REFERRAL PROCESS FOR SPECIALTY CARE FOR THE SERVICE AREA AS WELL INCLUDING THE SPECIALTIES OF BARIATRICS, CARDIOVASCULAR, ENDOCRINOLOGY, GENERAL SURGERY, GENETICS, MATERNAL-FETAL MEDICINE, NEUROLOGY, ONCOLOGY, NEUROLOGY, PAIN MANAGEMENT, PSYCHIATRY, PULMONARY, RHEUMATOLOGY, UROLOGY AND VASCULAR SURGERY. COMMUNITY INVOLVEMENT. TMH CONTINUES TO BE A KEY HEALTH PARTNER ON LOCAL HEALTH INITIATIVES AND ENCOURAGES PARTICIPATION FROM ITS LEADERS, BOARDS, GROUPS AND COUNCILS THAT WE WERE ACTIVELY ENGAGED IN THIS YEAR INCLUDE BUT ARE NOT LIMITED TO BIG BEND CARES BIG BEND HEALTHCARE COAL.</p>

Form and Line Reference	Explanation
<p>PART VI, LINE 5 (INFORMATION REGARDING PROMOTION OF COMMUNITY HEALTH)</p>	<p>ITION BIG BEND HOSPICE CAPITAL AREA HEALTHY START/MATERNAL CHILD EQUITY COLLABORATIVE CHIL DREN'S HOME SOCIETY CHOOSE TALLHASSEE DEPARTMENT OF HEALTH MEDICAL SURGE PROGRAM ADVISORY TEAM -BUREAU OF PREPAREDNESS AND RESPONSE-DIVISION OF EMERGENCY PREPAREDNESS & COMMUNITY SUPPORT DOCTORS MEMORIAL HOSPITAL FAMU ADVISORY BOARD FLORIDA COUNCIL FOR COMMUNITY BEHAVI ORAL HEALTH FLORIDA HOSPITAL ASSOCIATION FLORIDA ORGANIZATION OF NURSE EXECUTIVES (FONE) F LORIDA REGIONAL DOMESTIC SECURITY TASKFORCE FLORIDA SMART JUSTICE ALLIANCE FLORIDA SURGEON GENERAL DEPARTMENT OF HEALTH TASK FORCE GADSDEN HEALTH COUNCIL GEORGE E WEEMS HOSPITAL G OODWILL INDUSTRIES-BIG BEND GOODWOOD MUSEUM & GARDENS GOVERNORS HURRICANE CONFERENCE JUNIO R LEAGUE OF TALLHASSEE KEISER UNIVERSITY LEADERSHIP TALLAHASSEE LEON COUNTY EMS COLLABORA TIVE GROUPS LEON COUNTY BEST PRACTICES IMPLEMENTATION ACADEMY (NATIONAL ASSOCIATION OF COU NTIES) LEON COUNTY SHERIFF'S MENTAL HEALTH ADVISORY COMMITTEE MARCH OF DIMES MATERNAL MENT AL HEALTH AND DEPRESSION COALITION REFUGE HOUSE RONALD MCDONALD HOUSE SOUTHEASTERN UROLOGY SURGERY CENTER BOARD TALLHASSEE CHAMBER OF COMMERCE TALLAHASSEE COMMUNITY COLLEGE FOUNDA TION TALLAHASSEE PLASTICS BOARD THE AMERICAN CANCER SOCIETY THE AMERICAN HEART ASSOCIATION THE UNITED WAY OF THE BIG BEND THE MENTAL HEALTH COUNCIL OF THE BIG BEND THOMAS UNIVERSIT Y UNITED PARTNERS FOR HUMAN SERVICES WHOLE CHILD LEON YOUTH LEADERSHIP TALLAHASSEE EDUCATI ON & TRAINING PROGRAMS FOR MEDICAL PROFESSIONALS TMH CONTRIBUTES MILLIONS OF DOLLARS EACH YEAR TO THE CLINICAL EDUCATION OF HEALTHCARE PROFESSIONALS THIS INCLUDES TRAINING FOR FL ORIDA STATE UNIVERSITY COLLEGE OF MEDICINE STUDENTS, FLORIDA A&M PHARMACY STUDENTS, HANDS- ON EXPERIENCE FOR NURSES FROM MANY DIFFERENT NURSING SCHOOLS THROUGHOUT NORTH FLORIDA AND SOUTH GEORGIA AND CONTINUING MEDICAL EDUCATION FOR PHYSICIANS IN OUR COMMUNITY TMH AWARDE D A LAND GRANT TO TALLHASSEE COMMUNITY COLLEGE (TCC) AS PART OF ITS PLAN TO DEVELOP A HEA LTH EDUCATION PARTNERSHIP CAMPUS ON A PORTION OF THE 81 4 ACRES OF UNDEVELOPED LAND IT OWN S BEHIND THE HOSPITAL IN AUGUST 2011, TMH WELCOMED MORE THAN 400 TCC STUDENTS TO THE HOSP ITAL'S CAMPUS WITH THE OPENING OF THE NEW GHAZVINI CENTER FOR HEALTHCARE EDUCATION THE 85 ,000-SQUARE-FOOT, THREE-STORY EDUCATIONAL CENTER INCLUDES SIX CLASSROOMS, 13 LABORATORIES, A MULTI-PURPOSE LIBRARY AND LEARNING COMMONS, SIX SIMULATION CENTERS, PLUS ADDITIONAL SPA CE FOR EXPANSION AND A 296 -SEAT AUDITORIUM THE CENTER NOW HAS 530 STUDENTS ENROLLED ONE OF TMH'S MOST SIGNIFICANT CONTRIBUTIONS TO THE EDUCATION FOR HEALTHCARE PROFESSIONALS IS THE TALLAHASSEE MEMORIAL FAMILY MEDICINE RESIDENCY PROGRAM, WHICH TRAINS PHYSICIANS WHO HA VE COMPLETED MEDICAL SCHOOL AND WISH TO TRAIN IN THE SPECIALTY OF FAMILY MEDICINE AND BECO ME BOARD CERTIFIED THE FAMILY MEDICINE PROGRAM IS THE OLDEST FAMILY MEDICINE RESIDENCY IN FLORIDA (46 YEARS) AND HAS PRODUCED 393 GRADUATES SINCE ITS INCEPTION IN 1973 OF THOSE, 252 HAVE CHOSEN TO REMAIN IN TMH'S SERVICE AREA HELPING TO ENSURE ACCESS TO PRIMARY HEALTH CARE FOR RESIDENTS OF THE BIG BEND AND SOUTH GEORGIA IN THE FALL OF 2011, TALLAHASSEE MEM ORIAL AND THE FLORIDA STATE UNIVERSITY COLLEGE OF MEDICINE ESTABLISHED A JOINT INTERNAL ME DICINE RESIDENCY PROGRAM FOR THE BIG BEND REGION THE INTERNAL MEDICINE RESIDENCY PROGRAM CURRENTLY HAS 26 RESIDENTS IN 2016, THE FLORIDA STATE UNIVERSITY COLLEGE OF MEDICINE GENE RAL SURGERY RESIDENCY PROGRAM AT TALLAHASSEE MEMORIAL HEALTHCARE ACCEPTED ITS FIRST RESIDE NTS FOR ACADEMIC YEAR 2016-2017 THIS FIVE- YEAR PROGRAM IS THE FIRST SURGERY RESIDENCY PRO GRAM IN NORTHWEST FLORIDA AND WILL PRODUCE TWO NEW GENERAL SURGEONS EACH YEAR ONCE IT IS A T FULL CAPACITY THE FIRST GRADUATION OF RESIDENTS WILL BE IN JUNE OF 2020 IMPROVING META BOLIC HEALTH TALLAHASSEE MEMORIAL HEALTHCARE WAS AN ACTIVE FOUNDING SPONSOR FOR STOMP ST UDENTS STOMPING FOR GOOD HEALTH (FORMERLY STOMP OUT TYPE 2 DIABETES) EVENT TARGETED AT LEO N COUNTY SCHOOL STUDENTS, AND THEIR FAMI</p>

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 6 (AFFILIATED HEALTHCARE SYSTEM INFORMATION)	NOT APPLICABLE ----- PART VI, LINE 7 (STATE FILING OF COMMUNITY BENEFIT REPORT) NOT APPLICABLE -----

Schedule H (Form 990) 2017

Additional Data**Software ID:****Software Version:****EIN:** 59-1917016**Name:** TALLAHASSEE MEMORIAL HEALTHCARE INC**Form 990 Schedule H, Part V Section A. Hospital Facilities**

Section A. Hospital Facilities		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (Describe)	Facility reporting group
(list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? <u>1</u>											
Name, address, primary website address, and state license number											
1	TALLAHASSEE MEMORIAL HOSPITAL 1300 MICCOSUKEE ROAD TALLAHASSEE, FL 32309 WWW.TMH.ORG LICENSE #4080	X	X		X			X			

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 5, 6B (INPUT FROM COMMUNITY, COLLABORATION)	<p>TALLAHASSEE MEMORIAL HEALTHCARE, INC ("TMH") COMPLETED ITS SECOND COMMUNITY HEALTH NEEDS ASSESSMENT ("CHNA") DURING THE YEAR ENDING SEPTEMBER 30, 2016 YOU MAY FIND THE COMPREHENSIVE RESULTS AT https://www.tmh.org/about-us/community-reports/community-need-report TO SUMMARIZE THE REPORT, TMH USED A VARIETY OF ASSESSMENT TOOLS TO DETERMINE THE NEEDS OF ITS COMMUNITY AMONG THOSE ASSESSMENT TOOLS UTILIZED INCLUDED - LEON COUNTY COLLABORATIVE DATA, 2016 - STEP UP FOR GADSDEN GOALS AND STRATEGIES, 2016 - COUNTYHEALTHRANKINGS.ORG, 2016 - FLORIDA CHARTS COUNTY MINORITY HEALTH PROFILE, 2014 - GADSDEN COUNTY COMMUNITY HEALTH COUNCIL, 2016 - JEFFERSON COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN, 2015 - TALLAHASSEE MEMORIAL COMMUNITY SURVEY, 2016 - TALLAHASSEE MEMORIAL COMMUNITY MEETINGS, 2016 - INTERVIEWS WITH MAYOR OF TALLAHASSEE AND CHAIR LEON COUNTY COMMISSION THE COMMUNITY HEALTH ASSESSMENT SURVEY CONSISTED OF 94 QUESTIONS ABOUT VARIOUS HEALTH TOPICS THE SURVEY INSTRUMENT WAS ADAPTED FROM THE TOOLS CREATED BY HOUSTON DEPARTMENT OF HEALTH AND HUMAN SERVICES, FLORIDA DEPARTMENT OF HEALTH IN SARASOTA COUNTY, AND PACE-EH QUESTIONS WERE SAMPLED FROM MODEL INSTRUMENTS THAT HAD BEEN PREVIOUSLY TESTED FOR VALIDITY THE SURVEY HAD NINE SECTIONS 1) ENVIRONMENTAL HEALTH/BUILT ENVIRONMENT, 2) CHILDREN'S CONCERNS, 3) ACCESS TO CARE, 4) HEALTH AND WELLBEING, 5) HEALTH-RELATED BEHAVIORS, AND 6) DEMOGRAPHICS QUESTIONS WERE PRIMARILY MULTIPLE CHOICE, WITH SELECT OPEN-ENDED OPPORTUNITIES SURVEYS WERE ALL CODED WITH A UNIQUE IDENTIFICATION NUMBER OF THE 330 SURVEYS ATTEMPTED IN SIX CENSUS TRACTS, 300 WERE COMPLETED DURING THE COMMUNITY MEETINGS, RESIDENTS WERE PRESENTED WITH THE MAIN FINDINGS FROM THE CHNA QUANTITATIVE SURVEY RESULTS AFTER A PRESENTATION OF RESULTS AND SUPPORTING DATA, ATTENDEES AT EACH MEETING PARTICIPATED IN A FOCUSED CONVERSATION AND CONSENSUS BUILDING WORKSHOP THE PROCESS FOLLOWED THE TECHNOLOGY OF PARTICIPATION FRAMEWORK INDIVIDUALS WERE ASKED TO CONSIDER THE FOLLOWING SERIES OF QUESTIONS - WHAT INFORMATION STOOD OUT TO YOU? - WHERE ARE YOU REALLY CLEAR? WHERE ARE YOU CONFUSED? WHAT CONCERNS YOU? WHAT FEELS CRITICAL? - WHAT QUESTIONS DID THIS RAISE FOR YOU? WHAT OTHER THINGS DO WE NEED TO CONSIDER? - WHAT SEEMS TO BE THE MOST CRITICAL ISSUE OR CONCERN FOR THE COMMUNITY? ATTENDEES WERE ASKED TO WRITE THEIR MOST CRITICAL CONCERNS INDIVIDUALLY ON SEPARATE PIECES OF PAPER AFTERWARDS, THEY WERE GIVEN A CHANCE TO GROUP SIMILAR ISSUES/CONCERNS TOGETHER ALL PARTICIPANTS HAD AN OPPORTUNITY TO AGREE OR DISAGREE WITH THE SIMILARITY BETWEEN ITEMS AFTER ALL CONCERNS WERE GROUPED BY SIMILARITY, ATTENDEES WERE INSTRUCTED TO NAME EACH GROUP THE WORDING DESCRIBED THEIR ANSWER TO THE ORIGINAL QUESTION WHAT ARE THE MOST CRITICAL ISSUES/PROBLEMS IN YOUR COMMUNITY? THESE RESULTS ALONG WITH THE OBJECTIVE DATA ANALYSIS INFORMED THE DEVELOPMENT OF THE COMMUNITY HEALTH IMPROVEMENT PLAN TMH COLLABORATED WITH VARIOUS ORGANIZATIONS IN ORDER TO COMPLETE ITS CHNA</p>

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 5, 6B (INPUT FROM COMMUNITY, COLLABORATION)	PLEASE SEE THE MOST RECENTLY COMPLETED CHNA FOR THIS INFORMATION https //www tmh org/abo ut-us/community-reports/community-need-report -----

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

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 7A & 10A (CHNA & IMP PLAN AVAILABILITY TO PUBLIC)	THE CHNA AND IMPLEMENTATION PLAN CAN BE ACCESSED AT https //www tmh org/about-us/community-reports/community-need-report -----

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 11 (ADDRESSING THE NEEDS IDENTIFIED IN THE CHNA)	<p>TALLAHASSEE MEMORIAL HEALTHCARE ("TMH") CONDUCTED THE MOST RECENT COMMUNITY HEALTH NEEDS ASSESSMENT IN 2016 IDENTIFICATION OF FIVE KEY HEALTH PRIORITIES EVOLVED FOLLOWED BY CREATION OF A 2017-2019 IMPLEMENTATION PLAN TO ADDRESS EACH OF THESE PRIORITY AREAS THE FIVE KEY HEALTH PRIORITIES ARE (1) CHILDRENS CONCERNS (2) PERSONAL HEALTH (3) BEHAVIORAL HEALTH (4) ACCESS TO CARE AND (5) TOBACCO FREE TMH SERVICE LINES WORK IN PARTNERSHIP WITH MANY COMMUNITY BASED ORGANIZATIONS TO ADDRESS THESE HEALTH NEEDS THE FOLLOWING IS AN UPDATE OF PROGRESS MADE IN EACH PRIORITY AREA DURING FISCAL YEAR 2018 (1)CHILDRENS CONCERNS THE LONG-TERM GOAL FOR PRIORITY AREA, CHILDRENS CONCERNS, IS TO IMPROVE BREASTFEEDING RATES FOR MATERNAL PATIENTS THREE INTERMEDIATE GOALS WERE IDENTIFIED (1) ACHIEVE BABY FRIENDLY ACCREDITATION (2) INCREASE THE INITIATION AND DURATION OF BREASTFEEDING AND (3) INCREASE ACCESS TO PRE-NATAL SERVICES THAT SUPPORT HEALTH FOR LOW INCOME AND VULNERABLE POPULATIONS THE FOLLOWING SHARES OUR PROGRESS ON THESE GOALS DURING 2018 IN 2018, THE FIRST GOAL WAS ACHIEVED WHEN TMH BECAME A BABY FRIENDLY HOSPITAL TMH IS ONE OF 19 HOSPITALS IN THE STATE OF FLORIDA, AND THE FIRST IN THE BIG BEND REGION, TO BE AWARDED THE BABY-FRIENDLY ACCREDITATION BABY FRIENDLY IS A GLOBAL PROGRAM RECOGNIZING HOSPITALS AND BIRTHING CENTERS OFFERING AN OPTIMAL LEVEL OF CARE FOR INFANT FEEDING AND MOTHER/BABY BONDING OVER THE PAST FOUR YEARS, TMH COLLEAGUES WORKED TO CHANGE PROCESSES AND PROCEDURES FOR OUR ENTIRE ORGANIZATION AND PROVIDED A TREMENDOUS AMOUNT OF EDUCATION TO MEDICAL PROFESSIONALS AND THE GENERAL PUBLIC IT HAS BEEN A BENEFICIAL SHIFT FOR OUR ORGANIZATION AND, MOST IMPORTANTLY, THE BABIES BORN IN OUR FACILITY WHEN FAMILIES COME TO THE TALLAHASSEE MEMORIAL ALEXANDER D BRICKLER, MD WOMENS PAVILION, THEY CAN EXPECT TO EXPERIENCE SKIN-TO-SKIN CONTACT AFTER THEIR BABY IS BORN DURING THIS PROCESS, THE BABY IS PLACED DIRECTLY ON A PARENTS CHEST AND COVERED WITH A WARM BLANKET BABIES WHO EXPERIENCE SKIN-TO-SKIN ALSO HAVE LESS STRESS, REDUCED CRYING, ENHANCED BONDING AND IMPROVED BRAIN DEVELOPMENT EACH BABY ALSO EXPERIENCES A DELAYED BATH, TYPICALLY DELAYED UP TO 24 HOURS, TO HELP REDUCE STRESS AND TO SERVE AS A TEACHABLE MOMENT SO THE WHOLE FAMILY CAN BE INVOLVED IN THE BATHING PROCESS IN THE WOMENS PAVILION, A MOM AND HER BABY ALSO SHARE A ROOM THIS ROOMING IN MODEL ALLOWS FOR BETTER BONDING AND INCREASED BREASTFEEDING RATES WHILE ALSO HELPING MOMS TO FEEL MORE RELAXED WITH THEIR BABIES CLOSE BY THE ULTIMATE GOAL WITH EACH OF THESE EVIDENCE-BASED MATERNITY CARE PRACTICES IS TO PROVIDE MOMS AND BABIES WITH THE BEST START TO ADDRESS THE SECOND GOAL FOR CHILDRENS CONCERNS, TMH CONTINUES SUPPORT OF BREASTFEEDING ONCE MOM AND BABY HAVE LEFT THE HOSPITAL, BY OFFERING "MILK WITH MOMMY", A FREE BREASTFEEDING SUPPORT GROUP THAT MEETS TWICE A WEEK AND IS LED BY A CERTIFIED LACTATION CONSULTANT MILK WITH MOMMY IS OPEN TO ANYONE IN THE COMMUNITY AND OFFERS A</p>

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 11 (ADDRESSING THE NEEDS IDENTIFIED IN THE CHNA)	<p>CASUAL ENVIRONMENT FOR MOMS AND BABIES TO CONNECT WITH EACH OTHER SINCE MEASURING HOW MUCH MILK A BABY RECEIVES CAN BE A CHALLENGE WHEN BREASTFEEDING, WE PROVIDE AN INFANT SCALE TO WEIGH A BABY BEFORE AND AFTER FEEDING THIS VENUE ALSO PROVIDES A SOCIAL OUTLET FOR MOMS DURING THEIR TRANSITION AFTER DELIVERY PARTICIPATION IN SUPPORT GROUPS HAS BEEN STABLE OVER THE LAST FEW YEARS WITH APPROXIMATELY 2,300 MOTHERS ATTENDING IN FISCAL YEAR 2018 OVER THE LAST FEW YEARS, TMH HAS EXPERIENCED SIGNIFICANT IMPROVEMENT IN TWO IMPORTANT MEASURES INDUCTIONS AND INPATIENT BREASTFEEDING RATES THERE HAS BEEN A REDUCTION OF NON-MEDICALLY INDICATED INDUCTIONS BEFORE 39 WEEKS FROM 7 PERCENT TO 4 PERCENT AND THE NUMBER OF MOTHERS WHO ATTEMPTED BREASTFEEDING DURING THEIR STAY INCREASED FROM 41 PERCENT TO 49 PERCENT IN ADDITION, ALL NEW MOTHERS RECEIVE SAFE SLEEP EDUCATION IN THEIR TAKE-HOME PACKET THE THIRD GOAL FOR THE CHILDRENS CONCERNS HEALTH PRIORITY IS INCREASING ACCESS TO PRENATAL SERVICES FOR LOW INCOME AND VULNERABLE POPULATIONS THE TMH FAMILY MEDICINE RESIDENCY (FMR) PROGRAM PARTNERS WITH FIVE COUNTY HEALTH DEPARTMENTS, INCLUDING GADSDEN, JEFFERSON, MADISON, TAYLOR AND WAKULLA COUNTIES, TO PROVIDE FULL SCOPE PRENATAL CARE, COUNSELING AND BIRTH CONTROL TO MEDICALLY UNDERSERVED MOTHERS FAMILY MEDICINE PROVIDES THESE SAME SERVICES AT BOND COMMUNITY HEALTH CENTER, A FEDERALLY QUALIFIED HEALTH CENTER (FQHC) IN LEON COUNTY IN FISCAL YEAR 2018, OVER 2,000 WOMEN RECEIVED SERVICES FROM THE TMH FAMILY MEDICINE RESIDENCY PARTNERSHIP WITH COUNTY HEALTH DEPARTMENTS THE NUMBER OF WOMEN RECEIVING SERVICES WAS STABLE FROM YEARS PAST IN 2018, TMH DONATED APPROXIMATELY 700 PHYSICIAN HOURS, 1200 MID-WIFE HOURS AND OVER 500 NURSE HOURS TO THIS PRENATAL CARE IN ADDITION, OVER 400 PHYSICIAN HOURS WERE DEVOTED TO CARING FOR 500 WOMEN AT BOND COMMUNITY HEALTH CENTER, FQHC, IN 2018 IN ADDITION, THE FMR PROGRAM WAS AWARDED THE PRESTIGIOUS DESIGNATION AS AN ACCREDITED LOCATION FOR CENTERING, BECOMING 1 OF ONLY 3 IN FLORIDA WITH THIS PRACTICE AUTHORITY THE FIRST OF ITS KIND IN NORTH FLORIDA, THE CENTERING PROGRAM ADVANCES HIGH-QUALITY, EVIDENCE-BASED GROUP CARE, CREATING AN ENVIRONMENT THAT INSPIRES RELATIONSHIPS OF COLLECTIVE POWER IN THE HEALTH SYSTEM BY DISRUPTING THE STRUCTURES AND SYSTEMS THAT DRIVE POOR HEALTH TO CO-CREATE COMMUNITIES IN WHICH EVERYONE HAS AN EQUITABLE OPPORTUNITY TO THRIVE IN ADDITION TO THESE STRATEGIES OUTLINED IN OUR 2017-2019 IMPLEMENTATION STRATEGY, TMH ALSO SUPPORTS AND HOSTS OTHER HEALTH PROMOTION EVENTS, RELATED TO CHILDRENS CONCERNS, IN THE COMMUNITY, SUCH AS THE MARCH OF DIMES WALK AND THE BABY AND FAMILY FAIR EACH YEAR, TMH COLLEAGUES PARTICIPATE IN THE MARCH OF DIMES FUNDRAISING WALK THE MARCH OF DIMES USES FUNDS RAISED TO SUPPORT PROGRAMS AND SERVICES THAT BENEFIT LOCAL FAMILIES ONE EXAMPLE IS A MONTHLY DINNER FOR THE NICU PARENTS AT TMH CURRENT MARCH OF DIMES CAMPAIGNS ALSO INCLUDE SUPPORT FOR EDUCATION OF HEALTH CARE PROVIDERS A</p>

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 11 (ADDRESSING THE NEEDS IDENTIFIED IN THE CHNA)	<p>ND CONSUMERS AGAINST NON-MEDICALLY INDICATED INDUCTIONS BEFORE 39 WEEKS THE BABY & FAMILY FAIR IS A TMH ANNUAL EDUCATION AND HEALTH EVENT FOR BOTH EXPECTANT PARENTS AND FAMILIES WITH CHILDREN OF ALL AGES IT SHOW CASES PRODUCTS AND SERVICES FOR THOSE WHO ARE MAKING IMPORTANT DECISIONS ABOUT PREGNANCY, CHILDBIRTH AND RAISING A FAMILY APPROXIMATELY 350 FAMILIES PARTICIPATED IN THE BABY & FAMILY FAIR IN 2018 (2) PERSONAL HEALTH THE LONG-TERM GOAL FOR THE PRIORITY AREA, PERSONAL HEALTH, IS TO IMPROVE NUTRITION OF COMMUNITY MEMBERS IN AN EFFORT TO REDUCE THE IMPACT OF CHRONIC CONDITIONS SUCH AS DIABETES, OBESITY AND CARDIOVASCULAR DISEASE TWO INTERMEDIATE GOALS WERE IDENTIFIED (1) IMPROVE HEALTHY EATING AMONG RESIDENTS IN LOW-INCOME, UNDER-RESOURCED COMMUNITIES (2) IMPROVE ACCESS TO CARE FOR CHRONIC CONDITIONS IN 2018, WE CONTINUED EFFORTS AND EXPANDED ON SEVERAL STRATEGIES AIMED AT MEETING THESE GOALS ONE SUCH STRATEGY IS THE TMH AND WOLFSON CHILDRENS HOSPITAL PARTNERSHIP AS PART OF THIS PARTNERSHIP, A CHILD HEALTH PROGRAM COORDINATOR WAS HIRED TO OFFER A RANGE OF AGE-APPROPRIATE, SCHOOL-BASED LESSONS THAT ENCOURAGE AND EMPOWER CHILDREN TO DEVELOP HEALTHY NUTRITION HABITS AND VITAL SAFETY SKILLS THAT IMPROVE OVERALL PHYSICAL AND SOCIAL WELL-BEING THE PRIMARY FOCUS IN 2017 WAS BUILDING PARTNERSHIPS AND COLLABORATIVE RELATIONSHIPS WITH THE FOLLOWING EARLY LEARNING COALITION, WHOLE CHILD LEON, EARLY CHILDHOOD OBESITY PREVENTION, SAFE KIDS COALITION AND LEON COUNTY SCHOOLS IN 2018, THE CHILD HEALTH PROGRAM COORDINATOR BEGAN OFFERING NUTRITION EDUCATION TO SCHOOL AGE CHILDREN USING TWO CURRICULUMS ENTITLED "I CAN EAT A RAINBOW MISSION NUTRITION" IN 2018, OVER 600 STUDENTS, IN TWO ELEMENTARY SCHOOLS RECEIVED FOR NUTRITION EDUCATION IN 2018, TWO ADDITIONAL FACILITATORS WERE TRAINED TO DELIVER THESE PROGRAMS WITH PLANS TO EXPAND TO MORE SCHOOLS AND OTHER SETTINGS IN THE FUTURE ANOTHER IMPORTANT STRATEGY IMPLEMENTED TO ADDRESS THE NEEDS OF THE PERSONAL HEALTH PRIORITY IS A COMPREHENSIVE INITIATIVE TO IMPROVE HEALTHY FOOD ACCESS AND NUTRITIONAL INTAKE BY WAY OF THE SOUTHSIDE FARMERS MARKET AND FRESH FRUIT AND VEGETABLE RX PROGRAM THIS INITIATIVE WAS LAUNCHED IN MAY 2018 AND WAS PART OF ONGOING WORK OF THE LOCAL INVEST HEALTH TEAM WHICH BEGAN IN 2016 INVEST HEALTH IS A COLLABORATIVE INITIATIVE BETWEEN THE ROBERT WOOD JOHNSON FOUNDATION AND REINVESTMENT FUND THAT BRINGS TOGETHER DIVERSE LEADERS FROM MID-SIZED U.S. CITIES ACROSS THE NATION TO DEVELOP NEW STRATEGIES FOR INCREASING AND LEVERAGING PRIVATE AND PUBLIC INVESTMENTS TO ACCELERATE IMPROVEMENTS IN NEIGHBORHOODS FACING THE BIGGEST BARRIERS TO BETTER HEALTH THE SOUTHSIDE FARMERS MARKET AND FRESH FRUIT AND VEGETABLE RX PROGRAM IS A COMMUNITY-DRIVEN PARTNERSHIP THAT ADDRESSES THE OVERALL HEALTH AND WELL-BEING OF SOUTHSIDE TALLAHASSEE RESIDENTS THIS PROGRAM IS CARRIED OUT AS A PARTNERSHIP WITH CITY OF TALLAHASSEE NEIGHBORHOOD AFFAIRS, FLORIDA A & M UNIVERSITY AND TALLAHASSEE MEMORIAL HEALTH</p>

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

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

Form and Line Reference	Explanation
PART V, SECTION B, LINE 16 (FINANCIAL ASSISTANCE AVAILABILITY)	A COPY OF THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY, APPLICATION AND PLAIN LANGUAGE SUMMARY CAN BE ACCESSED AT https //www tmh org/patients-and-visitors/transparency-billing-and-quality -----

**Schedule I
(Form 990)**

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

OMB No 1545-0047

2017

**Open to Public
Inspection**

Department of the
Treasury
Internal Revenue Service

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

▶ Information about Schedule I (Form 990) and its instructions is at www.irs.gov/form990.

Name of the organization
TALLAHASSEE MEMORIAL HEALTHCARE INC

Employer identification number
59-1917016

Part I General Information on Grants and Assistance

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

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

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

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table ▶ _____ 7

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

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

Part III can be duplicated if additional space is needed

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

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

Return Reference	Explanation
FORM 990, SCHEDULE I, PART I, LINE 2	DESCRIPTION OF GRANT PROGRAMS TALLAHASSEE MEMORIAL HEALTHCARE, INC ("TMH") MAINAINS A SPONSORSHIP COMMITTEE WHICH OVERSEES THE ORGANIZATIONS SPONSORSHIP/GRANT-MAKING PROCESS COMPLETED APPLICATION FORMS MUST BE SUBMITTED IN ORDER FOR TMH TO EVALUATE THE BENEFITS OF THE PROPOSED ACTIVITY- HOW THE PROPOSED SPONSORSHIP OPPORTUNITY ALIGNS WITH TMHS MISSION AND VISION, AS WELL AS HOW THE PROPOSED ACTIVITY CAN HELP THE COMMUNITY APPLICATIONS AND FURTHER INFORMATION ARE AVAILABLE ON TMHS WEBSITE AT HTTPS //WWW TMH ORG/SPONSORSHIP

Additional Data

Software ID:
Software Version:
EIN: 59-1917016
Name: TALLAHASSEE MEMORIAL HEALTHCARE INC

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
AMERICAN HEART ASSOCIATION 2851 REMINGTON GREEN CIRCLE SUITE 101 TALLAHASSEE, FL 32308	13-5613797	501(C)(3)	15,500		FMV	N/A	SPONSORSHIP - RELAY FOR LIFE EVENTS
WORD OF SOUTH A FESTIVAL OF LITERATURE & MUSIC PO BOX 861 TALLAHASSEE, FL 32302	46-3527772	501(C)(3)	10,000		FMV	N/A	SPONSORSHIP - HEART WALK

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
GULF WINDS TRACK CLUB INC PO BOX 3447 TALLAHASSEE, FL 32315	59-1896178	501(C)(3)	10,000		FMV	N/A	MEMBERSHIP
MARCH OF DIMES FOUNDATION 1990 VILLAGE WAY 3 TALLAHASSEE, FL 32308	13-1846366	501(C)(3)	10,000		FMV	N/A	SPONSORSHIP - STOMP (DIABETES)

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
SPRINGTIME TALLAHASSEE INC 501 ETENNESSEE ST TALLAHASSEE, FL 32308	23-7241347	501(C)(3)	10,000		FMV	N/A	SPONSORSHIP - MARCH FOR BABIES
THE TALLAHASSEE COMMUNITY COLLEGE FDN 444 APPEYARD DR TALLAHASSEE, FL 32304	59-2091480	501(C)(3)	10,000		FMV	N/A	SPONSORSHIP - STONE CRAB FEST

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
TALLAHASSEE CHAMBER OF COMMERCE 300 E PARK AVE TALLAHASSEE, FL 32301	59-0474165		9,050		FMV	N/A	SPONSORSHIPS - AWARDS SPONSOR, RELOCATION PACKET
FLORIDA A & M UNIVERSITY FOUNDATION INC 625 E TENNESSEE ST SUITE 100 TALLAHASSEE, FL 32308	59-0977035	501(C)(3)	30,000		FMV	N/A	SPONSORSHIP - TALLAHASSEE MARATHON

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.**

▶ **Information about Schedule J (Form 990) and its instructions is at www.irs.gov/form990.**

OMB No 1545-0047

2017

Open to Public Inspection

Name of the organization
TALLAHASSEE MEMORIAL HEALTHCARE INC

Employer identification number
59-1917016

Part I Questions Regarding Compensation

		Yes	No		
<p>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.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <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 </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Housing allowance or residence for personal use <input type="checkbox"/> Payments for business use of personal residence <input checked="" type="checkbox"/> Health or social club dues or initiation fees <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef) </td> </tr> </table>	<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 checked="" type="checkbox"/> Health or social club dues or initiation fees <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)			
<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 checked="" type="checkbox"/> Health or social club dues or initiation fees <input type="checkbox"/> Personal services (e.g., maid, chauffeur, chef)				
<p>b If any of the boxes in 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.</p>	1b	Yes			
<p>2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?</p>	2	Yes			
<p>3 Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input checked="" type="checkbox"/> Compensation committee <input checked="" type="checkbox"/> Independent compensation consultant <input type="checkbox"/> Form 990 of other organizations </td> <td style="width: 50%; vertical-align: top;"> <input checked="" type="checkbox"/> Written employment contract <input checked="" type="checkbox"/> Compensation survey or study <input checked="" type="checkbox"/> Approval by the board or compensation committee </td> </tr> </table>	<input checked="" type="checkbox"/> Compensation committee <input checked="" type="checkbox"/> Independent compensation consultant <input type="checkbox"/> Form 990 of other organizations	<input checked="" type="checkbox"/> Written employment contract <input checked="" type="checkbox"/> Compensation survey or study <input checked="" type="checkbox"/> Approval by the board or compensation committee			
<input checked="" type="checkbox"/> Compensation committee <input checked="" type="checkbox"/> Independent compensation consultant <input type="checkbox"/> Form 990 of other organizations	<input checked="" type="checkbox"/> Written employment contract <input checked="" type="checkbox"/> Compensation survey or study <input checked="" type="checkbox"/> Approval by the board or compensation committee				
<p>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:</p> <p>a Receive a severance payment or change-of-control payment?</p> <p>b Participate in, or receive payment from, a supplemental nonqualified retirement plan?</p> <p>c Participate in, or receive payment from, an equity-based compensation arrangement?</p> <p>If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.</p>	4a	Yes			
	4b	Yes			
	4c		No		
<p>Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.</p>					
<p>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:</p> <p>a The organization?</p> <p>b Any related organization?</p> <p>If "Yes," on line 5a or 5b, describe in Part III.</p>	5a		No		
	5b		No		
<p>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:</p> <p>a The organization?</p> <p>b Any related organization?</p> <p>If "Yes," on line 6a or 6b, describe in Part III.</p>	6a		No		
	6b		No		
<p>7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III.</p>	7	Yes			
<p>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.</p>	8		No		
<p>9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?</p>	9				

Part III Supplemental Information

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

Return Reference	Explanation
FORM 990, SCHEDULE J, PART I, LINE 1A	QUESTIONS REGARDING COMPENSATION DIRECTORS RECEIVE COMPLIMENTARY ACCESS TO TMH'S HEALTH CLUB, PREMIER HEALTH AND FITNESS CENTER -----
FORM 990, SCHEDULE J, PART I, LINE 4A	DEATIL OF SEVERANCE PAYMENTS SEVERANCE PAYMENTS WERE MADE TO THE FOLLOWING INDIVIDUALS DURING THE FISCAL YEAR ENDING 9-30-2018 AND WERE INCLUDED AS A COMPONENT OF COMPENSATION REPORTED ON FORM 990, SCHEDULE J, PART II, COLUMN (B)(III) FOR EACH INDIVIDUAL JASON MOORE- \$208,827 ROBERT L MOORE- \$135,535 MICKEY S MOORE- \$31,011 -----
FORM 990, SCHEDULE J, PART I, LINE 4B	SUPPLEMENTAL NONQUALIFIED PLAN PARTICIPATION TMH MAINTAINS AN IRC SECTION 457(F) PLAN DESIGNED FOR CERTAIN SENIOR ADMINISTRATORS OF THE ORGANIZATION THE FOLLOWING INDIVIDUALS LISTED ON FORM 990, PART VII, SECTION A, LINE 1A PARTICIPATED IN THE TMH 457(F) PLAN AND/OR RECEIVED DISTRIBUTIONS DURING THE YEAR G MARK O'BRYANT- NO DISTRIBUTIONS BARBARA ALFORD- NO DISTRIBUTIONS STEPHANIE M DERZYPOLSKI- NO DISTRIBUTIONS WILLIAM GIUDICE- NO DISTRIBUTIONS STEVEN E HAYNES- NO DISTRIBUTIONS DONALD LINDSEY- NO DISTRIBUTIONS DEAN WATSON, MD- NO DISTRIBUTIONS YASHICA L WILSON-HEARNS- NO DISTRIBUTIONS -----
FORM 990, SCHEDULE J, PART I, LINE 7	PROVISION OF NON-FIXED PAYMENTS TMH MAINTAINS A VARIABLE COMPENSATION PROGRAM FOR CERTAIN MANAGERS THAT MAKE A BONUS PAYMENT BASED UPON ATTAINMENT OF INDIVIDUAL AND CORPORATE GOALS INDIVIDUAL GOALS ARE ESTABLISHED AT THE BEGINNING OF THE FISCAL YEAR AND INCLUDE QUALITATIVE AND QUANTITATIVE RESULTS CORPORATE GOALS ARE ESTABLISHED AT THE BEGINNING OF THE YEAR AND ARE BASED UPON THE BUDGET APPROVED BY THE BOARD OF DIRECTORS NO PAYMENT IS MADE FOR VARIABLE COMPENSATION PAYMENT UNLESS THE ORGANIZATION MEETS OR EXCEEDS ITS BUDGETED OPERATING MARGIN FOR THE YEAR UPON DETERMINATION THAT THE ACTUAL OPERATING MARGIN HAS MET OR EXCEEDED THE BUDGET VIA THE AUDITED FINANCIAL STATEMENTS, OTHER INDIVIDUAL AND CORPORATE GOALS ARE SCORED TO DETERMINE IF THEY MET OR EXCEEDED THE PRE-ESTABLISHED MEASUREMENT FOR THE YEAR THE ACTUAL AMOUNT OF THE BONUS IS BASED UPON AN INDIVIDUAL'S BASE COMPENSATION FOR THE FISCAL YEAR AND THE PERCENTAGE ATTAINMENT OF INDIVIDUAL AND CORPORATE GOALS PAYMENTS MADE TO ANY DISQUALIFIED PERSON IS APPROVED BY THE TMH COMPENSATION COMMITTEE THROUGH THE PROCESS DESCRIBED IN FORM 990, PART VI, SECTION B, LINE 15

Additional Data

Software ID:
Software Version:
EIN: 59-1917016
Name: TALLAHASSEE MEMORIAL HEALTHCARE INC

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1G MARK O'BRYANT EX-OFFICIO DIRECTOR & CEO	(i)	848,852	225,000	20,046	270,838	12,195	1,376,931	0
	(ii)	0	0	0	0	0	0	0
1WILLIAM GIUDICE CHIEF FINANCIAL OFFICER	(i)	485,482	67,607	18,278	74,789	12,189	658,345	0
	(ii)	0	0	0	0	0	0	0
2JASON MOORE FORMER CHIEF OPERATING OFFICER	(i)	0	0	208,827	12,739	6,011	227,577	0
	(ii)	0	0	0	0	0	0	0
3BARBARA ALFORD CHIEF CLINICAL OFFICER/CNO/VP	(i)	338,310	27,800	5,863	50,450	11,678	434,101	0
	(ii)	0	0	0	0	0	0	0
4CYNTHIA BLAIR CHIEF IMPROVEMENT/PLNG OFFICER	(i)	218,706	26,148	6,656	15,091	0	266,601	0
	(ii)	0	0	0	0	0	0	0
5STEPHANIE M DERZYPOLSKI CHIEF COMMUNICATION OFFICER	(i)	196,262	12,802	1,118	21,738	11,693	243,613	0
	(ii)	0	0	0	0	0	0	0
6ANDREA K FRIALL MD CHIEF MEDICAL STAFF OFFICER	(i)	175,011	0	0	0	0	175,011	0
	(ii)	0	0	0	0	0	0	0
7DONALD LINDSEY CHIEF INFORMATION OFFICER	(i)	229,034	29,292	2,125	24,804	12,078	297,333	0
	(ii)	0	0	0	0	0	0	0
8 MICKEY S MOORE- THRU 72018 CHIEF ADVANCEMENT OFFICER	(i)	191,567	1,084	1,578	17,730	191	212,150	0
	(ii)	0	0	0	0	0	0	0
9ROBERT L MOORE FORMER CHIEF HR OFFICER	(i)	0	0	133,535	8,012	0	141,547	0
	(ii)	0	0	0	0	0	0	0
10DEAN WATSON MD CHIEF HEALTH OPS OFFICER	(i)	421,339	58,429	7,606	58,973	12,078	558,425	0
	(ii)	0	0	0	0	0	0	0
11 YASHICA L WILSON-HEARNS VP/SUPPORT SERVICES	(i)	149,532	8,066	817	9,556	203	168,174	0
	(ii)	0	0	0	0	0	0	0
12OVIDIU MARINA MD RADIATION ONCOLOGIST	(i)	310,202	879,352	180	16,200	9,868	1,215,802	0
	(ii)	0	0	0	0	0	0	0
13PHILIP V SHARP MD RADIATION ONCOLOGIST	(i)	490,496	513,666	414	16,200	12,078	1,032,854	0
	(ii)	0	0	0	0	0	0	0
14ELIOT B SIELOFF MD GENERAL SURGEON	(i)	736,001	207,502	3,463	0	10,375	957,341	0
	(ii)	0	0	0	0	0	0	0
15WILLIAM DOBAK MD HEMATOLOGIST/ONCOLOGIST	(i)	440,432	320,599	270	0	11,252	772,553	0
	(ii)	0	0	0	0	0	0	0
16DHANANJAY D BENDRE MD RADIATION ONCOLOGIST	(i)	521,811	230,612	2,414	16,200	11,684	782,721	0
	(ii)	0	0	0	0	0	0	0
17STEVEN E HAYNES CHIEF HUMAN RESOURCE OFFICER	(i)	198,595	10,000	1,662	7,431	3,188	220,876	0
	(ii)	0	0	0	0	0	0	0

Schedule K (Form 990)

Supplemental Information on Tax-Exempt Bonds
 ▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
 ▶ Attach to Form 990.
 ▶ Information about Schedule K (Form 990) and its instructions is at www.irs.gov/form990.

OMB No 1545-0047
2017
Open to Public Inspection

Department of the Treasury
 Internal Revenue Service

Name of the organization
 TALLAHASSEE MEMORIAL HEALTHCARE INC

Employer identification number
 59-1917016

Part I Bond Issues

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pool financing	
							Yes	No	Yes	No	Yes	No
A	CITY OF TALLAHASSEE - SERIES 2015A	59-6000435		05-28-2015	111,332,927	REFUNDING 1992B, 2000 & 2015 BONDS		X		X		X
B	CITY OF TALLAHASSEE - SERIES 2016A & 2016B	59-6000435		02-02-2016	272,001,300	M T MUSTIAN CTR CONSTRUCTION		X		X		X

Part II Proceeds

	A	B	C	D
1 Amount of bonds retired	4,042,927	27,126,300		
2 Amount of bonds legally defeased	0	0		
3 Total proceeds of issue	111,332,927	272,001,300		
4 Gross proceeds in reserve funds	0	0		
5 Capitalized interest from proceeds	0	0		
6 Proceeds in refunding escrows	0	0		
7 Issuance costs from proceeds	1,176,569	1,790,765		
8 Credit enhancement from proceeds	0	0		
9 Working capital expenditures from proceeds	0	0		
10 Capital expenditures from proceeds	0	172,394,190		
11 Other spent proceeds	110,156,358	0		
12 Other unspent proceeds	0	97,816,345		
13 Year of substantial completion	2015			
	Yes	No	Yes	No
14 Were the bonds issued as part of a current refunding issue?		X	X	
15 Were the bonds issued as part of an advance refunding issue?	X		X	
16 Has the final allocation of proceeds been made?	X		X	
17 Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X	

Part III Private Business Use

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

Part III Private Business Use (Continued)

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?		X		X				
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
c Are there any research agreements that may result in private business use of bond-financed property?		X		X				
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶	0 %		0 %					
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶								
6 Total of lines 4 and 5								
7 Does the bond issue meet the private security or payment test?		X		X				
8a Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued?		X		X				
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of								
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?		X		X				
9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?	X		X					

Part IV Arbitrage

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X		X				
2 If "No" to line 1, did the following apply?								
a Rebate not due yet?		X		X				
b Exception to rebate?	X		X					
c No rebate due?		X		X				
If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3 Is the bond issue a variable rate issue?		X		X				
4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X		X				
b Name of provider	0		0					
c Term of hedge								
d Was the hedge superintegrated?								
e Was the hedge terminated?								

Part IV Arbitrage (Continued)

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

Part V Procedures To Undertake Corrective Action

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

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

Schedule L (Form 990 or 990-EZ)

Transactions with Interested Persons

OMB No 1545-0047

Complete if the organization answered "Yes" on Form 990, Part IV, lines 25a, 25b, 26, 27, 28a, 28b, or 28c, or Form 990-EZ, Part V, line 38a or 40b. Attach to Form 990 or Form 990-EZ. Information about Schedule L (Form 990 or 990-EZ) and its instructions is at www.irs.gov/form990.

2017

Open to Public Inspection

Department of the Treasury Internal Revenue Service

Name of the organization TALLAHASSEE MEMORIAL HEALTHCARE INC

Employer identification number 59-1917016

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

Table with 4 main columns: (a) Name of disqualified person, (b) Relationship between disqualified person and organization, (c) Description of transaction, (d) Corrected? (Yes/No)

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

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

Table with 9 main columns: (a) Name of interested person, (b) Relationship with organization, (c) Purpose of loan, (d) Loan to or from the organization (To/From), (e) Original principal amount, (f) Balance due, (g) In default? (Yes/No), (h) Approved by board or committee? (Yes/No), (i) Written agreement? (Yes/No)

Total \$

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

Table with 5 main columns: (a) Name of interested person, (b) Relationship between interested person and the organization, (c) Amount of assistance, (d) Type of assistance, (e) Purpose of assistance

Part IV Business Transactions Involving Interested Persons.

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

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

Part V Supplemental Information

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

Return Reference	Explanation

Additional Data

Software ID:

Software Version:

EIN: 59-1917016

Name: TALLAHASSEE MEMORIAL HEALTHCARE INC

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) VIVIAN MOORE	FAMILY MEMBER OF OFFICER	10,715	EMPLOYMENT		No
(1) JOSEPH L CAMPS	FAMILY MEMBER OF OFFICER	51,132	EMPLOYMENT		No

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(3) STEPHANIE TRUMAN	FAMILY MEMBER OF BOARD MEMBER	55,017	EMPLOYMENT		No
(1) AD BRICKLER MD	FAMILY MEMBER OF BOARD MEMBER	396,915	EMPLOYMENT		No

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(5) DAVID BRICKLER	FAMILY MEMBER OF BOARD MEMBER	80,834	EMPLOYMENT		No
(1) LYNN BRICKLER	FAMILY MEMBER OF BOARD MEMBER	68,561	EMPLOYMENT		No

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(7) MAD DOG CONSTRUCTION COMPANY	SIMILAR DIRECTOR/OWNER	1,780,517	CONSTRUCTION SERVICES		No

**SCHEDULE M
(Form 990)**

Noncash Contributions

OMB No 1545-0047

2017

▶ **Complete if the organizations answered "Yes" on Form 990, Part IV, lines 29 or 30.**
 ▶ **Attach to Form 990.**
 ▶ **Information about Schedule M (Form 990) and its instructions is at www.irs.gov/form990**

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization
TALLAHASSEE MEMORIAL HEALTHCARE INC

Employer identification number
59-1917016

Part I Types of Property

	(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1 Art—Works of art				
2 Art—Historical treasures				
3 Art—Fractional interests				
4 Books and publications				
5 Clothing and household goods				
6 Cars and other vehicles				
7 Boats and planes				
8 Intellectual property				
9 Securities—Publicly traded				
10 Securities—Closely held stock				
11 Securities—Partnership, LLC, or trust interests				
12 Securities—Miscellaneous				
13 Qualified conservation contribution—Historic structures				
14 Qualified conservation contribution—Other				
15 Real estate—Residential				
16 Real estate—Commercial				
17 Real estate—Other				
18 Collectibles				
19 Food inventory				
20 Drugs and medical supplies				
21 Taxidermy				
22 Historical artifacts				
23 Scientific specimens				
24 Archeological artifacts				
25 Other ▶ (GENERAL SUPPLIES)	X	50	44,301	ACTUAL COST
26 Other ▶ (OTHER ITEMS)	X	2	4,540	ACTUAL COST
27 Other ▶ (_____)				
28 Other ▶ (_____)				

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

29

30a During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least three years from the date of the initial contribution, and which is not required to be used for exempt purposes for the entire holding period?

	Yes	No
30a		No
31		No
32a		No

b If "Yes," describe the arrangement in Part II

31 Does the organization have a gift acceptance policy that requires the review of any nonstandard contributions?

32a Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions?

b If "Yes," describe in Part II

33 If the organization did not report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II

Part II**Supplemental Information.**

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

Return Reference

Explanation

SCHEDULE O
(Form 990 or 990-EZ)

Supplemental Information to Form 990 or 990-EZ

OMB No 1545-0047

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

▶ Attach to Form 990 or 990-EZ.

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

2017

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization

TALLAHASSEE MEMORIAL HEALTHCARE INC

Employer identification number

59-1917016

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11	FORM 990 REVIEW PROCESS INFORMATION RELATED TO TMH'S FORM 990 FILING IS GATHERED BY FINANC E STAFF AND PROVIDED TO PRICEWATERHOUSECOOPERS LLP FOR REVIEW AND RETURN PREPARATION THE 2017 FORM 990 FOR THE FISCAL YEAR ENDING SEPTEMBER 30 2018 WAS REVIEWED AND APPROVED BY VA RIOUS SENIOR FINANCE TEAM BEFORE IT WAS FILED TO THE IRS THE AUDIT AND COMPLIANCE COMMITTEE OF THE BOARD OF DIRECTORS REVIEWED THE 990 AT THE MEETING OF THE COMMITTEE PRIOR TO ITS FILING ALL MEMBERS OF THE BOARD WERE AFFORDED THE OPPORTUNITY TO REVIEW THE FORM 990 PRIOR TO ITS FILING -----

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	CONFLICT OF INTEREST POLICY AS PART OF OUR WRITTEN CONFLICTS OF INTEREST POLICY, OFFICERS, DIRECTORS TRUSTEES AND KEY EMPLOYEES ARE REQUIRED TO ANNUALLY DISCLOSE POTENTIAL CONFLICTS OF THEMSELVES AND THEIR FAMILY MEMBERS FINANCIAL STATEMENTS ARE AVAILABLE TO THE PUBLIC UPON REQUEST IN ADDITION, A COPY OF OUR CONFLICT OF INTEREST POLICY IS AVAILABLE ON THE TMH WEBSITE CONSOLIDATED FINANCIAL STATEMENTS ARE ALSO FILED WITH THE DIGITAL ASSURANCE CERTIFICATION, LLC, AGENCY FOR HEALTH CARE ADMINISTRATION A COPY OF OUR FORM 990 IS ALSO FILED WITH THE FLORIDA DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES -----

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15	COMPENSATION REVIEW PROCESS COMPENSATION ARRANGEMENTS INVOLVING OUR CEO AND SENIOR LEADERSHIP TEAM ARE ESTABLISHED BY TMH PURSUANT TO A PROCESS THAT SATISFIES THE REBUTTABLE PRESUMPTION PROCEDURE AVAILABLE TO SECTION 4958 EXCESS BENEFIT TRANSACTION TAX PURPOSES (WHICH REQUIRES A REVIEW OF COMPENSATION DETERMINATION BY DISINTERESTED PERSONS, USE OF APPROPRIATE COMPARABILITY DATA, AND CONTEMPORANEOUS DOCUMENTATION OF THE PROCESS) ----- THE BOARD WERE AFFORDED THE OPPORTUNITY TO REVIEW THE FORM 990 PRIOR TO ITS FILING ----- -----

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	DOCUMENTS AVAILAVILITY TO PUBLIC OUR GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY AND CONSOLIDATED FINANCIAL STATEMENTS ARE AVAILABLE TO THE PUBLIC UPON REQUEST IN ADDITION, A COPY OF OUR CONFLICT OF INTEREST POLICY IS AVAILABLE ON THE TMH WEBSITE CONSOLIDATED FINANCIAL STATEMENTS ARE ALSO FILED WITH THE DIGITAL ASSURANCE CERTIFICATION, LLC, AGENCY FOR HEALTH CARE ADMINISTRATION A COPY OF OUR FORM 990 IS ALSO FILED WITH THE FLORIDA DEPARTM ENT OF AGRICULTURE AND CONSUMER SERVICES DIRECTORS REVIEWED THE 990 AT THE MEETING OF THE COMITTEE PRIOR TO ITS FILING ALL MEMBERS OF THE BOARD WERE AFFORDED THE OPPORTUNITY TO R EVIEW THE FORM 990 PRIOR TO ITS FILING -----

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	DETAIL OF OTHER CHANGED IN NET ASSETS CHANGE IN ADDITIONAL PENSION LIABILITY \$61,183,141 C CHANGE IN FAIR VALUE OF DERIVATIVE (650,599) ADDITIONAL DEPRECIATION (103,118) _____ TOTAL \$60,429,424 -----

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION INDEPENDENT LAB TOTAL FEES 5364656

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION CONSULTING TOTAL FEES 4532316

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION OTHER PROFESSIONAL SERVICES TOTAL FEES 30578422

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION PHYSICIAN PROFESSIONAL FEES TOTAL FEES 38773042

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No 1545-0047

2017

**Open to Public
Inspection**

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
▶ Attach to Form 990.
▶ Information about Schedule R (Form 990) and its instructions is at www.irs.gov/form990.

Department of the Treasury
Internal Revenue Service

Name of the organization
TALLAHASSEE MEMORIAL HEALTHCARE INC

Employer identification number

59-1917016

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) MEDICUS SELECT LLC 1300 MICCOSUKEE ROAD TALLAHASSEE, FL 32308 45-2980304	LEASED LABOR	FL	0	2,298,805	TMH
(2) 1607 BUILDING LLC 1401 CENTERVILLE ROAD SUITE 210 TALLAHASSEE, FL 32308 30-0957508	ACQUIRED PROP	FL	-87,969	3,516,914	TMH

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) SOUTHEAST COMMUNITY HEALTH SERVICES INC 1300 MICCOSUKEE ROAD TALLAHASSEE, FL 32308 58-1434992	HOLDING CO	FL	501(C)(25)	N/A	TMH	Yes	
(2) TALLAHASSEE MEMORIAL HEALTHCARE FDN 1300 MICCOSUKEE ROAD TALLAHASSEE, FL 32308 59-1727645	FUNDRAISING	FL	501(C)(3)	7	TMH	Yes	

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
(1) TALLAHASSEE MEMORIAL HEALTH VENTURES INC 1300 MICCOSUKEE ROAD TALLAHASSEE, FL 32308 59-2717050	HOLDING COMPANY	FL	TMH	C CORP	2,286,271	19,955,043	100 000 %	Yes	
(2) PRIME MERIDIAN HEALTH VENTURES INC 1309 THOMASVILLE ROAD TALLAHASSEE, FL 32308 59-2668613	DIAG IMAGING	FL	TMHV	C CORP				Yes	
(3) TALLAHASSEE MEMORIAL TELEPHONE COMPANY 1309 THOMASVILLE ROAD TALLAHASSEE, FL 32308 59-3395937	TELEPHONE COMM	FL	TMHV	C CORP				Yes	
(4) PREMIER HEALTH & FITNESS CENTER INC 3521 MACLAY BOULEVARD TALLAHASSEE, FL 32312 59-2471569	FITNESS CENTER	FL	TMHV	C CORP				Yes	

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

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

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

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

See Additional Data Table

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

Part VII **Supplemental Information**

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

Additional Data

Software ID:
Software Version:
EIN: 59-1917016
Name: TALLAHASSEE MEMORIAL HEALTHCARE INC

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

(a) Name of related organization	(b) Transaction type(a-s)	(c) Amount Involved	(d) Method of determining amount involved
SOUTHEAST COMMUNITY HEALTH SERVICES	A	675	FMV
SOUTHEAST COMMUNITY HEALTH SERVICES	K	592,284	FMV
TALLAHASSEE MEMORIAL HEALTHCARE FOUNDATION	C	2,679,722	FMV
SOUTHEAST COMMUNITY HEALTH SERVICES	O	50,953	FMV
TALLAHASSEE MEMORIAL HEALTHCARE FOUNDATION	O	968,124	FMV
TALLAHASSEE MEMORIAL HEALTHCARE VENTURES INC	A	1,401,864	FMV
TALLAHASSEE MEMORIAL HEALTHCARE VENTURES INC	K	330,561	FMV