

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

Return of Organization Exempt From Income Tax

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

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

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

OMB No 1545-0047
2018
Open to Public Inspection

A For the 2019 calendar year, or tax year beginning 10-01-2018, and ending 09-30-2019

<p>B Check if applicable:</p> <input type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	<p>C Name of organization TALLAHASSEE MEMORIAL HEALTHCARE INC</p> <p>% WILLIAM A GIUDICE CFO Doing business as</p> <hr/> <p>Number and street (or P O box if mail is not delivered to street address) Room/suite 1300 MICCOSUKEE ROAD</p> <hr/> <p>City or town, state or province, country, and ZIP or foreign postal code TALLAHASSEE, FL 323085054</p>	<p>D Employer identification number 59-1917016</p> <hr/> <p>E Telephone number (850) 431-5238</p> <hr/> <p>G Gross receipts \$ 786,723,306</p>
<p>F Name and address of principal officer WILLIAM GIUDICE CFO 1300 MICCOSUKEE ROAD TALLAHASSEE, FL 323085054</p>		<p>H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list (see instructions)</p> <p>H(c) Group exemption number ▶</p>
<p>I Tax-exempt status <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () ◀(insert no) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527</p>		
<p>J Website: ▶ www tmh org</p>		
<p>K Form of organization <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶</p>		<p>L Year of formation 1979 M State of legal domicile FL</p>

Part I Summary

Activities & Governance	<p>1 Briefly describe the organization's mission or most significant activities TALLAHASSEE MEMORIAL HEALTHCARE, INC IS A PRIVATE 772-BED, COMMUNITY HEALTHCARE SYSTEM THAT PROVIDES CHARITABLE, COMPASSIONATE, LEADING-EDGE, PATIENT-CENTERED HEALTH CARE</p>		
	<p>2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets</p>		
	3 Number of voting members of the governing body (Part VI, line 1a)	3	16
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4	12
	5 Total number of individuals employed in calendar year 2018 (Part V, line 2a)	5	6,175
	6 Total number of volunteers (estimate if necessary)	6	875
	7a Total unrelated business revenue from Part VIII, column (C), line 12	7a	1,570,235
	b Net unrelated business taxable income from Form 990-T, line 34	7b	1,259,247
Revenue		Prior Year	Current Year
	8 Contributions and grants (Part VIII, line 1h)	3,724,422	1,129,931
	9 Program service revenue (Part VIII, line 2g)	607,338,244	434,770,045
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	6,889,175	7,452,998
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	222,696,483	261,909,803
	12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	840,648,324	705,262,777
Expenses			
	13 Grants and similar amounts paid (Part IX, column (A), lines 1-3)	201,302	366,411
	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)	316,200,752	333,002,955
	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)	473,248,528	365,285,861
	18 Total expenses Add lines 13-17 (must equal Part IX, column (A), line 25)	789,650,582	698,655,227
	19 Revenue less expenses Subtract line 18 from line 12	50,997,742	6,607,550
Net Assets or Fund Balances		Beginning of Current Year	End of Year
	20 Total assets (Part X, line 16)	1,056,902,686	991,316,249
	21 Total liabilities (Part X, line 26)	523,704,032	520,662,735
	22 Net assets or fund balances Subtract line 21 from line 20	533,198,654	470,653,514

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

Signature of officer	2020-08-14 Date
WILLIAM GIUDICE CFO Type or print name and title	

Paid Preparer Use Only	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN P00858539
	Firm's name ▶ PRICEWATERHOUSECOOPERS LLP			Firm's EIN ▶	
	Firm's address ▶ 2001 MARKET STREET SUITE 1800 PHILADELPHIA, PA 19103			Phone no (267) 330-3000	

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission

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 [X] 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 [X] 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 \$ 619,400,940 including grants of \$ 366,411) (Revenue \$ 697,275,947) 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 ▶ 619,400,940

Part IV Checklist of Required Schedules

Table with 3 columns: Question number, Question text, and Yes/No response. Rows include questions 1 through 22 regarding organizational requirements and reporting.

Part IV Checklist of Required Schedules (continued)

Table with 3 columns: Question ID, Question Text, and Yes/No columns. Rows include questions 23 through 38 regarding compensation, bond issues, escrow accounts, and various organizational transactions.

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 3 columns: Question ID, Question Text, and Yes/No columns. Rows include questions 1a, 1b, and 1c regarding Form 1096, Forms W-2G, and backup withholding rules.

2a Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return		2a	6,175		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? Note. If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	2b	Yes		
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?	3a	Yes		
b	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation in Schedule O	3b	Yes		
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a		No	
b	If "Yes," enter the name of the foreign country ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR)				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a		No	
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b		No	
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	5c			
6a	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a		No	
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b			
7 Organizations that may receive deductible contributions under section 170(c).					
a	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?	7a		No	
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b			
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c		No	
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e		No	
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f		No	
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h			
8 Sponsoring organizations maintaining donor advised funds.					
	Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	8			
9a	Did the sponsoring organization make any taxable distributions under section 4966?	9a			
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	9b			
10 Section 501(c)(7) organizations. Enter					
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11 Section 501(c)(12) organizations. Enter					
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)	11b			
12a Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?					
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13 Section 501(c)(29) qualified nonprofit health insurance issuers.					
a	Is the organization licensed to issue qualified health plans in more than one state? Note. See the instructions for additional information the organization must report on Schedule O	13a			
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a		No	
b	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation in Schedule O	14b			
15	Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see instructions and file Form 4720, Schedule N	15		No	
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O	16		No	

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



Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a Enter the number of voting members of the governing body at the end of the tax year (16); 1b Enter the number of voting members included in line 1a, above, who are independent (12); 2 Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee? (No); 3 Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? (No); 4 Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? (No); 5 Did the organization become aware during the year of a significant diversion of the organization's assets? (No); 6 Did the organization have members or stockholders? (No); 7a Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body? (No); 7b Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body? (No); 8 Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following: 8a The governing body? (Yes); 8b Each committee with authority to act on behalf of the governing body? (Yes); 9 Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O (No)

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

Table with 3 columns: Question, Yes, No. Rows include: 10a Did the organization have local chapters, branches, or affiliates? (No); 10b If "Yes," did the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with the organization's exempt purposes?; 11a Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form? (Yes); 11b Describe in Schedule O the process, if any, used by the organization to review this Form 990; 12a Did the organization have a written conflict of interest policy? If "No," go to line 13 (Yes); 12b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts? (Yes); 12c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done (Yes); 13 Did the organization have a written whistleblower policy? (Yes); 14 Did the organization have a written document retention and destruction policy? (Yes); 15 Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision? 15a The organization's CEO, Executive Director, or top management official (Yes); 15b Other officers or key employees of the organization (Yes); If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions); 16a Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year? (No); 16b If "Yes," did the organization follow a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable federal tax law, and take steps to safeguard the organization's exempt status with respect to such arrangements?

Section C. Disclosure

Table with 2 columns: Question, Answer. Rows include: 17 List the States with which a copy of this Form 990 is required to be filed (FL); 18 Section 6104 requires an organization to make its Form 1023 (or 1024-A if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply: Own website, Another's website, Upon request, Other (explain in Schedule O); 19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year; 20 State the name, address, and telephone number of the person who possesses the organization's books and records: 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	706,419			
	e Government grants (contributions)	1e	295,788			
	f All other contributions, gifts, grants, and similar amounts not included above	1f	127,724			
	g Noncash contributions included in lines 1a - 1f \$		10,689			
	h Total. Add lines 1a-1f		1,129,931			
Program Service Revenue	2a NET HEALTH CARE SERVICE REVENUES	Business Code				
		621500	434,770,045	434,202,737	567,308	
	b _____					
	c _____					
	d _____					
	e _____					
	f All other program service revenue		434,770,045			
g Total. Add lines 2a-2f		434,770,045				
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts)		7,361,108		7,361,108	
	4 Income from investment of tax-exempt bond proceeds		0			
	5 Royalties		0			
	6a Gross rents	(i) Real	(ii) Personal			
		3,269,100				
		b Less rental expenses	3,865,199			
		c Rental income or (loss)	-596,099	0		
	d Net rental income or (loss)			-596,099	1,002,927	-1,599,026
	7a Gross amount from sales of assets other than inventory	(i) Securities	(ii) Other			
		15,730,258	-27,835			
		b Less cost or other basis and sales expenses	15,610,533	0		
		c Gain or (loss)	119,725	-27,835		
	d Net gain or (loss)			91,890		91,890
	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					
	320,064,004					
	b Less cost of goods sold	b	61,984,797			
c Net income or (loss) from sales of inventory			258,079,207	258,079,207		
Miscellaneous Revenue	Business Code					
11a VENDOR REBATES	900099	3,375,148	3,375,148			
b PARKING DECK	900099	457,643	457,643			
c CONTRACTUAL LATE FEES	900099	120,690	120,690			
d All other revenue		473,214	473,214			
e Total. Add lines 11a-11d		4,426,695				
12 Total revenue. See Instructions		705,262,777	696,708,639	1,570,235	5,853,972	

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.	366,411	366,411		
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.	5,698,160	5,066,096	632,064	0
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.	283,272,355	253,498,462	29,773,893	0
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions).	-1,358,629	-1,148,612	-210,017	
9 Other employee benefits.	25,311,837	22,651,387	2,660,450	
10 Payroll taxes.	20,079,232	17,968,766	2,110,466	
11 Fees for services (non-employees)				
a Management.	0			
b Legal.	2,956,293	2,776,881	179,412	
c Accounting.	1,102,692		1,102,692	
d Lobbying.	91,430	91,430		
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).	86,846,589	81,281,195	5,565,394	0
12 Advertising and promotion.	2,155,693		2,155,693	
13 Office expenses.	28,317,610	25,930,884	2,386,726	
14 Information technology.	26,314,466	13,268,014	13,046,452	
15 Royalties.	0			
16 Occupancy.	7,964,025	6,483,222	1,480,803	
17 Travel.	2,971,261	1,756,754	1,214,507	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials.	0			
19 Conferences, conventions, and meetings.	1,061,351	353,012	708,339	
20 Interest.	9,623,658	9,623,658		
21 Payments to affiliates.	0			
22 Depreciation, depletion, and amortization.	36,160,672	32,149,787	4,010,885	
23 Insurance.	11,568,416	11,180,914	387,502	
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a PATIENT EXPENSES	101,215,355	101,215,355	0	0
b SERVICE/MAINTENANCE	20,780,850	15,091,473	5,689,377	0
c INDIGENT CARE ASSESSMENT	9,385,647	9,385,647	0	0
d ALL OTHER EXPENSES	16,769,853	10,410,204	6,359,649	0
e All other expenses.				
25 Total functional expenses. Add lines 1 through 24e.	698,655,227	619,400,940	79,254,287	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	307,702,627	2	286,803,986
	3 Pledges and grants receivable, net	0	3	0
	4 Accounts receivable, net	91,048,606	4	91,487,414
	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	10,225,267	8	13,571,249
	9 Prepaid expenses and deferred charges	16,862,080	9	19,122,585
	10a Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	10a 963,624,583		
	b Less accumulated depreciation	10b 441,615,803	446,258,459	10c 522,008,780
	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	184,778,347	15	58,294,935
16 Total assets. Add lines 1 through 15 (must equal line 34)	1,056,902,686	16	991,316,249	
Liabilities	17 Accounts payable and accrued expenses	84,578,616	17	86,552,962
	18 Grants payable	0	18	0
	19 Deferred revenue	0	19	0
	20 Tax-exempt bond liabilities	369,293,175	20	364,393,333
	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	20,654,554	23	20,102,680
	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	49,177,687	25	49,613,760
	26 Total liabilities. Add lines 17 through 25	523,704,032	26	520,662,735
Net Assets or Fund Balances	Organizations that follow SFAS 117 (ASC 958), check here <input checked="" type="checkbox"/> and complete lines 27 through 29, and lines 33 and 34.			
	27 Unrestricted net assets	533,198,654	27	470,653,514
	28 Temporarily restricted net assets	0	28	0
	29 Permanently restricted net assets	0	29	0
	Organizations that do not follow SFAS 117 (ASC 958), check here <input type="checkbox"/> and complete lines 30 through 34.			
	30 Capital stock or trust principal, or current funds		30	
	31 Paid-in or capital surplus, or land, building or equipment fund		31	
	32 Retained earnings, endowment, accumulated income, or other funds		32	
33 Total net assets or fund balances	533,198,654	33	470,653,514	
34 Total liabilities and net assets/fund balances	1,056,902,686	34	991,316,249	

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	705,262,777
2	Total expenses (must equal Part IX, column (A), line 25)	2	698,655,227
3	Revenue less expenses Subtract line 2 from line 1	3	6,607,550
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	533,198,654
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	-69,152,690
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	470,653,514

Part XII Financial Statements and Reporting

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

- 1** Accounting method used to prepare the Form 990 Cash Accrual Other _____
 If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O
- 2a** Were the organization's financial statements compiled or reviewed by an independent accountant?
 If 'Yes,' check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both
 Separate basis Consolidated basis Both consolidated and separate basis
- b** Were the organization's financial statements audited by an independent accountant?
 If 'Yes,' check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both
 Separate basis Consolidated basis Both consolidated and separate basis
- c** If "Yes," to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?
 If the organization changed either its oversight process or selection process during the tax year, explain in Schedule O
- 3a** As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?
- b** If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why in Schedule O and describe any steps taken to undergo such audits

	Yes	No
2a		No
2b	Yes	
2c	Yes	
3a		No
3b		

Additional Data

Software ID:

Software Version:

EIN: 59-1917016

Name: TALLAHASSEE MEMORIAL HEALTHCARE INC

Form 990 (2018)

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. PROVIDING INNOVATIVE TECHNOLOGY AND A BROAD SPECTRUM OF SERVICES, TMH HOLDS A NUMBER OF IMPORTANT DISTINCTIONS WITHIN THE REGIONAL HEALTH SECTOR. TMH IS HOME TO THE AREA'S ONLY STATE-DESIGNATED TRAUMA CENTER AND THE REGION'S ONLY ACCREDITED COMMUNITY HOSPITAL CANCER PROGRAM. TMH IS RECOGNIZED BY THE SOCIETY OF CHEST PAIN CENTERS AS AN ACCREDITED CHEST PAIN CENTER WITH PCI. ADDITIONALLY, TMH HAS THE ONLY NEUROLOGICAL AND LEVEL III NEONATAL INTENSIVE CARE UNITS AND IS NORTH FLORIDA'S ONLY COMPREHENSIVE STROKE CENTER. 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.

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			
CHRISTOPHER RUMANA MD CHAIR	2 0	X		X				0	0	0
MARTHA BARNETT CHAIR-ELECT	2 0	X		X				0	0	0
LEE HINKLE SECRETARY	2 0	X		X				0	0	0
ANDREW WONG MD TREASURER	2 0	X		X				0	0	0
SHELBY BLANK MD DIRECTOR	1 5	X						620,852	0	21,629
AJ BRICKLER MD DIRECTOR, INDEPENDENT PHYS	1 5	X						0	0	0
BRANT COPELAND DIRECTOR	1 5	X						0	0	0
KELLY DOZIER DIRECTOR	1 5	X						0	0	0
STEVEN EVANS DIRECTOR	1 5	X						0	0	0
WINSTON HOWELL DIRECTOR	1 5	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			
JAMES KILLIUS MD DIRECTOR	1 5 0 0	X						0	0	0
AVERY MCKNIGHT DIRECTOR	1 5 0 0	X						0	0	0
ERMAN MURRAY JR DIRECTOR	1 5 0 0	X						0	0	0
MARY PANKOWSKI PHD DIRECTOR	1 5 0 0	X						0	0	0
THOMAS TRUMAN MD DIRECTOR	1 5 0 0	X						0	0	0
GARY WINCHESTER DIRECTOR	1 5 0 0	X						0	0	0
ED CANUP EX-OFFICIO DIRECTOR	1 0 1 0	X						0	0	0
BETH GREEN EX-OFFICIO DIRECTOR	1 0 0 0	X						0	0	0
JOSEPH SOTTO MD 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				1,166,791	0	292,377

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 GUIDICE VP/CFO	54 0 1 0			X				618,303	0	90,948
BARBARA ALFORD CHIEF CLINICAL OFFICER/CNO/VP	55 0 0 0			X				521,952	0	64,791
CYNTHIA BLAIR CHIEF IMPROVEMENT/PLNG OFFICER	55 0 0 0			X				281,271	0	16,500
STEPHANIE M DERZYPOLSKI CHIEF COMMUNICATION OFFICER	55 0 0 0			X				236,023	0	39,993
ANDREA K FRIALL MD CHIEF MEDICAL STAFF OFFICER	18 0 0 0			X				212,950	0	0
DONALD LINDSEY CHIEF INFORMATION OFFICER	55 0 0 0			X				274,613	0	38,479
DEAN WATSON MD CHIEF HEALTH OPS OFFICER	55 0 0 0			X				531,923	0	73,531
YASHICA L WILSON-HEARNS VP/SUPPORT SERVICES	55 0 0 0			X				175,573	0	20,009
JOSEPH L CAMPS MD CHIEF INTEGRATION OFFICER/VP	15 0 0 0			X				183,207	0	0
STEVEN E HAYNES CHIEF HUMAN RESOURCE OFFICER	55 0 0 0			X				316,904	0	31,699

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			
NIGEL ALLEN CHIEF ADVANCEMENT OFFICER/VP	54 0 1 0			X				30,866	0	1,620
CHARLES YOWELL MD UROLOGIST	55 0 0 0					X		712,362	0	728
PHILIP V SHARP MD RADIATION ONCOLOGIST	55 0 0 0					X		831,736	0	29,474
ELIOT B SIELOGG MD GENERAL SURGEON	55 0 0 0					X		853,054	0	29,474
WILLIAM DOBAK MD HEMATOLOGIST/ONCOLOGIST	55 0 0 0					X		922,585	0	29,534
OVIDIU MARINA MD RADIATION ONCOLOGIST	55 0 0 0					X		1,293,514	0	29,515
MICKEY S MOORE FORMER CHIEF ADVANCEMENT OFF	0 0 0 0						X	257,081	0	14,077

SCHEDULE A
(Form 990 or 990-EZ)

Public Charity Status and Public Support

Complete if the organization is a section 501(c)(3) organization or a section 4947(a)(1) nonexempt charitable trust.
 Attach to Form 990 or Form 990-EZ.
 Go to www.irs.gov/Form990 for the latest information.

2018

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

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

- 1 A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
- 2 A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ))
- 3 A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
- 4 A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state _____
- 5 An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II)
- 6 A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
- 7 An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II)
- 8 A community trust described in **section 170(b)(1)(A)(vi)** (Complete Part II)
- 9 An agricultural research organization described in **170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land grant college of agriculture See instructions Enter the name, city, and state of the college or university _____
- 10 An organization that normally receives (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2).** (Complete Part III)
- 11 An organization organized and operated exclusively to test for public safety See **section 509(a)(4).**
- 12 An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g
 - a **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization **You must complete Part IV, Sections A and B.**
 - b **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s) **You must complete Part IV, Sections A and C.**
 - c **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions) **You must complete Part IV, Sections A, D, and E.**
 - d **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions) **You must complete Part IV, Sections A and D, and Part V.**
 - e Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization
 - f Enter the number of supported organizations _____
 - 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) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(f) Total
1	Gifts, grants, contributions, and membership fees received (Do not include any "unusual grant.")	1,892,594	1,602,289	1,171,428	3,724,422	1,129,931	9,520,664
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	1,892,594	1,602,289	1,171,428	3,724,422	1,129,931	9,520,664
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						9,520,664

Section B. Total Support

	Calendar year (or fiscal year beginning in) ▶	(a)2014	(b)2015	(c)2016	(d)2017	(e)2018	(f)Total
7	Amounts from line 4	1,892,594	1,602,289	1,171,428	3,724,422	1,129,931	9,520,664
8	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources	-374,956	105,610	287,579	5,048,467	6,765,009	11,831,709
9	Net income from unrelated business activities, whether or not the business is regularly carried on	1,016,454	1,134,955	1,091,544	1,642,699	1,259,247	6,144,899
10	Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						0
11	Total support. Add lines 7 through 10						27,497,272
12	Gross receipts from related activities, etc. (see instructions)					12	3,919,063,635

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 2018 (line 6, column (f) divided by line 11, column (f))	14	34.624%
15	Public support percentage for 2017 Schedule A, Part II, line 14	15	42.378%

- 16a 33 1/3% support test—2018.** 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—2017.** 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—2018.** 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—2017.** 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) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(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) 2014	(b) 2015	(c) 2016	(d) 2017	(e) 2018	(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 2018 (line 8, column (f) divided by line 13, column (f))	15	
16	Public support percentage from 2017 Schedule A, Part III, line 15	16	

Section D. Computation of Investment Income Percentage

17	Investment income percentage for 2018 (line 10c, column (f) divided by line 13, column (f))	17	
18	Investment income percentage from 2017 Schedule A, Part III, line 17	18	

19a 33 1/3% support tests—2018. 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—2017. 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

- 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 2018 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-2018	(iii) Distributable Amount for 2018
1 Distributable amount for 2018 from Section C, line 6			
2 Underdistributions, if any, for years prior to 2018 (reasonable cause required-- explain in Part VI) See instructions			
3 Excess distributions carryover, if any, to 2018			
a From 2013.			
b From 2014.			
c From 2015.			
d From 2016.			
e From 2017.			
f Total of lines 3a through e			
g Applied to underdistributions of prior years			
h Applied to 2018 distributable amount			
i Carryover from 2013 not applied (see instructions)			
j Remainder Subtract lines 3g, 3h, and 3i from 3f			
4 Distributions for 2018 from Section D, line 7			
\$			
a Applied to underdistributions of prior years			
b Applied to 2018 distributable amount			
c Remainder Subtract lines 4a and 4b from 4			
5 Remaining underdistributions for years prior to 2018, 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 2018 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 2019. Add lines 3j and 4c			
8 Breakdown of line 7			
a Excess from 2014.			
b Excess from 2015.			
c Excess from 2016.			
d Excess from 2017.			
e Excess from 2018.			

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

OMB No 1545-0047

2018
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
---	--

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)	91,430	91,430												
c	Total lobbying expenditures (add lines 1a and 1b)	91,430	91,430												
d	Other exempt purpose expenditures	698,563,797	700,195,903												
e	Total exempt purpose expenditures (add lines 1c and 1d)	698,655,227	700,287,333												
f	Lobbying nontaxable amount Enter the amount from the following table in both columns	1,000,000	1,000,000												
<table border="1" style="width: 100%;"> <thead> <tr> <th style="width: 50%;">If the amount on line 1e, column (a) or (b) is:</th> <th style="width: 50%;">The lobbying nontaxable amount is:</th> </tr> </thead> <tbody> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000</td> </tr> </tbody> </table>		If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:	Not over \$500,000	20% of the amount on line 1e	Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000	Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000	Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000	Over \$17,000,000	\$1,000,000		
If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:														
Not over \$500,000	20% of the amount on line 1e														
Over \$500,000 but not over \$1,000,000	\$100,000 plus 15% of the excess over \$500,000														
Over \$1,000,000 but not over \$1,500,000	\$175,000 plus 10% of the excess over \$1,000,000														
Over \$1,500,000 but not over \$17,000,000	\$225,000 plus 5% of the excess over \$1,500,000														
Over \$17,000,000	\$1,000,000														
g	Grassroots nontaxable amount (enter 25% of line 1f)	250,000	250,000												
h	Subtract line 1g from line 1a If zero or less, enter -0-														
i	Subtract line 1f from line 1c If zero or less, enter -0-														
j	If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?	<input type="checkbox"/> Yes <input type="checkbox"/> No													

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

Lobbying Expenditures During 4-Year Averaging Period					
Calendar year (or fiscal year beginning in)	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(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	97,499	79,152	93,548	91,430	361,629
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

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)).

	(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 AMERICAN HOSPITAL ASSOCIATION (AHA) AND FLORIDA HOSPITAL ASSOCIATION (FHA) MEMBERSHIP DUES ALLOCATED TO LOBBYING EXPENSES ----- AFFILIATED GROUP INFORMATION NAME OF ELECTING ORGANIZATION ----- TALLAHASSEE MEMORIAL HEALTHCARE, INC - DIRECT LOBBYING EXPENDITURES \$91,430 - OTHER EXEMPT PURPOSE EXPENDITURES \$698,563,797 THIS ORGANIZATION HAS MADE THE LOBBYING ELECTION UNDER I R C SECTION 501(H) FOR THE TAX YEAR ENDED SEPTEMBER 30, 2019 THIS ELECTION HAS NO BEEN REVOKED BEFORE THE START OF THE ORGANIZATION'S TAX YEAR THAT BEGAN IN 2018 NAME OF NON-ELECTING ORGANIZATION ----- SOUTHEAST COMMUNITY HEALTH SRVS, INC - DIRECT LOBBYING EXPENDITURES \$0 - OTHER EXEMPT PURPOSE EXPENDITURES \$215,162 TALLAHASSEE MEMORIAL HEALTHCARE FND - DIRECT LOBBYING EXPENDITURES \$0 - OTHER EXEMPT PURPOSE EXPENDITURES \$1,416,944

SCHEDULE D
(Form 990)

Department of the Treasury
Internal Revenue Service

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

OMB No 1545-0047
2018
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 7/25/06, and not on a historic structure listed in the National Register	2d	

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part IV Escrow and Custodial Arrangements.

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

- 1a** Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? Yes No
- b** If "Yes," explain the arrangement in Part XIII and complete the following table
- | | Amount |
|--|--------|
| c Beginning balance | |
| 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	8,370,073	7,958,119	7,521,314	7,134,085	9,171,531
b Contributions	205,387	251,445	256,272	195,126	375,335
c Net investment earnings, gains, and losses	246,929	164,009	181,583	198,103	94,119
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	8,822,389	8,370,073	7,958,119	7,521,314	7,134,085

- 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 |
| (ii) related organizations | Yes | 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		24,491,820		24,491,820
b Buildings		573,836,135	201,908,033	371,928,102
c Leasehold improvements		7,794,993	3,719,265	4,075,728
d Equipment		344,497,983	235,988,505	108,509,478
e Other		13,003,652		13,003,652
Total. Add lines 1a through 1e (Column (d) must equal Form 990, Part X, column (B), line 10(c)) . . . ▶				522,008,780

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	8,102,411
(2) DEPOSITS AND OTHER ASSETS	8,494,044
(3) OTHER RECEIVABLES	6,731,217
(4) SELF INSURANCE TRUST FUND	5,338,124
(5) UNEXPENDED CONSTRUCTION FUND	19,064,610
(6) SWAP COLLATERAL	150,000
(7) DUE FROM MEDICARE	10,414,529
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 15)	58,294,935

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	1,997,082
PROFESSIONAL LIABILITY SELF IN	22,321,007
OBLIGATION FOR SUPPLEMENTAL EX	3,818,785
DEFERRED COMP ARRANGEMENT	4,498,009
ASSET RETIREMENT OBLIGATION	380,000
AHCA ASSESSMENT	6,064,213
OTHER LIABILITIES	10,532,164
SECURITY DEPOSITS	2,500
(9)	
Total. (Column (b) must equal Form 990, Part X, col (B) line 25)	49,613,760

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

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

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

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

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

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

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

Part XIII Supplemental Information

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

Return Reference	Explanation
See Additional Data Table	

Part XIII Supplemental Information *(continued)*

Return Reference	Explanation

Additional Data

Software ID:
Software Version:
EIN: 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	1,997,082
PROFESSIONAL LIABILITY SELF IN	22,321,007
OBLIGATION FOR SUPPLEMENTAL EX	3,818,785
DEFERRED COMP ARRANGEMENT	4,498,009
ASSET RETIREMENT OBLIGATION	380,000
AHCA ASSESSMENT	6,064,213
OTHER LIABILITIES	10,532,164
SECURITY DEPOSITS	2,500

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)**

Department of the Treasury
Internal Revenue Service

Statement of Activities Outside the United States

▶ Complete if the organization answered "Yes" to Form 990, Part IV, line 14b, 15, or 16.
▶ Attach to Form 990.

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

OMB No 1545-0047

2018

Open to Public Inspection

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
Central America and the Caribbean			Program Services	Insurance Coverage	216,578
3a Sub-total					216,578
b Total from continuation sheets to Part I					
c Totals (add lines 3a and 3b)					216,578

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)

- 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 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, don't 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, don't file with Form 990)* Yes No

SCHEDULE H (Form 990)

Hospitals

OMB No 1545-0047

2018

Open to Public Inspection

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

Department of the Treasury

Name of the organization
TALLAHASSEE MEMORIAL HEALTHCARE INC

Employer identification number
59-1917016

Part I Financial Assistance and Certain Other Community Benefits at Cost

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

	Yes	No
1a	Yes	
1b	Yes	
3a	Yes	
3b	Yes	
4	Yes	
5a	Yes	
5b		No
5c		
6a	Yes	
6b	Yes	

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			25,666,559	0	25,666,559	3 670 %
b Medicaid (from Worksheet 3, column a)			69,982,161	47,906,555	22,075,606	3 160 %
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d Total Financial Assistance and Means-Tested Government Programs			95,648,720	47,906,555	47,742,165	6 830 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)						
f Health professions education (from Worksheet 5)			21,269,970	3,780,293	17,489,677	2 500 %
g Subsidized health services (from Worksheet 6)			89,797,724	61,331,931	28,465,793	4 080 %
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j Total. Other Benefits			111,067,694	65,112,224	45,955,470	6 580 %
k Total. Add lines 7d and 7j			206,716,414	113,018,779	93,697,635	13 410 %

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			590,418		590,418	
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			590,418		590,418	

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

		Yes	No
1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1		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	2		
			178,980,000
3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3		
			48,715,230
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		118,349,855
6 Enter Medicare allowable costs of care relating to payments on line 5	6		124,402,640
7 Subtract line 6 from line 5 This is the surplus (or shortfall)	7		-6,052,785
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 (owned 10% or more by officers, directors, trustees, key employees, and physicians—see instructions)

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

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

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

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

1

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

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 18</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 19</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	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?	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)	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 checked="" 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)	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
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)	DUE TO THE ADOPTION OF NEW ACCOUNTING PRONOUNCEMENT ASC 606, CURRENT YEAR IMPLICIT PRICE CONCESSIONS ARE TREATED AS A CONTRA-REVENUE ITEM ON THE STATEMENT OF REVENUE 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 OF THE FORM 990, SCHEDULE H INSTRUCTIONS -----

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, SECTION A, LINE 1 (BAD DEBT EXPENSE)	TMH REPORTS ITS IMPLICIT PRICE CONCESSIONS IN ACCORDANCE WITH GAAP AND AICPA GUIDELINES HFMA STATEMENT NO 15 HAS NOT BEEN ADOPTED BY THE AICPA ----- PART III, SECTION A, LINE 2/3 (IMPLICIT PRICE CONCESSIONS/BAD DEBT EXPENSE) 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 AND RECORDED AS IMPLICIT PRICE CONCESSIONS UNDER NEW ACCOUNTING PRONOUNCEMENT ASC 606)

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, SECTION A, LINE 4 (IMPLICIT PRICE CONCESSION FOOTNOTE)	THE IMPLICIT PRICE CONCESSION (BAD DEBT EXPENSE) FOOTNOTE DISCLOSURE CAN BE FOUND STARTING ON PAGE 16 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)	TMH 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
<p>PART VI, LINE 3 (PATIENT EDUCATION OF ELIGIBILITY FOR ASSISTANCE)</p>	<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)	TALLAHASSEE MEMORIAL HEALTHCARE (TMH) IS LOCATED IN FLORIDA'S CAPITAL CITY OF TALLAHASSEE, 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 TOTAL POPULATION OF MORE THAN 390,000. LOCATED IN LEON COUNTY - THE LARGEST IN THE PSA, REPRESENTING 75% OF THE FOUR-COUNTY POPULATION - TMH SERVES A VERY DIVERSE POPULATION. THE UNEMPLOYMENT RATE IN PSA RANGES FROM 3.3% TO 4.6%. THE NUMBER OF CHILDREN IN POVERTY RANGES FROM 16% IN WAKULLA COUNTY TO 38% IN GADSDEN COUNTY. THERE IS A DRAMATIC DIFFERENCE IN COLLEGE EDUCATION RATES BETWEEN THE SURROUNDING COUNTIES (AVERAGE OF 19%) COMPARED TO LEON COUNTY, HOME TO TWO STATE UNIVERSITIES, (AVERAGE OF 45.7%) (SOURCE: FLORIDA OFFICE OF ECONOMIC & DEMOGRAPHIC RESEARCH). THE HOUSEHOLD INCOME IN THESE FOUR COUNTIES RANGES FROM \$40,922 TO \$62,778. AS THE LARGEST SAFETY NET HOSPITAL IN THE SERVICE AREA, SERVING 17 COUNTIES IN NORTH FLORIDA AND SOUTH GEORGIA, TMH HAS A LONG HISTORY OF IMPROVING OVERALL HEALTH AND QUALITY OF LIFE THROUGHOUT THE REGION. DURING FISCAL YEAR 2019, TMH EXPANDED ACCESS TO CARE BY BRINGING NEW PHYSICIANS, FACILITIES AND TECHNOLOGIES TO THE AREA AND REACHED THE COMMUNITY WITH EDUCATIONAL EVENTS AND INITIATIVES. -----

Form and Line Reference	Explanation
<p>PART VI, LINE 5 (INFORMATION REGARDING PROMOTION OF COMMUNITY HEALTH)</p>	<p>AS THE LARGEST SAFETY NET HOSPITAL IN THE SERVICE AREA, SERVING 17 COUNTIES IN NORTH FLORIDA AND SOUTH GEORGIA, TMH HAS A LONG HISTORY OF IMPROVING OVERALL HEALTH AND QUALITY OF LIFE THROUGHOUT THE REGION. DURING FISCAL YEAR 2019, 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 MUCH NEEDED IN THE COMMUNITY. THE MAJORITY OF THESE SERVICES ARE PROVIDED BY THE TALLAHASSEE MEMORIAL METABOLIC HEALTH CENTER, THE TALLAHASSEE MEMORIAL TRANSITION CENTER, THE TALLAHASSEE MEMORIAL BIXLER TRAUMA & EMERGENCY, THE TALLAHASSEE MEMORIAL EMERGENCY CENTER - NORTHEAST AND RURAL CLINICS THROUGHOUT THE BIG BEND REGION. 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 METABOLIC HEALTH CENTER HELPS ADULT AND PEDIATRIC PATIENTS BETTER MANAGE THEIR DIABETES AND AVOID COMPLICATIONS. NEARLY A THIRD OF THESE 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. IN 2019, TMH EXPANDED THE TRANSITION CENTER'S SERVICES BY OPENING A SATELLITE LOCATION WITHIN THE KEARNEY CENTER - THE LARGEST SHELTER IN THE BIG BEND REGION, PROVIDING EMERGENCY SERVICES TO INDIVIDUALS EXPERIENCING, OR ON THE VERGE OF EXPERIENCING, HOMELESSNESS. THE PRESENCE OF THE TRANSITION CENTER WITHIN THE KEARNEY CENTER HAS SIGNIFICANTLY REDUCED CALLS FOR EMS, RESULTING IN LARGE SAVINGS FOR LEON COUNTY. PROVIDING A SPACE WHERE PATIENTS FEEL SAFE AND WELCOME HAS HELPED BREAK DOWN HEALTHCARE BARRIERS AND PROVIDE BETTER, EQUITABLE CARE TO OUR RESIDENTS. 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 THROUGH THE YEARS, TMH HAS INVESTED IN EXPANDING ACCESSIBILITY TO HEALTHCARE FOR THE COMMUNITY. IN ADDITION TO ESTABLISHING THE TRANSITION CENTER AND OPENING THE EMERGENCY CENTER - NORTHEAST, TMH HAS IMPLEMENTED TELEMEDICINE TECHNOLOGIES AND CULTIVATED RESIDENCY PROGRAMS AS ADDITIONAL AVENUES FOR OFFERING INCREASINGLY ACCESSIBLE HEALTHCARE. TELEMEDICINE ALLOWS PHYSICIANS, SPECIALISTS AND HEALTHCARE STAFF TO PROVIDE CONSULTATIONS TO FELLOW PHYSICIANS AND CONNECT WITH PATIENTS REMOTELY, EXPANDING ACCESS TO CARE FOR RESIDENTS IN 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. AS THE REGION'S SAFETY NET HOSPITAL, TMH'S TRAUMA AND EMERGENCY SERVICES OPERATE AT A FINANCIAL LOSS. HOWEVER, PROVIDING THE COMMUNITY ACCESS TO A DESIGNATED LEVEL II TRAUMA CENTER IS AN ESSENTIAL SERVICE FOR TMH'S SERVICE AREA. BY PROVIDING INCREASED COMPLEXITY AND VOLUME OF CARE IN THE EMERGENCY CENTER, THE FACILITY OFTEN REACHES CAPACITY AND EXPERIENCES EXTENDED WAIT TIMES FOR EMERGENT PATIENT CARE. BETWEEN THE BIXLER TRAUMA & EMERGENCY CENTER AND EMERGENCY CENTER - NORTHEAST ABOUT 315 PATIENTS ARE SEEN EACH DAY. THE MEDIAN PATIENT ARRIVAL TIME TO PATIENT PLACEMENT IN A BED WAS 17.5 MINUTES FISCAL YEAR 2019, WHILE THE MEDIAN PATIENT ARRIVAL TO PROVIDER EVALUATION TIME WAS 38.5 MINUTES. OPENED IN 2013, THE EMERGENCY CENTER - NORTHEAST CONTINUES TO EVOLVE AND TAKE ON A LARGER PATIENT POPULATION, INCLUDING THE OPENING OF A CHILDREN'S EMERGENCY CENTER IN AFFILIATION WITH WOLFSON CHILDREN'S HOSPITAL. THE AVERAGE DAILY PATIENT COUNT WAS 87 IN 2014 AND THEY NOW SEE AN AVERAGE OF 129 PATIENTS A DAY, NEARLY A QUARTER OF WHICH ARE PEDIATRIC PATIENTS. THIS HAS GREATLY INCREASED THE COMMUNITY'S ACCESS TO CARE. THE NUMBER OF PATIENTS WHO LEFT BEFORE BEING SEEN HAS REMAINED BELOW THE NATIONAL AVERAGE AT 2.85 PERCENT FOR FISCAL YEAR 2019. REGIONAL ACCESS TO PHYSICIANS. TMH'S FIVE RURAL FAMILY MEDICINE PRACTICES LOCATED IN GADSDEN, JEFFERSON, TAYLOR, WAKULLA AND CALHOUN COUNTIES ALSO INCREASE ACCESSIBILITY TO HEALTHCARE IN SURROUNDING RURAL COMMUNITIES. PRIMARY CARE OFFICES PROVIDE MUCH-NEEDED SERVICES TO THE RESIDENTS OF RURAL THESE COUNTIES THAT HAVE LIMITED ACCESS TO HEALTHCARE IN THEIR COMMUNITIES. AS PART OF THIS STRATEGY, TMH PHYSICIAN PARTNERS HAS EXPANDED THE REGIONAL REFERRAL PROCESS FOR SPECIALTY CARE IN THE SERVICE AREA AS WELL, COMPLEMENTI</p>

Form and Line Reference	Explanation
PART VI, LINE 5 (INFORMATION REGARDING PROMOTION OF COMMUNITY HEALTH)	<p>NG ALREADY ESTABLISHED PROVIDERS IN THESE AREAS THE SURROUNDING COUNTIES NOW HAVE ACCESS TO MEDICAL SPECIALTIES INCLUDING BARIATRICS, CARDIOVASCULAR, CARDIOTHORACIC, ENDOCRINOLOGY , GENERAL SURGERY, GENETICS, GYNECOLOGICAL-ONCOLOGY, ORAL MAXILLOFACIAL SURGERY, HEART FAI LURE, LIPIDS, MATERNAL-FETAL MEDICINE, NEUROLOGY, ONCOLOGY, PAIN MANAGEMENT, PSYCHIATRY, P ULMONARY, RHEUMATOLOGY AND UROLOGY, WITHOUT HAVING TO TRAVEL FAR FROM HOME (A BARRIER TO C ARE FOR MANY) EDUCATION & TRAINING PROGRAMS FOR MEDICAL PROFESSIONALS TMH CONTRIBUTES MI LLIONS OF DOLLARS EACH YEAR TO THE CLINICAL EDUCATION OF HEALTHCARE PROFESSIONALS THIS IN CLUDES TRAINING FOR FLORIDA STATE UNIVERSITY COLLEGE OF MEDICINE STUDENTS, FLORIDA A & M U NIVERSITY PHARMACY STUDENTS, HANDS-ON EXPERIENCE FOR NURSES FROM MANY DIFFERENT NURSING SC HOOLS THROUGHOUT NORTH FLORIDA AND SOUTH GEORGIA AND CONTINUING MEDICAL EDUCATION FOR PHYS ICIANs IN OUR COMMUNITY TMH AWARDED A LAND GRANT TO TALLAHASSEE COMMUNITY COLLEGE (TCC) A S PART OF ITS PLAN TO DEVELOP A HEALTH EDUCATION PARTNERSHIP CAMPUS ON A PORTION OF 81 4 A CRES OF UNDEVELOPED LAND ON THE HOSPITAL'S CAMPUS TODAY, THE 85,000-SQUARE-FOOT, THREE-ST ORY CENTER FEATURES SIX SIMULATION CENTERS, A 296-SEAT AUDITORIUM AND ADDITIONAL SPACE FOR EXPANSION ONE OF TMH'S MOST SIGNIFICANT CONTRIBUTIONS TO PROVIDING EDUCATION FOR HEALTHC ARE PROFESSIONALS IN OUR COMMUNITY IS THROUGH THE TALLAHASSEE MEMORIAL FAMILY MEDICINE RES IDENCY PROGRAM (FMRP), WHICH TRAINS PHYSICIANS WHO HAVE COMPLETED MEDICAL SCHOOL AND WISH TO TRAIN AND BECOME BOARD CERTIFIED IN THE SPECIALTY OF FAMILY MEDICINE FMRP IS THE OLDES T FAMILY MEDICINE RESIDENCY IN FLORIDA (46 YEARS) AND HAS PRODUCED 404 GRADUATES SINCE ITS INCEPTION IN 1973 OF THOSE, 175 HAVE CHOSEN TO REMAIN IN FLORIDA AND 144 IN TMH'S SERVIC E AREA, HELPING TO ENSURE ACCESS TO PRIMARY HEALTHCARE FOR RESIDENTS OF THE BIG BEND AND S OUTH GEORGIA IN THE FALL OF 2011, TALLAHASSEE MEMORIAL AND THE FLORIDA STATE UNIVERSITY C OLLEGE OF MEDICINE ESTABLISHED A JOINT INTERNAL MEDICINE RESIDENCY PROGRAM FOR THE BIG BEN D REGION THE INTERNAL MEDICINE RESIDENCY PROGRAM CURRENTLY HAS 27 RESIDENTS IN 2016, THE FLORIDA STATE UNIVERSITY COLLEGE OF MEDICINE GENERAL SURGERY RESIDENCY PROGRAM AT TALLAHA SSEE MEMORIAL HEALTHCARE ACCEPTED ITS FIRST RESIDENTS FOR ACADEMIC YEAR 2016-2017 THIS FI VE-YEAR PROGRAM IS THE FIRST SURGERY RESIDENCY PROGRAM IN NORTHWEST FLORIDA AND WILL PRODU CE TWO NEW GENERAL SURGEONS EACH YEAR ONCE IT IS AT FULL CAPACITY THE FIRST GRADUATION OF RESIDENTS WILL BE IN JUNE OF 2020 IMPROVING METABOLIC HEALTH TALLAHASSEE MEMORIAL HEALT HCARE WAS AN ACTIVE FOUNDING SPONSOR FOR THE STOMP STUDENTS STOMPING FOR GOOD HEALTH (FOR MERLY STOMP OUT TYPE 2 DIABETES) EVENT TARGETED AT LEON COUNTY SCHOOL STUDENTS, AND THEIR FAMILIES, TO PROMOTE HEALTHY WEIGHT, EATING BEHAVIORS AND PHYSICAL ACTIVITY SINCE OPENING , THE METABOLIC HEALTH CENTER HAS OFFERED DIABETES, NUTRITION AND CARDIOVASCULAR DISEASE E DUCATION AND PREVENTATIVE WELLNESS TALKS TO IMPROVE POPULATION HEALTH ADDITIONALLY, DIABE TES EDUCATION AND NUTRITION COUNSELING CONTINUE TO BE OFFERED MONTHLY AT OUTREACH SITES IN QUINCY, BLOUNTSTOWN, PERRY AND CRAWFORDVILLE THE METABOLIC CENTER ALSO HOUSES OUR COMMUN ITY'S ONLY DIABETES PREVENTION PROGRAM ACCREDITED BY THE CENTERS FOR DISEASE CONTROL AND P REVENTION (CDC) AND THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) IN FISCAL YEAR 201 9, THE PROGRAM SUPPORTED 30 PARTICIPANTS WHO HAD AN AVERAGE WEIGHT LOSS OF 5 98% OF THEIR BODY WEIGHT IN FISCAL YEAR 2019, TMH BEGAN UTILIZING TELEMEDICINE AS WAY TO CONNECT NEWLY DIAGNOSED PEDIATRIC DIABETES PATIENTS WITH EDUCATORS, NURSES AND DIETICIANS AT THE METABO LIC HEALTH CENTER PREVIOUSLY, THESE PATIENTS WOULD BE DIAGNOSED IN THE INPATIENT CHILDREN 'S CENTER, THEN SCHEDULE FOLLOW-UP APPOINTMENTS WITH THE OUTPATIENT METABOLIC HEALTH CENTE R, REQUIRING MULTIPLE TRIPS AND A LAPSE IN TIME BETWEEN DIAGNOSIS AND EDUCATION TELEMEDIC INE NOW ALLOWS EDUCATION TO BEGIN IN THE</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

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 (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? 1		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER—24 hours	ER—other	Other (Describe)	Facility reporting group
1	TALLAHASSEE MEMORIAL HOSPITAL 1300 MICCOSUKEE ROAD TALLAHASSEE, FL 32309 WWW TMH ORG LICENSE# 4080	X	X		X			X			

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 5, 6B (INPUT FROM COMMUNITY, COLLABORATION)	TALLAHASSEE MEMORIAL HEALTHCARE, INC ("TMH") COMPLETED ITS THIRD COMMUNITY HEALTH NEEDS ASSESSMENT ("CHNA") DURING THE YEAR ENDING SEPTEMBER 30, 2019 YOU MAY FIND FURTHER DETAILS AND COMPREHENSIVE RESULTS AT HTTPS //WWW TMH ORG/ABOUT-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 ----- PART V, SECTION B, LINE 9 (TAX YEAR THE MOST RECENT IMP STRATEGY WAS ADOPTED) THE ORGANIZATION'S MOST RECENT IMPLEMENTATION STRATEGY WAS ADOPTED BY 2/15/2020, AS PERMITTED UNDER THE REGULATIONS -----

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
<p>PART V, SECTION B, LINE 11 (ADDRESSING THE NEEDS IDENTIFIED IN THE CHNA)</p>	<p>TALLAHASSEE MEMORIAL HEALTHCARE (TMH) CONDUCTED A COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) IN 2016 IDENTIFICATION OF FIVE KEY HEALTH PRIORITIES EVOLVED FOLLOWED BY CREATION OF A 2 017-2019 IMPLEMENTATION PLAN TO ADDRESS EACH OF THESE PRIORITY AREAS THE FIVE KEY HEALTH PRIORITIES ARE (1) CHILDREN'S 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 2019 PLEASE VISIT HTTPS //WWW TMH ORG/ABOUT -US/COMMUNITY-REPORTS/COMMUNITY-NEED-REPORT TO VIEW OUR MOST RECENT CHNA PUBLISHED IN SEPT EMBER 2019 AND IMPLEMENTATION STRATEGY PUBLISHED IN FEBRUARY 2020 FOR FISCAL YEARS 2020 TO 2022 (1) CHILDREN'S CONCERNS THE LONG-TERM GOAL FOR PRIORITY AREA, CHILDREN'S 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 AS OF 2019 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 H OSPITALS 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, M D WOMEN'S 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 PARENT'S 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 WOMEN'S 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 CHILDREN'S CONCERNS, TMH CONTINUES SUPPORT OF BREAST FEEDING ONCE MOM AND BABY HAVE</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>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 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 SERVICE ALSO PROVIDES A SOCIAL OUTLET FOR MOMS DURING THEIR TRANSITION AFTER DELIVERY PARTICIPATION IN SUPPORT GROUPS EXPERIENCED AN INCREASE IN 2019 COMPARED TO THE LAST FEW YEARS APPROXIMATELY 2,500 MOTHERS ATTENDED IN FISCAL YEAR 2019, COMPARED TO ABOUT 2,300 MOTHERS THE PREVIOUS YEARS, SHOWING A 9% INCREASE IN PARTICIPATION OVER THE LAST FEW YEARS, TMH HAS EXPERIENCED SIGNIFICANT IMPROVEMENT IN INPATIENT BREASTFEEDING RATES IN 2019, TALLAHASSEE MEMORIAL HEALTHCARE DELIVERED 3,700 BABIES BREASTFEEDING INITIATION RATE FOR BABIES ELIGIBLE TO RECEIVE BREASTMILK WAS 84%, EXCEEDING THE GOAL OF 80% FIFTY-SIX PERCENT OF BABIES WHO WERE ELIGIBLE TO RECEIVE BREASTMILK WERE EXCLUSIVELY BREASTFED, EXCEEDING THE GOAL OF 50% IN 2019, THE WOMEN AND CHILDREN'S CENTER BEGAN PREPARATION FOR SAFE SLEEP CERTIFICATION THIS PROGRAM WILL BE AWARDED THROUGH DISPLAY OF SEVERAL STEPS TO FURTHER EDUCATE PARENTS REGARDING THEIR NEWBORNS SAFETY DURING SLEEP INCLUDING SAFE SLEEP TECHNIQUE, SLEEP SACKS DISTRIBUTED TO EACH NEWBORN AND WRITTEN EDUCATION FOR PARENTS THE THIRD GOAL FOR THE CHILDREN'S 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 2019, OVER 2,000 WOMEN RECEIVED SERVICES FROM THE TMH FAMILY MEDICINE RESIDENCY PARTNERSHIP WITH THOSE HEALTH DEPARTMENTS THE NUMBER OF WOMEN RECEIVING SERVICES WAS STABLE FROM YEARS PAST IN 2019, 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 FY 2019 WHAT BEGAN IN 2018, EVOLVED INTO A 24/7/365 SERVICE AT THE HOSPITAL DEDICATED SOLELY TO SERVING PREGNANT WOMEN THIS OB TRIAGE/EMERGENCY UNIT IS NOW FULLY STAFFED BY FAMILY MEDICINE RESIDENCY MIDWIVES/APRN, RESIDENT PHYSICIANS, AND OB FELLOWS ANY PATIENT WHO ARRIVES, REGARDLESS OF THEIR ABILITY TO PAY, THEIR PRENATAL CARE HISTORY, AND/OR THEIR PCP, WILL RECEIVE CONSISTENT, HIGH-QUALITY, FOCUSED OBSTETRICAL CARE THIS IS THE ONLY SERVICE OF ITS TYPE IN THE SURROUNDING BIG BEND REGION (</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>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 2019, WE CONTINUED EFFORTS AND EXPANDED ON SEVERAL STRATEGIES AIMED AT MEETING THESE GOALS THE PRIMARY 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 HEALTHCARE THE PROGRAM IS DESIGNED TO ADDRESS BOTH SOCIAL DETERMINANTS OF HEALTH, PARTICULARLY ENVIRONMENTS AND BEHAVIORS LINKED TO HEALTHY NUTRITION CHOICES AND FRUIT AND VEGETABLE CONSUMPTION AND THE CLINICAL CARE NEEDS OF PATIENTS VAST HEALTH AND SOCIAL DISPARITIES EXIST BETWEEN BLACK AND WHITE POPULATIONS IN LEON COUNTY, FLORIDA THE SOUTHSIDE TALLAHASSEE COMMUNITY IS PREDOMINANTLY BLACK WITH APPROXIMATELY 88-99% BLACK RESIDENTS THE 2016 LEON COUNTY MINORITY HEALTH PROFILE SHOWS THE BLACK/WHITE RATIO FOR ADULT DIABETES DIAGNOSIS TO BE 1.5:1, ER VISITS DUE TO DIABETES 2.7:1, HOSPITALIZATION RATE 2.3:1 AND AGE-ADJUSTED DEATH RATE 3.1:1 IN ADDITION, THIS PROFILE ALSO SHOWS A 2:1 RATIO FOR POVERTY, 2.7:1 RATIO FOR UNEMPLOYMENT AND 0.6:1 RATIOS FOR BOTH HOUSEHOLD INCOME AND OWNER OCCUPIED HOUSING UNITS SINCE ITS INCEPTION IN MAY 2018, THE SOUTHSIDE FARMER'S MARKET HAS SERVED OVER 7,500 PARTICIPANTS MARKETS ARE HELD TWICE A MONTH FROM MAY TO DECEMBER EACH YEAR AND SERVICE OVER 250 ATTENDEES PER MARKET A WIDE VARIETY OF FRESH, LOCAL FRUITS AND VEGETABLES, EGGS, HONEY AND OTHER HANDMADE GOODS SUCH AS SOAPS, FACIAL CARE AND CANDLES WERE INFUSED INTO THE COMMUNITY BOTH IMPROVING ACCESS TO THE SE ITEMS AND SUPPORTING THE LOCAL ECONOMY OVER \$12,000 WORTH OF FRESH, LOCAL PRODUCE AND GOODS WERE INFUSED INTO THE COMMUNITY EACH MARKET SEASON COMMUNITY BUILDING IS ANOTHER IMPORTANT FACET OF THE MARKETS</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 -----

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

Schedule I (Form 990)

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

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

Attach to Form 990.

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

OMB No 1545-0047

2018

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 General Information on Grants and Assistance

- 1 Does the organization maintain records to substantiate the amount of the grants or assistance...
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

Table with 8 columns: (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. Rows 1-12.

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table 10
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") MAINTAINS A SPONSORSHIP COMMITTEE WHICH OVERSEES THE ORGANIZATION'S SPONSORSHIP AND GRANT-MAKING PROCESSES 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 TMH'S MISSION AND VISION, AS WELL AS HOW THE PROPOSED ACTIVITY CAN HELP THE COMMUNITY APPLICATIONS AND FURTHER INFORMATION ARE AVAILABLE ON TMH'S 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)	10,000		FMV	N/A	SPONSORSHIP - HEART WALK
WORD OF SOUTH A FESTIVAL OF LITERATURE & MUSIC PO BOX 861 TALLAHASSEE, FL 32302	46-3527772	501(C)(3)	12,500		FMV	N/A	SPONSORSHIP - WORD OF SOUTH

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	SPONSORSHIP - TURKEY TROT
MARCH OF DIMES FOUNDATION 1990 VILLAGE WAY 3 TALLAHASSEE, FL 32308	13-1846366	501(C)(3)	10,000		FMV	N/A	SPONSORSHIP - MARCH FOR BABIES

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 - SPRING TIME TALLAHASSEE
THE TALLAHASSEE COMMUNITY COLLEGE FDN 444 APPEYARD DR TALLAHASSEE, FL 32304	59-2091480	501(C)(3)	10,000		FMV	N/A	SPONSORSHIP - CLEAVER & CORK

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		13,400		FMV	N/A	SPONSORSHIPS - AWARDS SPONSOR
FLORIDA A & M UNIVERSITY FOUNDATION INC 625 E TENNESSEE ST SUITE 100 TALLAHASSEE, FL 32308	59-0977035	501(C)(3)	35,000		FMV	N/A	SPONSORSHIP - FAMU

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 CANCER SOCIETY 2619 CENTENNIAL BLVD TALLAHASSEE, FL 32308	13-1788491	501(C)(3)	7,000		FMV	N/A	SPONSORSHIP - RELAY FOR LIFE EVENT
GOODWOOD MUSEUM & GARDENS INC 1600 MICCOSUKEE ROAD TALLAHASSEE, FL 32308	31-1539800	501(C)(3)	30,000		FMV	N/A	SPONSORSHIP - PATH TO WELLNESS

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

(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
UNITED WAY OF THE BIG BEND INC 307 EAST 7TH AVENUE TALLAHASSEE, FL 32303	59-6011150	501(C)(3)	105,000		FMV	N/A	SPONSORSHIP - UNITED WAY PROGRAMS

Schedule J
(Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

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

OMB No 1545-0047

2018

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 -----

Return Reference	Explanation
FORM 990, SCHEDULE J, PART I, LINE 4A	<p>DETAIL OF SEVERANCE PAYMENTS SEVERANCE PAYMENTS WERE MADE TO THE FOLLOWING INDIVIDUALS DURING THE FISCAL YEAR ENDING 9-30-2019 AND WERE INCLUDED AS A COMPONENT OF COMPENSATION REPORTED ON FORM 990, SCHEDULE J, PART II, COLUMN (B)(III) FOR EACH INDIVIDUAL</p> <p>MICKEY S MOORE- \$85,250 -----</p>

Return Reference	Explanation
FORM 990, SCHEDULE J, LINE 4B	<p>DETAIL OF SUPPLEMENTAL NONQUALIFIED RETIREMENT PLANS 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- DISTRIBUTIONS OF \$105,959 STEPHANIE M DERZYPOLSKI- NO DISTRIBUTIONS WILLIAM GIUDICE- NO DISTRIBUTIONS STEVEN E HAYNES- NO DISTRIBUTIONS DONALD LINDSEY- NO DISTRIBUTIONS DEAN WATSON, MD- NO DISTRIBUTIONS YASHICA WILSON-HEARNS- NO DISTRIBUTIONS NIGEL ALLEN- NO DISTRIBUTIONS -----</p>

Return Reference	Explanation
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 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



Schedule J (Form 990) 2018

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				
SHELBY BLANK MD DIRECTOR	(i)	288,010	330,428	2,414	16,500	5,129	642,481	0
	(ii)	0	0	0	0	0	0	0
G MARK O'BRYANT EX-OFFICIO DIRECTOR & CEO	(i)	884,020	236,640	46,131	278,856	13,521	1,459,168	0
	(ii)	0	0	0	0	0	0	0
WILLIAM GUIDICE VP/CFO	(i)	509,819	96,424	12,060	77,432	13,516	709,251	0
	(ii)	0	0	0	0	0	0	0
BARBARA ALFORD CHIEF CLINICAL OFFICER/CNO/VP	(i)	347,515	58,325	116,112	51,779	13,012	586,743	0
	(ii)	0	0	0	0	0	0	0
CYNTHIA BLAIR CHIEF IMPROVEMENT/PLNG OFFICER	(i)	225,866	48,854	6,551	16,500	0	297,771	0
	(ii)	0	0	0	0	0	0	0
STEPHANIE M DERZYPOLSKI CHIEF COMMUNICATION OFFICER	(i)	201,154	33,757	1,112	26,978	13,015	276,016	0
	(ii)	0	0	0	0	0	0	0
ANDREA K FRIALL MD CHIEF MEDICAL STAFF OFFICER	(i)	184,075	28,875	0	0	0	212,950	0
	(ii)	0	0	0	0	0	0	0
DONALD LINDSEY CHIEF INFORMATION OFFICER	(i)	237,264	35,247	2,102	25,505	12,974	313,092	0
	(ii)	0	0	0	0	0	0	0
MICKEY S MOORE FORMER CHIEF ADVANCEMENT OFF	(i)	112,943	41,099	103,039	13,960	117	271,158	0
	(ii)	0	0	0	0	0	0	0
DEAN WATSON MD CHIEF HEALTH OPS OFFICER	(i)	434,960	84,743	12,220	60,557	12,974	605,454	0
	(ii)	0	0	0	0	0	0	0
YASHICA L WILSON-HEARNS VP/SUPPORT SERVICES	(i)	154,464	20,161	948	19,806	203	195,582	0
	(ii)	0	0	0	0	0	0	0
JOSEPH L CAMPS MD CHIEF INTEGRATION OFFICER/VP	(i)	183,207	0	0	0	0	183,207	0
	(ii)	0	0	0	0	0	0	0
STEVEN E HAYNES CHIEF HUMAN RESOURCE OFFICER	(i)	287,401	24,000	5,503	26,349	5,350	348,603	0
	(ii)	0	0	0	0	0	0	0
CHARLES YOWELL MD UROLOGIST	(i)	592,082	120,010	270	0	728	713,090	0
	(ii)	0	0	0	0	0	0	0
PHILIP V SHARP MD RADIATION ONCOLOGIST	(i)	491,912	339,410	414	16,500	12,974	861,210	0
	(ii)	0	0	0	0	0	0	0
ELIOT B SIELOGG MD GENERAL SURGEON	(i)	645,151	204,836	3,067	16,500	12,974	882,528	0
	(ii)	0	0	0	0	0	0	0
WILLIAM DOBAK MD HEMATOLOGIST/ONCOLOGIST	(i)	484,548	437,767	270	16,500	13,034	952,119	0
	(ii)	0	0	0	0	0	0	0
OVIDIU MARINA MD RADIATION ONCOLOGIST	(i)	401,761	891,573	180	16,500	13,015	1,323,029	0
	(ii)	0	0	0	0	0	0	0

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

Schedule K (Form 990)

Supplemental Information on Tax-Exempt Bonds

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

OMB No 1545-0047

2018

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		29,821,300					
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		251,166,124					
11	Other spent proceeds	110,156,358		0					
12	Other unspent proceeds	0		19,044,411					
13	Year of substantial completion	2015		2019					
		Yes	No	Yes	No	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 ▶	0 %		0 %					
6 Total of lines 4 and 5	0 %		0 %					
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	0 %		0 %					
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.**
 ▶ **Go to www.irs.gov/Form990 for the latest information.**

2018

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

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

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

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

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

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

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

Part IV Business Transactions Involving Interested Persons.

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

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

Part V Supplemental Information

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

Return Reference	Explanation

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
JOSEPH L CAMPS	FAMILY MEMBER OF OFFICER	63,228	EMPLOYMENT		No
STEPHANIE TRUMAN	FAMILY MEMBER OF BOARD MEMBER	56,154	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
AJ BRICKLER MD	FAMILY MEMBER OF BOARD MEMBER	160,609	EMPLOYMENT		No
DAVID BRICKLER	FAMILY MEMBER OF BOARD MEMBER	139,196	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
LYNN BRICKLER	FAMILY MEMBER OF BOARD MEMBER	92,499	EMPLOYMENT		No
MAD DOG CONSTRUCTION COMPANY	SIMILAR DIRECTOR/OWNER	2,431,787	CONSTRUCTION SERVICES		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
SHELBY BLANK MD	BOARD MEMBER	616,914	EMPLOYMENT		No

SCHEDULE O
(Form 990 or 990-EZ)

Supplemental Information to Form 990 or 990-EZ

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

▶ Attach to Form 990 or 990-EZ.

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

OMB No 1545-0047

2018

Open to Public Inspection

Department of the Treasury

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, LINE 11	<p>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 2018 FORM 990 FOR THE FISCAL YEAR ENDING SEPTEMBER 30 2019 WAS REVIEWED AND APPROVED BY VA RIOUS SENIOR FINANCE TEAM MEMBERS BEFORE IT WAS FILED WITH THE IRS THE AUDIT AND COMPLIAN CE COMMITTEE OF THE BOARD OF DIRECTORS REVIEWED THE 990 PRIOR TO ITS FILING ALL MEMBERS O F THE BOARD WERE AFFORDED THE OPPORTUNITY TO REVIEW THE FORM 990 PRIOR TO ITS FILING ----</p> <p>-----</p>

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, 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 -----

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, 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 TRANSACTIONS FOR TAX PURPOSES THIS IS REQUIRES A REVIEW OF COMPENSATION DETERMINATION BY DISINTERESTED PERSONS, USE OF APPROPRIATE COMPARABILITY DATA AND CONTEMPORANEOUS DOCUMENTATION OF THE PROCESS -----

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, LINE 19	AVAILABILITY OF DOCUMENTS TO THE PUBLIC OUR GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY AND CONSOLIDATED FINANCIAL STATEMENTS ARE AVAILABLE TO THE PUBLIC UPON REQUEST A COPY OF OUR CONFLICT OF INTEREST POLICY IS ALSO AVAILABLE TO THE PUBLIC ON THE TMH WEBSITE CONSOLIDATED FINANCIAL STATEMENTS ARE FILED WITH THE DIGITAL ASSURANCE CERTIFICATION, LLC, AGENCY FOR HEALTH CARE ADMINISTRATION AND A COPY OF OUR FORM 990 IS FILED WITH THE FLORIDA DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES -----

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	DETAIL OF OTHER CHANGES IN NET ASSETS CHANGE IN ADDITIONAL PENSION LIABILITY \$ (71,708,509) CHANGE IN FAIR VALUE OF DERIVATIVE 2,658,939 ADDITIONAL DEPRECIATION (103,120) ----- ----- TOTAL \$(69,152,690) -----

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION INDEPENDENT LAB TOTAL FEES 5484515

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION CONSULTING TOTAL FEES 4225497

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION OTHER PROFESSIONAL SERVICES TOTAL FEES 35324615

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990 PART IX LINE 11G	DESCRIPTION PHYSICIAN PROFESSIONAL FEES TOTAL FEES 41811962

**SCHEDULE R
(Form 990)**

Related Organizations and Unrelated Partnerships

OMB No 1545-0047

2018

**Open to Public
Inspection**

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

Department of the Treasury
Internal Revenue Service

Name of the organization
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

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	2,985,899	24,607,391	100 000 %	Yes	
(2) PRIME MERIDIAN HEALTH VENTURES INC 1309 THOMASVILLE ROAD TALLAHASSEE, FL 32308 59-2668613	DIAG IMAGING	FL	TMHV	C CORP			100 000 %	Yes	
(3) TALLAHASSEE MEMORIAL TELEPHONE COMPANY 1309 THOMASVILLE ROAD TALLAHASSEE, FL 32308 59-3395937	TELEPHONE COMM	FL	TMHV	C CORP			100 000 %	Yes	
(4) PREMIER HEALTH & FITNESS CENTER INC 3521 MACLAY BOULEVARD TALLAHASSEE, FL 32312 59-2471569	FITNESS CENTER	FL	TMHV	C CORP			100 000 %	Yes	

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

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

	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 Yes	
i Exchange of assets with related organization(s)	1i	No
j Lease of facilities, equipment, or other assets to related organization(s)	1j Yes	
k Lease of facilities, equipment, or other assets from related organization(s)	1k Yes	
l Performance of services or membership or fundraising solicitations for related organization(s)	1l	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)

Return Reference	Explanation

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
(1)	SOUTHEAST COMMUNITY HEALTH SERVICES	A	675	FMV
(1)	SOUTHEAST COMMUNITY HEALTH SERVICES	K	489,092	FMV
(2)	TALLAHASSEE MEMORIAL HEALTHCARE FOUNDATION	C	706,419	FMV
(3)	SOUTHEAST COMMUNITY HEALTH SERVICES	O,Q	53,021	FMV
(4)	TALLAHASSEE MEMORIAL HEALTHCARE FOUNDATION	O,Q	968,124	FMV
(5)	TALLAHASSEE MEMORIAL HEALTHCARE VENTURES INC	A	1,401,864	FMV
(6)	TALLAHASSEE MEMORIAL HEALTHCARE VENTURES INC	K	322,114	FMV