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Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

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

OMB No 1545-0047

2018

Open to Public Inspection

A For the 2019 calendar year, or tax year beginning 01-01-2018 , and ending 12-31-2018

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

C Name of organization
TRUSTEES OF MEASE HOSPITAL INC

Doing business as

Number and street (or P O box if mail is not delivered to street address) | Room/suite
601 MAIN STREET

City or town, state or province, country, and ZIP or foreign postal code
DUNEDIN, FL 34698

D Employer identification number
59-0855412

E Telephone number
(727) 462-7697

G Gross receipts $ 487,213,041

F Name and address of principal officer
GLENN WATERS
601 MAIN STREET
DUNEDIN, FL 34698

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

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

H(c) Group exemption number ▶

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

J Website: ▶ SEE SCHEDULE O

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

L Year of formation 1938

M State of legal domicile FL

Part I Summary

1 Briefly describe the organization's mission or most significant activities
TRUSTEES OF MEASE HOSPITAL, INC WILL IMPROVE THE HEALTH OF ALL WE SERVE THROUGH COMMUNITY-OWNED HEALTH CARE SERVICES THAT SET THE STANDARD FOR HIGH-QUALITY, COMPASSIONATE CARE

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

3	Number of voting members of the governing body (Part VI, line 1a)	**3**	21
4	Number of independent voting members of the governing body (Part VI, line 1b)	**4**	18
5	Total number of individuals employed in calendar year 2018 (Part V, line 2a)	**5**	3,073
6	Total number of volunteers (estimate if necessary)	**6**	819
7a	Total unrelated business revenue from Part VIII, column (C), line 12	**7a**	40,449
b	Net unrelated business taxable income from Form 990-T, line 34	**7b**	88,510

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	955,244	1,581,367
9	Program service revenue (Part VIII, line 2g)	460,195,897	481,637,016
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	-657	70,350
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	4,743,638	3,924,108
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	465,894,122	487,212,841
13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	112,108	109,474
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)	161,666,570	167,126,900
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)	240,927,256	256,552,007
18	Total expenses Add lines 13–17 (must equal Part IX, column (A), line 25)	402,705,934	423,788,381
19	Revenue less expenses Subtract line 18 from line 12	63,188,188	63,424,460

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	819,861,552	880,583,582
21	Total liabilities (Part X, line 26)	29,678,113	28,499,695
22	Net assets or fund balances Subtract line 21 from line 20	790,183,439	852,083,887

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge

Sign Here

Signature of officer — Date: 2019-11-12

RONALD BEAMON CFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check ☐ if self-employed	PTIN
				P01346034

Firm's name ▶ ERNST & YOUNG US LLP — Firm's EIN ▶ 34-6565596

Firm's address ▶ 201 NORTH FRANKLIN STREET SUITE 2400 TAMPA, FL 33602 — Phone no (813) 225-4800

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

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission

TRUSTEES OF MEASE HOSPITAL, INC WILL IMPROVE THE HEALTH OF ALL WE SERVE THROUGH COMMUNITY-OWNED HEALTH CARE SERVICES THAT SET THE STANDARD FOR HIGH-QUALITY, COMPASSIONATE CARE

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

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

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

If "Yes," describe these changes on Schedule O

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

4a (Code) (Expenses $ 346,980,972 including grants of $ 109,474) (Revenue $ 481,997,385)

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** ▶ 346,980,972

Part IV Checklist of Required Schedules

			Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1	Yes	
2	Is the organization required to complete *Schedule B, Schedule of Contributors* (see instructions)?	2	Yes	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3		No
4	**Section 501(c)(3) organizations.** Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? *If "Yes," complete Schedule C, Part II*	4	Yes	
5	Is the organization a section 501(c)(4), 501(c)(5), or 501(c)(6) organization that receives membership dues, assessments, or similar amounts as defined in Revenue Procedure 98-19? *If "Yes," complete Schedule C, Part III*	5		No
6	Did the organization maintain any donor advised funds or any similar funds or accounts for which donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		No
7	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas, or historic structures? *If "Yes," complete Schedule D, Part II*	7		No
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		No
9	Did the organization report an amount in Part X, line 21 for escrow or custodial account liability, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		No
10	Did the organization, directly or through a related organization, hold assets in temporarily restricted endowments, permanent endowments, or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10		No
11	If the organization's answer to any of the following questions is "Yes," then complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable			
a	Did the organization report an amount for land, buildings, and equipment in Part X, line 10? *If "Yes," complete Schedule D, Part VI*	11a	Yes	
b	Did the organization report an amount for investments—other securities in Part X, line 12 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VII*	11b		No
c	Did the organization report an amount for investments—program related in Part X, line 13 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part VIII*	11c		No
d	Did the organization report an amount for other assets in Part X, line 15 that is 5% or more of its total assets reported in Part X, line 16? *If "Yes," complete Schedule D, Part IX*	11d	Yes	
e	Did the organization report an amount for other liabilities in Part X, line 25? *If "Yes," complete Schedule D, Part X*	11e	Yes	
f	Did the organization's separate or consolidated financial statements for the tax year include a footnote that addresses the organization's liability for uncertain tax positions under FIN 48 (ASC 740)? *If "Yes," complete Schedule D, Part X*	11f	Yes	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? *If "Yes," complete Schedule D, Parts XI and XII*	12a		No
b	Was the organization included in consolidated, independent audited financial statements for the tax year? *If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional*	12b	Yes	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		No
14a	Did the organization maintain an office, employees, or agents outside of the United States?	14a		No
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*	14b		No
15	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or other assistance to or for any foreign organization? *If "Yes," complete Schedule F, Parts II and IV*	15		No
16	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or other assistance to or for foreign individuals? *If "Yes," complete Schedule F, Parts III and IV*	16		No
17	Did the organization report a total of more than $15,000 of expenses for professional fundraising services on Part IX, column (A), lines 6 and 11e? *If "Yes," complete Schedule G, Part I* (see instructions)	17		No
18	Did the organization report more than $15,000 total of fundraising event gross income and contributions on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		No
19	Did the organization report more than $15,000 of gross income from gaming activities on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		No
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	Yes	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	Yes	
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21	Yes	
22	Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22		No

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	**23**	Yes	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K If "No," go to line 25a*	**24a**		No
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	**24b**		
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	**24c**		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	**24d**		
25a	**Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	**25a**		No
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	**25b**		No
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? *If "Yes," complete Schedule L, Part II*	**26**		No
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	**27**		No
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions)			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	**28a**		No
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	**28b**	Yes	
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	**28c**		No
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	**29**	Yes	
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	**30**		No
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	**31**		No
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	**32**		No
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301 7701-2 and 301 7701-3? *If "Yes," complete Schedule R, Part I*	**33**		No
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	**34**	Yes	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	**35a**	Yes	
b	If 'Yes' to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	**35b**	Yes	
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	**36**		No
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	**37**		No
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	**38**	Yes	

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

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

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**	3,073		
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?			**12a**	
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	**12b**			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state? **Note.** See the instructions for additional information the organization must report on Schedule O			**13a**	
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	**13b**			
c	Enter the amount of reserves on hand	**13c**			
14a	Did the organization receive any payments for indoor tanning services during the tax year?			**14a**	No
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O* . .			**14b**	
15	Is the organization subject to the section 4960 tax on payment(s) of more than $1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see instructions and file Form 4720, Schedule N			**15**	No
16	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O			**16**	No

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

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

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	**1a**	21		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O				
b	Enter the number of voting members included in line 1a, above, who are independent	**1b**	18		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	**2**			No
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person? .	**3**			No
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed? .	**4**			No
5	Did the organization become aware during the year of a significant diversion of the organization's assets? .	**5**			No
6	Did the organization have members or stockholders?	**6**		Yes	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	**7a**		Yes	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	**7b**		Yes	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following				
a	The governing body?	**8a**		Yes	
b	Each committee with authority to act on behalf of the governing body?	**8b**		Yes	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	**9**			No

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

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

Section C. Disclosure

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

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
▶JANICE POLO EVP & CFO 2985 DREW STREET CLEARWATER, FL 33759 (727) 820-8021

Part VII **Compensation of Officers, Directors,Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors**

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

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
See Additional Data Table										

Part VII **Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees** *(continued)*

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
See Additional Data Table										
1b Sub-Total ▶										
c Total from continuation sheets to Part VII, **Section A** ▶										
d Total (add lines 1b and 1c) ▶								1,616,888	3,566,834	464,387

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 104

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
THE HASKELL COMPANY 111 RIVERSIDE AVE JACKSONVILLE, FL 32202	CONSTRUCTION SERVICES	12,497,949
FREEMANWHITE INC 8845 RED OAK BLVD CHARLOTTE, NC 28217	CONSTRUCTION SERVICES/CONSULTING	3,261,234
BAY LINEN INC 11525 47TH ST N CLEARWATER, FL 33762	LAUNDRY SERVICES	2,481,802
OB HOSPITALIST GROUP LLC 777 LOWNDES HILL RD GREENVILLE, SC 29607	MEDICAL SERVICES	1,479,782
SAYYAHS CLEANING SERVICES INC 7703 ANN BALLARD RD TAMPA, FL 33634	CLEANING SERVICES	1,143,761

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 43

Part VIII Statement of Revenue

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

		(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	**1a** Federated campaigns . .	1a			
	b Membership dues . .	1b			
	c Fundraising events . .	1c			
	d Related organizations	1d	1,524,016		
	e Government grants (contributions)	1e			
	f All other contributions, gifts, grants, and similar amounts not included above	1f	57,351		
	g Noncash contributions included in lines 1a - 1f $ 26,114				
	h Total. Add lines 1a-1f . . . . . ▶		1,581,367		
Program Service Revenue		Business Code			
	2a HOSPITAL PATIENT CARE	623990	270,511,274	270,511,274	
	b MEDICARE/MEDICAID PMNT	623990	209,441,298	209,441,298	
	c RENTAL INC FROM AFFILI	532000	1,684,444	1,684,444	
	d				
	e				
	f All other program service revenue				
	g Total. Add lines 2a–2f . . . . ▶		481,637,016		
Other Revenue	**3** Investment income (including dividends, interest, and other similar amounts) . . . . . ▶				
	4 Income from investment of tax-exempt bond proceeds ▶				
	5 Royalties . . . . . ▶				
		(i) Real	(ii) Personal		
	6a Gross rents	1,213,434			
	b Less rental expenses	0			
	c Rental income or (loss)	1,213,434			
	d Net rental income or (loss) . . . . . ▶		1,213,434		1,213,434
		(i) Securities	(ii) Other		
	7a Gross amount from sales of assets other than inventory		70,550		
	b Less cost or other basis and sales expenses	200	0		
	c Gain or (loss)	-200	70,550		
	d Net gain or (loss) . . . . . ▶		70,350		70,350
	8a Gross income from fundraising events (not including $ _____ of contributions reported on line 1c) See Part IV, line 18 . . . . a				
	b Less direct expenses . . . b				
	c Net income or (loss) from fundraising events . . ▶				
	9a Gross income from gaming activities See Part IV, line 19 . . . a				
	b Less direct expenses . . . b				
	c Net income or (loss) from gaming activities . . ▶				
	10a Gross sales of inventory, less returns and allowances . . a				
	b Less cost of goods sold . . b				
	c Net income or (loss) from sales of inventory . . ▶				
	Miscellaneous Revenue	Business Code			
	11a CAFETERIA	722514	2,309,856	0	2,309,856
	b CIN EMPLOYEE CLINIC FE	900099	258,318	258,318	
	c MISCELLANEOUS REVENUE	900099	142,500	102,051	40,449
	d All other revenue				
	e Total. Add lines 11a–11d . . . . . ▶		2,710,674		
	12 Total revenue. See Instructions . . . . . ▶		487,212,841	481,997,385	40,449	3,593,640

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraisingexpenses
1 Grants and other assistance to domestic organizations and domestic governments See Part IV, line 21	109,474	109,474		
2 Grants and other assistance to domestic individuals See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals See Part IV, line 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	441,680		441,680	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages	140,257,286	140,227,527	29,759	
8 Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions)	5,306,558	5,305,432	1,126	
9 Other employee benefits	11,082,313	11,079,962	2,351	
10 Payroll taxes	10,039,063	10,015,110	23,953	
11 Fees for services (non-employees)				
a Management				
b Legal	248,251		248,251	
c Accounting	360		360	
d Lobbying	1,526	1,526		
e Professional fundraising services See Part IV, line 17				
f Investment management fees				
g Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	15,157,790	14,674,825	482,965	
12 Advertising and promotion	225,547	225,547		
13 Office expenses	6,845,602	4,663,800	2,181,802	
14 Information technology	1,077,985	526,298	551,687	
15 Royalties				
16 Occupancy	8,435,411	8,416,398	19,013	
17 Travel	541,984	391,696	150,288	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings				
20 Interest	6,129,479	6,129,479		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	20,080,923	19,092,107	988,816	
23 Insurance	8,005,425	8,005,425		
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 UBI TAXES	5,371	5,371		
b MEDICAL SUPPLIES	78,305,028	78,247,021	58,007	
c MANAGEMENT FEES	59,706,388		59,706,388	
d BAD DEBT EXPENSE	23,883,803	23,883,803		
e All other expenses	27,901,134	15,980,171	11,920,963	
25 **Total functional expenses.** Add lines 1 through 24e	423,788,381	346,980,972	76,807,409	0
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

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

				(A) Beginning of year		(B) End of year
Assets	1	Cash–non-interest-bearing		133,805	1	138,295
	2	Savings and temporary cash investments			2	
	3	Pledges and grants receivable, net			3	
	4	Accounts receivable, net		40,638,750	4	41,115,043
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees Complete Part II of Schedule L			5	
	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			6	
	7	Notes and loans receivable, net		45,683	7	43,484
	8	Inventories for sale or use		6,667,659	8	7,540,812
	9	Prepaid expenses and deferred charges		1,554,116	9	662,679
	10a	Land, buildings, and equipment cost or other basis Complete Part VI of Schedule D	10a 463,953,434			
	b	Less accumulated depreciation	10b 276,130,342	168,597,503	10c	187,823,092
	11	Investments—publicly traded securities			11	
	12	Investments—other securities See Part IV, line 11			12	
	13	Investments—program-related See Part IV, line 11		698,870	13	770,514
	14	Intangible assets		2,383,420	14	1,650,060
	15	Other assets See Part IV, line 11		599,141,746	15	640,839,603
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		819,861,552	16	880,583,582
Liabilities	17	Accounts payable and accrued expenses		18,293,705	17	22,740,242
	18	Grants payable			18	
	19	Deferred revenue			19	75,627
	20	Tax-exempt bond liabilities			20	
	21	Escrow or custodial account liability Complete Part IV of Schedule D			21	
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons Complete Part II of Schedule L			22	
	23	Secured mortgages and notes payable to unrelated third parties		2,584,883	23	2,059,663
	24	Unsecured notes and loans payable to unrelated third parties			24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17 - 24) Complete Part X of Schedule D		8,799,525	25	3,624,163
	26	**Total liabilities.** Add lines 17 through 25		29,678,113	26	28,499,695
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ ☑ and complete lines 27 through 29, and lines 33 and 34.**				
	27	Unrestricted net assets		790,183,439	27	852,083,887
	28	Temporarily restricted net assets			28	
	29	Permanently restricted net assets			29	
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ 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		790,183,439	33	852,083,887
	34	Total liabilities and net assets/fund balances		819,861,552	34	880,583,582

Part XI Reconcilliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	487,212,841
2	Total expenses (must equal Part IX, column (A), line 25)	2	423,788,381
3	Revenue less expenses Subtract line 2 from line 1	3	63,424,460
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	790,183,439
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	-1,524,012
10	Net assets or fund balances at end of year Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	852,083,887

Part XII Financial Statements and Reporting

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

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

Additional Data

Software ID:

Software Version:

EIN: 59-0855412

Name: TRUSTEES OF MEASE HOSPITAL INC

Form 990 (2018)

Form 990, Part III, Line 4a:

TRUSTEES OF MEASE HOSPITAL, INC (TOM) IS A FULL-SERVICE 431-BED COMMUNITY HOSPITAL DURING 2018, TOM PROVIDED IMPATIENT CARE TO 24,584 PATIENTS, TREATED 83,929 PATIENTS IN THE EMERGENCY DEPARTMENT, AND DELIVERED 2,223 BABIES TROUGH EFFORTS OF THE MEDICAL ASSISTANCE PROGRAM AND THE HOSPITAL'S CHARITY CARE PROGRAM TOM SAW A NET COMMUNITY BENEFIT EXPENSE OF $38 7 MILLION THE HOSPITAL ALSO PROVIDED OTHER COMMUNITY SERVICES TOTALING MORE THAN $3 1 MILLION THESE INCLUDE HEALTH SCREENINGS, EDUCATIONAL PROGRAMS, SPONSORSHIPS AND RESEARCH REFER TO SCHEDULE H FOR ADDITIONAL INFORMATION

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			
JENNIFER BUCK TRUSTEE TILL FEBRUARY	1 00 0 00	X						0	0	0
ANDY BURWELL TRUSTEE/TREASURER	1 00 0 00	X		X				0	0	0
JAMES CANTONIS TRUSTEE/IMM PAST CHAIR	1 00 1 00	X						0	0	0
RICK CHESLER TRUSTEE	1 00 0 00	X						0	0	0
KATIE COLE TRUSTEE	1 00 0 00	X						0	0	0
EARLE COOPER EX-OFFICIO TRUSTEE	1 00 0 00	X						0	0	0
KURT ERICKSON TRUSTEE/VICE CHAIR	1 00 1 00	X		X				0	17,100	0
V RAYMOND FERRARA TRUSTEE/IMM PAST CHAIR TILL FEBRUARY	1 00 1 00	X						0	0	0
ISAY GULLEY TRUSTEE	1 00 0 00	X						0	0	0
LONNIE KLEIN TRUSTEE TILL FEBRUARY	1 00 0 00	X						0	46,073	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			
GAY LANCASTER TRUSTEE/CHAIRMAN	1 00 1 00	X		X				0	0	0
SUSAN LATVALA TRUSTEE/SECRETARY	1 00 1 00	X		X				0	0	0
KEVIN MASON TRUSTEE	1 00 0 00	X						0	0	0
JORGE NAVAS TRUSTEE	1 00 0 00	X						0	0	0
CHRISTOS PITARYS TRUSTEE TILL FEBRUARY	1 00 0 00	X						0	0	0
VAKESH RAJANI TRUSTEE	1 00 0 00	X						0	0	0
NANCY RIDENOUR TRUSTEE	1 00 0 00	X						0	0	0
GREG SMITH TRUSTEE TILL FEBRUARY	1 00 0 00	X						0	0	0
DEBBIE WHITE TRUSTEE TILL FEBRUARY	1 00 0 00	X						0	0	0
BENJAMIN DAMSKER TRUSTEE	1 00 0 00	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			
ROBERT ENTEL EX-OFFICIO TRUSTEE	1 00 0 00	X						0	0	0
CANDACE GLEWEN EX-OFFICIO TRUSTEE	1 00 0 00	X						0	0	0
RICHARD RODRIGUEZ EX-OFFICIO TRUSTEE	1 00 0 00	X						0	0	0
MICHAEL SZOSTAK EX-OFFICIO TRUSTEE	1 00 0 00	X						0	22,160	0
TINA TENRET TRUSTEE	1 00 0 00	X						0	0	0
TONJUA WILLIAMS TRUSTEE	1 00 0 00	X						0	0	0
GLENN WATERS EX-OFFICIO TRUSTEE/EVP, COO BAYCARE	1 00 60 00	X		X				0	1,549,036	59,994
CARL TREMONTI VP, CFO BAYCARE HOSP DIV TILL MAY	1 00 63 00			X				0	698,208	26,327
RONALD BEAMON VP, CFO BAYCARE HOSP DIV EFF MAY	1 00 13 00			X				0	310,364	21,585
LOUIS GALDIERI PRESIDENT TILL DECEMBER	1 00 46 00				X			0	608,379	41,465

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			
MATTHEW NOVAK PRESIDENT EFF DECEMBER	45 00 1 00				X			0	315,514	69,191
JOHN POLLARD DIRECTOR, SURGICAL SVCS	45 00 0 00				X			195,284	0	35,374
REBECCA SCHULKOWSKI DIR, OPERATIONS MEASE	45 00 0 00				X			180,001	0	31,021
ROBIN LAPHAM DIRECTOR, PATIENT SVCS	45 00 0 00				X			192,268	0	30,703
MOHSEN HABIB MANAGER PHARMACY	45 00 0 00					X		198,462	0	32,746
MAIKEL BOLOS CLINICAL PHARMACIST	45 00 0 00					X		185,780	0	21,460
RODNEY CAVALIER CLINICAL PHARMACIST	45 00 0 00					X		198,092	0	27,451
RENEE BURDI DIR, PATIENT SVCS	45 00 0 00					X		179,327	0	31,033
JOSEPH SCHUMACHER CLINICAL PHARMACIST	45 00 0 00					X		163,292	0	29,379
KELLY CULLEN FORMER DIR, OPERATIONS	45 00 0 00						X	124,382	0	6,658

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SCHEDULE A (Form 990 or 990EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

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

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
TRUSTEES OF MEASE HOSPITAL INC

Employer identification number
59-0855412

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

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

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

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

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

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

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

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

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

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

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

_____

10 ☐ An organization that normally receives (1) more than 331/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions—subject to certain exceptions, and (2) no more than 331/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975 See **section 509(a)(2).** (Complete Part III)

11 ☐ An organization organized and operated exclusively to test for public safety See **section 509(a)(4).**

12 ☐ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2).** See **section 509(a)(3).** Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g

a ☐ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization **You must complete Part IV, Sections A and B.**

b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s) **You must complete Part IV, Sections A and C.**

c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions) **You must complete Part IV, Sections A, D, and E.**

d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions) **You must complete Part IV, Sections A and D, and Part V.**

e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization

f Enter the number of supported organizations _____

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

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

Part II **Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv), 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 ")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a)2014	(b)2015	(c)2016	(d)2017	(e)2018	(f)Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income Do not include gain or loss from the sale of capital assets (Explain in Part VI)						
11 **Total support.** Add lines 7 through 10						

12 Gross receipts from related activities, etc (see instructions) **12**

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2018 (line 6, column (f) divided by line 11, column (f)) **14**

15 Public support percentage for 2017 Schedule A, Part II, line 14 **15**

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?	11a		
b	A family member of a person described in (a) above?	11b		
c	A 35% controlled entity of a person described in (a) or (b) above? *If "Yes" to a, b, or c, provide detail in Part VI*	11c		

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally-Integrated Supporting Organizations

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

- **a** ☐ The organization satisfied the Activities Test Complete **line 2** below
- **b** ☐ The organization is the parent of each of its supported organizations Complete **line 3** below
- **c** ☐ The organization supported a governmental entity Describe in **Part VI** how you supported a government entity (see instructions)

			Yes	No
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? *If "Yes," then in* ***Part VI identify those supported organizations and explain*** *how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities*	2a		
b	Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? *If "Yes," explain in* ***Part VI*** *the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement*	2b		
3	Parent of Supported Organizations **Answer (a) and (b) below.**			
a	Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? *Provide details in* ***Part VI.***	3a		
b	Did the organization exercise a substantial degree of direction over the policies, programs and activities of each of its supported organizations? *If "Yes," describe in* ***Part VI.*** *the role played by the organization in this regard*	3b		

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

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

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

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

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

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

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

Section D - Distributions	**Current Year**
1 Amounts paid to supported organizations to accomplish exempt purposes	
2 Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3 Administrative expenses paid to accomplish exempt purposes of supported organizations	
4 Amounts paid to acquire exempt-use assets	
5 Qualified set-aside amounts (prior IRS approval required)	
6 Other distributions (describe in **Part VI**) See instructions	
7 **Total annual distributions.** Add lines 1 through 6	
8 Distributions to attentive supported organizations to which the organization is responsive (provide details in **Part VI**) See instructions	
9 Distributable amount for 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: 59-0855412

Name: TRUSTEES OF MEASE HOSPITAL 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

efile GRAPHIC print - DO NOT PROCESS | As Filed Data - | DLN: 93493317096139

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	Employer identification number
TRUSTEES OF MEASE HOSPITAL INC	59-0855412

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

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

2 Political campaign activity expenditures (see instructions) ▶ $

3 Volunteer hours for political campaign activities (see instructions)

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

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

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

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

4a Was a correction made? ☐ Yes ☐ No

b If "Yes," describe in Part IV

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

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

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

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

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

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

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

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

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

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

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	**(a)** Filing organization's totals	**(b)** Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount Enter the amount from the following table in both columns		
g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a If zero or less, enter -0-		
i Subtract line 1f from line 1c If zero or less, enter -0-		

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

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

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

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	**(a)** 2015	**(b)** 2016	**(c)** 2017	**(d)** 2018	**(e)** Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes" response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity		(a) Yes	(a) No	(b) Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
a	Volunteers?		No	
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?	Yes		
c	Media advertisements?		No	
d	Mailings to members, legislators, or the public?		No	
e	Publications, or published or broadcast statements?		No	
f	Grants to other organizations for lobbying purposes?		No	
g	Direct contact with legislators, their staffs, government officials, or a legislative body?	Yes		200
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		No	
i	Other activities?	Yes		1,526
j	Total Add lines 1c through 1i			1,726
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		No	
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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
SCHEDULE C PART II - B, LINE 1I, SUPPLEMENTAL INFORMATION	LINE 1B AND 1G LOBBYING ACTIVITIES PERFORMED BY EMPLOYEES CONCERNING HEALTH ISSUES LINE 1I DUES WERE PAID TO THE AMERICAN PHYSICAL THERAPY ASSOCIATION, FLORIDA SOCIETY OF HEALTH-SYSTEM PHARMACISTS, NATIONAL ASSOCIATION OF PSYCHIATRIC HEALTH SYSTEMS, AACVPR, APIC, AMERICAN HEALTH INFORMATION MANAGEMENT ASSOCIATION, AND THE AMERICAN SOCIETY FOR HEALTHCARE ENGINEERING THESE ASSOCIATIONS USE A PORTION OF THEIR DUES TO CONDUCT LOBBYING ACTIVITIES

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SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
TRUSTEES OF MEASE HOSPITAL INC

Employer identification number
59-0855412

Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.

Complete if the organization answered "Yes" on Form 990, Part IV, line 6.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

	Amount
c Beginning balance	1c
d Additions during the year	1d
e Distributions during the year	1e
f Ending balance	1f

2a Did the organization include an amount on Form 990, Part X, line 21, for escrow or custodial account liability? . . . ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIII Check here if the explanation has been provided in Part XIII . . . . ☐

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
1a Beginning of year balance					
b Contributions . . .					
c Net investment earnings, gains, and losses					
d Grants or scholarships . . .					
e Other expenditures for facilities and programs . . .					
f Administrative expenses					
g End of year balance					

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 ▶
- 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

	Yes	No
(i) unrelated organizations	3a(i)	
(ii) related organizations	3a(ii)	
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		11,886,639		11,886,639
b Buildings		260,305,188	139,888,792	120,416,396
c Leasehold improvements		555,164	291,995	263,169
d Equipment		161,152,126	135,949,555	25,202,571
e Other		30,054,317		30,054,317
Total. Add lines 1a through 1e *(Column (d) must equal Form 990, Part X, column (B), line 10(c))* . . ▶				187,823,092

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

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

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

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

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

(a) Description	(b) Book value
(1) DUE FROM AFFILIATES	640,835,468
(2) INCOME TAX RECEIVABLE	4,135
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col (B) line 15)* ▶	640,839,603

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
DEPOSITS	7,519
ASSET RETIREMENT OBLIGATION ST	110,000
EST THIRD PARTY SETTLEMENTS	3,506,644
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col (B) line 25)* ▶	3,624,163

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	461,734,471
2	Amounts included on line 1 but not on Form 990, Part VIII, line 12				
a	Net unrealized gains (losses) on investments	2a			
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIII)	2d			
e	Add lines **2a** through **2d**			2e	0
3	Subtract line **2e** from line **1**			3	461,734,471
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	25,478,370		
c	Add lines **4a** and **4b**			4c	25,478,370
5	Total revenue Add lines **3** and **4c.** (This must equal Form 990, Part I, line 12)			5	487,212,841

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	399,834,023
2	Amounts included on line 1 but not on Form 990, Part IX, line 25				
a	Donated services and use of facilities	2a			
b	Prior year adjustments	2b			
c	Other losses	2c			
d	Other (Describe in Part XIII)	2d			
e	Add lines **2a** through **2d**			2e	0
3	Subtract line **2e** from line **1**			3	399,834,023
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	23,954,358		
c	Add lines **4a** and **4b**			4c	23,954,358
5	Total expenses Add lines **3** and **4c.** (This must equal Form 990, Part I, line 18)			5	423,788,381

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: 59-0855412
Name: TRUSTEES OF MEASE HOSPITAL INC

Supplemental Information

Return Reference	Explanation
PART X, LINE 2	MANAGEMENT BELIEVES THAT ALL TAX POSITIONS TAKEN WITH RESPECT TO EXEMPT STATUS ISSUES AND UBTI ISSUES, IF EXAMINED BY THE IRS WITH FULL KNOWLEDGE OF ALL MATERIAL FACTS, ARE MORE LI KELY THAN NOT TO BE SUSTAINED THEREFORE, THE FULL BENEFITS OF THE TAX POSITIONS TAKEN ARE RECOGNIZED IN THE FINANCIAL STATEMENTS

Supplemental Information

Return Reference	Explanation
PART XI, LINE 4B - OTHER ADJUSTMENTS	BAD DEBT EXPENSE 23,883,803 CONTRIBUTIONS IN NET ASSETS 1,524,016 ROUNDING 1 G/L SALE OF ASSET 70,550

Supplemental Information

Return Reference	Explanation
PART XII, LINE 4B - OTHER ADJUSTMENTS	BAD DEBT EXPENSE 23,883,803 ROUNDING 5 G/L SALE OF ASSET 70,550

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SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
TRUSTEES OF MEASE HOSPITAL INC

Employer identification number
59-0855412

Part I Financial Assistance and Certain Other Community Benefits at Cost

			Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	Yes	
b	If "Yes," was it a written policy?	1b	Yes	
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year			
	☑ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities			
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year			
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care	3a	Yes	
	☐ 100% ☐ 150% ☐ 200% ☑ Other 25000 0000000000 %			
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	3b		No
	☐ 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"?	4	Yes	
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	Yes	
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b	Yes	
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligibile for free or discounted care?	5c		No
6a	Did the organization prepare a community benefit report during the tax year?	6a	Yes	
b	If "Yes," did the organization make it available to the public?	6b	Yes	
	Complete the following table using the worksheets provided in the Schedule H instructions Do not submit these worksheets with the Schedule H			

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			13,828,120	307,327	13,520,793	3 380 %
b Medicaid (from Worksheet 3, column a)			41,582,275	16,419,921	25,162,354	6 300 %
c Costs of other means-tested government programs (from Worksheet 3, column b)			100,127	34,123	66,004	0 020 %
d **Total** Financial Assistance and Means-Tested Government Programs			55,510,522	16,761,371	38,749,151	9 700 %
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			1,700,313	0	1,700,313	0 430 %
f Health professions education (from Worksheet 5)			1,199,973	0	1,199,973	0 300 %
g Subsidized health services (from Worksheet 6)						
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)			226,230	0	226,230	0 060 %
j **Total.** Other Benefits			3,126,516		3,126,516	0 790 %
k **Total.** Add lines 7d and 7j			58,637,038	16,761,371	41,875,667	10 490 %

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			62,662	0	62,662	0 020 %
4 Environmental improvements			26,540	0	26,540	0 010 %
5 Leadership development and training for community members						
6 Coalition building						
7 Community health improvement advocacy						
8 Workforce development			2,402	0	2,402	0 %
9 Other						
10 Total			91,604		91,604	0 030 %

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 Heathcare Financial Management Association Statement No 15?	1	Yes		
2	Enter the amount of the organization's bad debt expense Explain in Part VI the methodology used by the organization to estimate this amount	2	23,883,803		
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	14,937,804		
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	98,118,850
6	Enter Medicare allowable costs of care relating to payments on line 5	6	112,400,746
7	Subtract line 6 from line 5 This is the surplus (or shortfall)	7	-14,281,896
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6 Check the box that describes the method used		

☐ Cost accounting system ☑ Cost to charge ratio ☐ Other

Section C. Collection Practices

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

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

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

Part V Facility Information

Section A. Hospital Facilities

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

How many hospital facilities did the organization operate during the tax year? **1**

	Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
	See Additional Data Table										

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group TRUSTEES OF MEASE HOSPITAL INC

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

		Yes	No
Community Health Needs Assessment			
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	**1**		No
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	**2**		No
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	**3**	Yes	
If "Yes," indicate what the CHNA report describes (check all that apply)			
a ☑ A definition of the community served by the hospital facility			
b ☑ Demographics of the community			
c ☑ Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d ☑ How data was obtained			
e ☑ The significant health needs of the community			
f ☑ Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g ☑ The process for identifying and prioritizing community health needs and services to meet the community health needs			
h ☑ The process for consulting with persons representing the community's interests			
i ☑ The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j ☐ Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA 20 16			
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	**5**	Yes	
6 a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	**6a**	Yes	
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C	**6b**		No
7 Did the hospital facility make its CHNA report widely available to the public?	**7**	Yes	
If "Yes," indicate how the CHNA report was made widely available (check all that apply)			
a ☑ Hospital facility's website (list url) SEE PART V, PAGE 8			
b ☑ Other website (list url) SEE PART V, PAGE 8			
c ☐ Made a paper copy available for public inspection without charge at the hospital facility			
d ☐ Other (describe in Section C)			
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	**8**	Yes	
9 Indicate the tax year the hospital facility last adopted an implementation strategy 20 16			
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	**10**		No
If "Yes" (list url) **a**			
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	**10b**	Yes	
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed			
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	**12a**		No
b If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	**12b**		
c If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? $			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

TRUSTEES OF MEASE HOSPITAL INC

Name of hospital facility or letter of facility reporting group

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	Yes	
	If "Yes," indicate the eligibility criteria explained in the FAP			
a	☑ Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 250 000000000000 % and FPG family income limit for eligibility for discounted care of 0 000000000000 %			
b	☑ Income level other than FPG (describe in Section C)			
c	☑ Asset level			
d	☑ Medical indigency			
e	☑ Insurance status			
f	☑ Underinsurance discount			
g	☑ Residency			
h	☐ Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	Yes	
15	Explained the method for applying for financial assistance?	15	Yes	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply)			
a	☑ Described the information the hospital facility may require an individual to provide as part of his or her application			
b	☑ Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	☑ Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	☐ Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	☐ Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	Yes	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply)			
a	☑ The FAP was widely available on a website (list url) HTTPS //BAYCARE ORG/BILLING-AND-INSURANCE/FINANCIAL-ASSISTANCE			
b	☑ The FAP application form was widely available on a website (list url) HTTPS //BAYCARE ORG/BILLING-AND-INSURANCE/FINANCIAL-ASSISTANCE			
c	☑ A plain language summary of the FAP was widely available on a website (list url) HTTPS //BAYCARE ORG/BILLING-AND-INSURANCE/FINANCIAL-ASSISTANCE			
d	☑ The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	☑ The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	☑ A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	☑ Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	☑ Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	☑ The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	☐ Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

TRUSTEES OF MEASE HOSPITAL INC

Name of hospital facility or letter of facility reporting group

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

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

TRUSTEES OF MEASE HOSPITAL INC

Name of hospital facility or letter of facility reporting group

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

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

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

Form and Line Reference	Explanation
See Add'l Data	

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

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility
(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? **10**

	Name and address	Type of Facility (describe)
1	1 - MEASE COUNTRYSIDE SURGERY CENTER 1880 MEASE DR SAFETY HARBOR, FL 34695	DAY SURGERY CENTER
2	2 - MEASE OUTPATIENT IMAGING 1840 MEASE DR STE 103 SAFETY HARBOR, FL 34695	OUTPATIENT IMAGING CENTER
3	3 - MPM OUTPATIENT REHABIILATATION SERVICES 32672 US HIGHWAY 19 NORTH PALM HARBOR, FL 34684	REHABILITATION SERVICES
4	4 - MEASE SPORTS MEDICINE CENTER 3251 MCMULLEN BOOTH RD STE 200 SAFETY HARBOR, FL 34695	OUTPATIENT CLINIC
5	5 - MEASE HAND CLINIC 1840 MEASE DR STE 409 SAFETY HARBOR, FL 34695	OUTPATIENT CLINIC
6	6 - MCH CARDIAC & PULMONARY REHABILITATION 1840 MEASE DRIVE SUITE 105 SAFETY HARBOR, FL 34695	REHABILITATION SERVICES
7	7 - MCH SUSAN CHEEK NEEDLER BREAST CENTER 1840 MEASE DRIVE SUITE 103 SAFETY HARBOR, FL 34695	IMAGING CENTER
8	8 - MEASE COUNTRYSIDE SLEEP DISORDERS CENTER 1840 MEASE DR SUITE 102 SAFETY HARBOR, FL 34695	OUTPATIENT CLINIC
9	9 - BAYCARE WOUND CENTER 3890 TAMPA ROAD PALM HARBOR, FL 34684	OUTPATIENT CLINIC
10	10 - BAYCARE OP SLEEP DISORDERS CENTER 12780 RACE TRACK RD SUITE 115 TAMPA, FL 34684	OUTPATIENT CLINIC

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 3C	PATIENTS WHO ARE UNINSURED OR UNDERINSURED AND CANNOT PAY FOR HOSPITAL SERVICES ARE ELIGIBLE FOR CHARITY CONSIDERATION THESE PATIENTS ARE SCREENED BY DESIGNATED TEAM MEMBERS IN OUR FINANCIAL ASSISTANCE DEPARTMENT THE AGENCY FOR HEALTH CARE ADMINISTRATION (AHCA) DEFINES CHARITY ELIGIBILITY AT 200 PERCENT OF THE FEDERAL POVERTY GUIDELINES, UNLESS THE TOTAL HOSPITAL BILL IS MORE THAN 25 PERCENT OF THE PATIENT'S ANNUAL INCOME MEDICAID RECIPIENTS WHO HAVE EXCEEDED THEIR COVERAGE LIMITS ARE ALSO CONSIDERED FOR CHARITY CARE TRUSTEES OF MEASE HOSPITAL, INC GOES ABOVE AND BEYOND THE AHCA REQUIREMENTS BY PROVIDING ADDITIONAL "HARDSHIP" CHARITY FOR PATIENTS WHO ARE AT 250 PERCENT OF THE FEDERAL POVERTY GUIDELINES IN ADDITION, AN UNINSURED DISCOUNT OF 40% IS AUTOMATICALLY GIVEN TO ANY PATIENT WHO DOES NOT HAVE INSURANCE COVERAGE OR BENEFITS THERE IS NO INCOME OR ASSET TEST REQUIRED FOR THE UNINSURED DISCOUNT PATIENTS RECEIVE AN ADDITIONAL 10% DISCOUNT IF THE ACCOUNT IS PAID WITHIN 30 DAYS PRESUMPTIVE FINANCIAL ASSISTANCE DECISIONS FOR UNINSURED ER PATIENTS MAY BE DETERMINED BASED ON THIRD PARTY ANALYTICS, USING A CREDIT INQUIRY PROCESS, UNDER THE FOLLOWING CIRCUMSTANCES - UNINSURED ACCOUNTS OF PATIENTS NOT SEEN BY THE FINANCIAL ASSISTANCE TEAM OR WITHOUT A CURRENT FINANCIAL ASSISTANCE APPLICATION ON FILE - THE REPORTED FEDERAL POVERTY LEVEL (FPL) OF THE PATIENT MEETS THE CRITERIA FOR TRUSTEES OF MEASE HOSPITAL FINANCIAL ASSISTANCE (250%)

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 6A	THE COMMUNITY BENEFIT REPORT IS AVAILABLE TO THE PUBLIC AND WAS PREPARED BY BAYCARE HEALTH SYSTEM INC, A RELATED ORGANIZATION

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LINE 7	FINANCIAL ASSISTANCE AND MEANS-TESTED GOVERNMENT PROGRAMS COSTS (LINES A THROUGH D) ARE DETERMINED USING OUR COST ACCOUNTING SYSTEM, WHICH CAPTURES ALL INPATIENTS AND OUTPATIENTS, INCLUDING EMERGENCY ROOM PATIENTS THE SYSTEM ALSO CAPTURES ALL PATIENT PAY TYPES - PRIVATE INSURANCE, MEDICARE, MEDICAID, UNINSURED AND SELF-PAY THE COSTS HAVE BEEN OFFSET BY ANY PAYMENTS RECEIVED FROM MEDICAID OR ANY OTHER UNCOMPENSATED CARE PROGRAM OTHER BENEFITS AT COST (LINES E THROUGH J, AS WELL AS AMOUNTS REPORTED IN PART II) WERE COMPILED BY THE COMMUNITY HEALTH DEPARTMENT USING THE CATHOLIC HEALTH ASSOCIATION GUIDE FOR PLANNING AND REPORTING COMMUNITY BENEFITS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART I, LN 7 COL(F)	BAD DEBT EXPENSE OF $23,883,803 WAS INCLUDED ON FORM 990, PART IX, LINE 25, COLUMN (A), BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGE IN THIS COLUMN

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART II, COMMUNITY BUILDING ACTIVITIES	MEASE HOSPITALS SUPPORT THE COMMUNITY THROUGH COMMUNITY SUPPORT, ENVIRONMENTAL IMPROVEMENTS, AND WORKFORCE DEVELOPMENT THIS INCLUDES - FUNDING SUPPORT FOR GENERATIONS CHURCH, THE ROTARY CLUB OF DUNEDIN, HUMANE SOCIETY OF PINELLAS, KIWANIS CLUB OF DUNEDIN AND THE CITY OF SAFETY HARBOR THAT ADDRESS THE ROOT CAUSES OF HEALTH AND SAFETY ISSUES AND PROMOTE ECONOMIC STABILITY - RECYCLING COSTS FOR DISPOSABLE ITEMS- TEAM MEMBER TIME DEDICATED TO WORKING WITH HEALTH CARE OBSERVERS, INTERESTED IN PURSUING A CAREER IN THE MEDICAL FIELD

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 2	BAD DEBT EXPENSE IS REPORTED AS TOTAL BAD DEBT FOR THE FACILITY THE AMOUNT OF BAD DEBT EXPENSE ATTRIBUTABLE TO PATIENTS POTENTIALLY ELIGIBLE FOR FINANCIAL ASSISTANCE IS CALCULATED AS A CHARGE RATIO, DERIVED FROM DATA SAMPLING THE RESULTING CHARGE RATIO IS THEN APPLIED TO TOTAL BAD DEBT ACCOUNTS OF THE ORGANIZATION, WHICH CALCULATES THE BAD DEBT ATTRIBUTABLE TO FINANCIAL ASSISTANCE THE STATE OF FLORIDA REQUIRES THE PATIENT TO PROVIDE CERTAIN DOCUMENTATION IN ORDER TO QUALIFY FOR FINANCIAL ASSISTANCE IN CASES WHERE THE PATIENT HAS NOT RESPONDED TO HOSPITAL REQUESTS OR BILLING STATEMENT ALERTS, THOSE ACCOUNTS ARE PROCESSED AS BAD DEBT, IF UNPAID

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 3	SEE PART III, LINE 2

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 4	THE ORGANIZATION'S FINANCIAL STATEMENTS INCLUDE A FOOTNOTE THAT DESCRIBES BAD DEBT EXPENSE ON PAGE 12 OF THE BAYCARE HEALTH SYSTEM, INC AND AFFILIATES NOTES TO COMBINED FINANCIAL STATEMENTS

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 8	COST REPORTS WERE USED TO REPORT MEDICARE ALLOWABLE COSTS MEDICARE DEFINES ALLOWABLE COSTS AS THOSE APPROPRIATE AND HELPFUL IN DEVELOPING AND MAINTAINING THE OPERATION OF PATIENT CARE FACILITIES AND ACTIVITIES IT SPECIFICALLY EXCLUDES CERTAIN COSTS THAT ARE NOT DIRECTLY RELATED TO PATIENT CARE THE HOSPITAL INCURS ADDITIONAL EXPENSE RELATED TO THE PROVISION OF CARE TO MEDICARE PATIENTS THAT MEDICARE HAS DEEMED NON-ALLOWABLE THIS ADDITIONAL EXPENSE INCLUDES COSTS OF PHYSICIAN SERVICES (EMERGENCY ON-CALL FEES, HOSPITALIST PROGRAM, RECRUITMENT, ETC), ADVERTISING COSTS, CAFETERIA COSTS FOR MEALS SOLD TO VISITORS, ETC THE HOSPITAL ATTEMPTS TO COLLECT COINSURANCE AND DEDUCTIBLES FROM MEDICARE BENEFICIARIES TO THE EXTENT COLLECTION EFFORTS ARE UNSUCCESSFUL, MEDICARE REIMBURSES THE HOSPITAL AT 65% OF UNPAID AMOUNTS THE FOLLOWING TABLE RECONCILES THE SURPLUS OR SHORTFALL FROM LINE 7 TO THE ACTUAL SURPLUS OR SHORTFALL THE ADDITIONAL COSTS WERE ALLOCATED TO MEDICARE BASED UPON MEDICARE'S PERCENTAGE OF TOTAL ALLOWABLE COSTS THE UNPAID COINSURANCE/DEDUCTIBLES WERE ESTIMATED USING HISTORICAL COLLECTION RESULTS ANY SHORTFALL AMOUNTS HAVE NOT BEEN TREATED AS COMMUNITY BENEFIT - LINE 7 SURPLUS OR (SHORTFALL) ($14,281,896) - ADDITIONAL NON-ALLOWABLE COSTS AND UNPAID/NON-REIMBURSED COINSURANCE/DEDUCTIBLES ($13,092,216) - TOTAL SURPLUS OR (SHORTFALL) ($27,374,112)

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART III, LINE 9B	PATIENTS WHO ARE UNABLE TO PAY ARE ENCOURAGED BY BAYCARE HEALTH SYSTEM REPRESENTATIVES, VIA PERSONAL INTERVIEWS, SIGNAGE, ON PATIENT BILLING STATEMENTS, BROCHURES OR CUSTOMER SERVICE PHONE CALLS, TO SUBMIT FINANCIAL INFORMATION TO THE FINANCIAL ASSISTANCE DEPARTMENT TO DETERMINE ELIGIBILITY FOR PROGRAMS, SUCH AS COUNTY, MEDICAID, DISABILITY, VICTIMS OF CRIME, CHARITY, ETC FOR THOSE PATIENTS WHO PROVIDE ALL THE NECESSARY DOCUMENTATION AND QUALIFY FOR CHARITY ACCORDING TO THE FINANCIAL ASSISTANCE POLICY, (DEFINED IN PART I, LINE 3C), THE PATIENT'S ACCOUNT BALANCE WOULD BE WRITTEN OFF COMPLETELY TO CHARITY AND NOT BILLED TO THE PATIENT

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 2	TRUSTEES OF MEASE HOSPITAL, INC IS COMMITTED TO MEETING THE NEEDS OF THE COMMUNITY IT SERVES OUR QUALITY PHILOSOPHY IS MODELED AROUND UNDERSTANDING OUR CUSTOMERS' NEEDS IN THE COMMUNITIES IT SERVES TRUSTEES OF MEASE HOSPITAL, INC ADDRESSES COMMUNITY HEALTH STATUS ASSESSMENTS BY ACCESSING EXISTING THIRD PARTY DATABASES PROFILING HEALTH STATUS INFORMATION FOR GEOGRAPHIES IT SERVES THE ASSESSMENTS PROVIDE A PROFILE OF HEALTH STATUS INDICATORS IN COMPARISON TO STATE AVERAGES AND, IF AVAILABLE, NATIONAL BENCHMARKS IN ADDITION, TRUSTEES OF MEASE HOSPITAL, INC CONDUCTS PHYSICIAN COMMUNITY NEED STUDIES THAT OUTLINE PHYSICIANDEFICITS BY SPECIALTY FOR THE GEOGRAPHIC AREA SERVED STUDIES ARE ALSO CONDUCTED TO IDENTIFY GAPS IN GEOGRAPHIC ACCESS TO SERVICES SUCH AS PRIMARY CARE, OUTPATIENT SERVICES AND INPATIENT SERVICES ALL OF THE ABOVE PROCESSES OCCUR ON AN ONGOING BASIS TO ASSIST TRUSTEES OF MEASEHOSPITAL, INC IN DEVELOPING INITIATIVES AND PROGRAMS/SERVICES TO ADDRESS IDENTIFIED HEALTH CARE NEEDS IN THE COMMUNITIES IT SERVES

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 3	TRUSTESS OF MEASE HOSPITAL, INC FINANCIAL ASSISTANCE TEAM MEMBERS ARE DEDICATED TO ASSISTING PATIENTS IN OBTAINING ASSISTANCE THROUGH FEDERAL, STATE AND LOCAL GOVERNMENT PROGRAMS OR THROUGH THE TRUSTEES OF MEASE HOSPITAL, INC FINANCIAL ASSISTANCE POLICY SIGNAGE AND BROCHURES ARE AVAILABLE, AS WELL AS TEAM MEMBERS WHOSE FULL RESPONSIBILITY IS TO ASSIST PATIENTS IN THE EMERGENCY ROOM AND ON INPATIENT UNITS THE FINANCIAL ASSISTANCE TEAM INTERVIEWS PATIENTS FOR ALL AVAILABLE PROGRAMS, ASSISTS THE PATIENTS IN COMPLETING APPLICATIONS TO GOVERNMENT AGENCIES AND FOR HOSPITAL CHARITY CARE, ADVISES PATIENTS REGARDING AVAILABLE COMMUNITY RESOURCES FOR HEALTH CARE, REVIEWS AND APPROVES PATIENT REQUESTS FOR CHARITY CARE, AND PROVIDES EDUCATION AND SUPPORT TO THE PATIENT THROUGHOUT THE ASSISTANCE PROCESS IN ADDITION TO THE AFOREMENTIONED COMPREHENSIVE PROCESS, TRUSTEES OF MEASE HOSPITAL, INC ALSO INFORMS AND EDUCATES PATIENTS WHO MAY BE BILLED FOR PATIENT CARE, BUT MAY BE ELIGIBLE FOR CHARITY OR OTHER PROGRAMS, VIA PATIENT BILLING STATEMENTS AND CUSTOMER SERVICE REPRESENTATIVE CALLS THE GOAL IN USING THESE VARIOUS MEANS IS TO EFFECTIVELY COMMUNICATE WITH THE ENTIRE PATIENT POPULATION SO THEY ARE INFORMED AND EDUCATED ABOUT THEIR ELIGIBILITY FOR ASSISTANCE

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 4	MEASE HOSPITALS ARE ACUTE CARE FACILITIES SERVING PARTS OF HILLSBOROUGH, PASCO AND PINELLAS COUNTIES THE AVERAGE HOUSEHOLD INCOME IN THIS AREA IS $3,856 BELOW THE STATE AVERAGE AND $13,600 BELOW THE NATIONAL AVERAGE 11 9% OF HOUSEHOLDS HAVE ANNUAL HOUSEHOLD INCOME BELOW $15,000 PER YEAR THE POPULATION SERVED IS PREDOMINANTLY CAUCASIAN AND HIGH-SCHOOL OR HIGHER EDUCATED HISPANICS ARE THE SECOND LARGEST ETHNIC GROUP REPRESENTING 13 6% OF THE POPULATION MEASE HOSPITALS ARE PART OF BAYCARE HEALTH SYSTEM THAT SERVES WEST CENTRAL FLORIDA THE AREA SERVED BY THE MEASE HOSPITALS HAS 16 ACUTE CARE HOSPITALS (7 NOT-FOR-PROFIT), 2 LONG TERM ACUTE CARE HOSPITALS (1 NOT-FOR-PROFIT) AND 1 FOR-PROFIT REHABILITATION HOSPITAL THERE ARE 8 FEDERALLY DESIGNATED MEDICALLY UNDERSERVED AREA/MEDICALLY UNDERSERVED POPULATIONS IN MEASE HOSPITALS' SERVICE AREA WITH THE OVER 65 POPULATION EXPECTED TO GROW 16 5% IN THE NEXT FIVE YEARS, THE HEALTH CARE NEEDS OF OUR SERVICE AREA ARE EXPANDING AND CHANGING THE POPULATION SERVED BY MEASE HOSPITALS IS EXPECTED TO GROW 5 7% IN THE NEXT 5 YEARS THIS EXPECTED GROWTH IS HIGHER THAN THE EXPECTED GROWTH RATE FOR THE UNITED STATES WHICH IS 3 5% BASED ON FLORIDA INPATIENT DISCHARGE DATA FOR THE PERIOD OF 10/01/2017-9/30/2018, THE PAYER MIX FOR THE GEOGRAPHIC AREA CONSISTS OF 55 3% MEDICARE/MEDICARE HMO, 13 7% MEDICAID/MEDICAID HMO, 19 1% COMMERCIAL INSURANCE, 7 8% SELF PAY/NON-PAY, AND 4 0% OTHER

Form and Line Reference	Explanation
PART VI, LINE 5	RESIDENTS OF THE SMALL CITY OF DUNEDIN ENCOURAGED DR JACK MEASE TO BUILD A HOSPITAL WITH THE COMMUNITY'S HELP IN 1937 TODAY MEASE DUNEDIN IS A 120-BED HOSPITAL COMMITTED TO CONTI NUING MORE THAN 80 YEARS OF MEETING THE NEEDS OF THE COMMUNITY IT SERVES MEASE COUNTRYSID E HOSPITAL ORIGINALLY BEGAN AS A SATELLITE CLINIC TO MEASE DUNEDIN HOSPITAL THE NEEDS OF THE COMMUNITY GREW ALONG WITH A HOUSING BOOM AND IN 1985, MEASE COUNTRYSIDE HOSPITAL OPENE D MEASE COUNTRYSIDE HOSPITAL HAS BEEN SERVING ITS FAST-GROWING COMMUNITY FOR MORE THAN 30 YEARS WITH THE SAME COMMITMENT AND IS A 311-BED FACILITY MEASE COUNTRYSIDE AND MEASE DUNE DIN HOSPITALS ARE PART OF MORTON PLANT MEASE HEALTH CARE THE OTHER HOSPITALS INCLUDED IN MORTON PLANT MEASE HEALTH CARE ARE MORTON PLANT AND MORTON PLANT NORTH BAY EVEN THOUGH MO RTON PLANT AND MORTON PLANT NORTH BAY HOSPITALS FILE THEIR OWN TAX RETURN, THE FOUR HOSPIT ALS WORK TOGETHER AS MORTON PLANT MEASE HEALTH CARE (REFERRED TO AS MORTON PLANT MEASE) TO SUPPORT COMMUNITY HEALTH CARE NEEDS AND SERVICES COMMUNITY INVOLVEMENTMEASE COUNTRYSIDE AND MEASE DUNEDIN HOSPITALS INVOLVES COMMUNITY MEMBERS AS AN ESSENTIAL COMPONENT OF THE BO ARD OF TRUSTEES CONDUIT FOR USING DONATED FUNDSPATIENT TRANSPORTATIONTHROUGH A GRANT FROM THE FLORIDA BLUE FOUNDATION AND A PARTNERSHIP WITH UBER TECHNOLOGIES, A NON-EMERGENCY TRAN SPORTATION SOLUTION IS PROVIDED FOR LOW INCOME PATIENTS ACROSS BAYCARE'S FOUR-COUNTY SERVI CE AREA TO ACCESS FOLLOW-UP HEALTH SERVICES IN 2018, THE PROGRAM PROVIDED RIDES TO MORE T HAN 5,800 DISCHARGED PATIENTS ALLEGANY FRANCISCAN MINISTRIES (FAITH COMMUNITY NURSING GRAN T) BAYCARE HAS RECEIVED FUNDING FROM ALLEGANY FRANCISCAN MINISTRIES TO PROVIDE CAPACITY AN D SUPPORT TO OUR FAITH COMMUNITY NURSING PROGRAM TO REDUCE UNNECESSARY HOSPITAL UTILIZATIO N AND IMPROVE HEALTH OUTCOMES FOR PARTICIPANTS ANNUAL FUNDING OF $160,000 SUPPORTS THIS W ORK ACROSS BAYCARE HEALTH SYSTEM ALLEGANY FRANCISCAN MINISTRIES (MEDICATION ASSISTANCE PR OGRAM)BAYCARE HAS RECEIVED FUNDING FROM ALLEGANY FRANCISCAN MINISTRIES TO PROVIDE ASSISTAN CE TO THOSE WHO FACE FINANCIAL BARRIERS IN GETTING THEIR NEEDED PRESCRIPTION MEDICATIONS MEDICATION ASSISTANCE COORDINATORS WORK WITH PATIENTS TO DETERMINE IF THERE ARE VOUCHERS A VAILABLE OR WORK WITH THE PATIENT'S DOCTOR TO SEE IF A MORE COST EFFECTIVE, ALTERNATIVE ME DICATION IS AVAILABLE ANNUAL FUNDING OF $65,000 PROVIDES SUPPORT FOR THIS PROGRAM ACROSS BAYCARE HEALTH SYSTEM ECONOMIC IMPACTTHERE ARE 7,200 MORTON PLANT MEASE EMPLOYEES AND MORE THAN 1,300 PHYSICIANS WHO HAVE BROUGHT THE HOSPITALS' MISSION TO LIFE BY INVITING THE NEX T GENERATION OF HEALTH CARE WORKERS TO LEARN FROM THE SKILL AND EXPERTISE OF OUR CURRENT T EAM MEMBERS, MORTON PLANT MEASE PROVIDES VALUABLE BENEFIT TO THE COMMUNITY STUDENT CLINIC AL EXPERIENCES AFFORD HEALTH CARE STUDENTS OPPORTUNITIES TO LEARN SKILLS AND KNOWLEDGE NEC ESSARY TO FUNCTION IN ACUTE CARE FACILITIES AND GAIN COMPETENCE IN CLINICAL TECHNIQUES IN TOTAL, $1,199,973 IN STAFF TIME FOR NURSES, DIETITIANS, LAB TECHNOLOGISTS AND RESPIRATORY THERAPISTS WAS USED TO EDUCATE THESE FUTURE HEALTH CARE PROVIDERS ABOUT MANY ASPECTS OF P ATIENT CARE STUDENTS PURSUING CAREERS IN EMERGENCY MEDICAL SERVICES (EMS) ALSO COMPLETED INTERNSHIPS AND CLINICAL ROTATIONS AT MEASE HOSPITALS IN 2018, EMS STUDENTS STUDIED AT OU R FACILITIES WITH TEAM MEMBERS DEVOTING MORE THAN $60,000 TOWARD THEIR TIME AND TRAINING IN 2018, STUDENTS FROM SIX COLLEGES AND UNIVERSITIES ALSO BENEFITTED FROM CLINICAL INTERNS HIPS CAMP NURSE JR SEVENTH- AND EIGHTH-GRADE STUDENTS WHO ARE INTERESTED IN BECOMING A DO CTOR, NURSE OR OTHER HEALTH CARE PROFESSIONAL ATTENDED CAMP NURSE JR AT MEASE DUNEDIN HOS PITAL TAUGHT BY REGISTERED NURSES FROM MORTON PLANT MEASE HEALTH CARE, STUDENTS EXPERIENC ED HEALTH CARE CAREERS THROUGH VISITS TO VARIOUS HOSPITAL DEPARTMENTS AND HANDS-ON ACTIVIT IES SUCH AS WORKING WITH COMPUTERIZED PATIENT SIMULATORS DURING THE THREE-DAY SUMMER CAMP GOOD NEIGHBORSMEASE COUNTRYSIDE AND MEASE DUNEDIN HOSPITALS PROVIDE FREE MEETING SPACE FO R A WIDE ARRAY OF COMMUNITY GROUPS INCLUDING SUPPORT GROUPS AND CIVIC ORGANIZATIONS RECOGN ITIONEXCELLENCE IN CLINICAL CARE - MEASE COUNTRYSIDE HOSPITAL HAS BEEN NATIONALLY RECOGNIZ ED AS THE BESTPERFORMING HOSPITAL IN THE U S 11 TIMES BY IBM WATSON HEALTH 100 TOP HOSPIT ALS AND IS THE ONLY FLORIDA HOSPITAL TO BE NAMED 11 TIMES NURSING ALL FOUR MORTON PLANT ME ASE HOSPITALS - MEASE COUNTRYSIDE, MEASE DUNEDIN, MORTON PLANT AND MORTON PLANT NORTH BAY ACHIEVED PATHWAY DESIGNATION FROM THE AMERICAN NURSES CREDENTIALING CENTER (ANCC), WHICH R ECOGNIZES HEALTH CARE ORGANIZATIONS FOR POSITIVE PRACTICE ENVIRONMENTS WHERE NURSES EXCEL NATIONALLY ACCREDITED BARIATRIC PROGRAMIN 2018, MEASE DUNEDIN HOSPITAL'S BARIATRIC PROGRA M WAS RE-ACCREDITED AS A COMPREHENSIVE CENTER BY THE METABOLIC AND BARIATRIC SURGERY ACCRE DITATION AND QUALITY IMPROVEMENT PROGRAM (MBSAQIP), IN RECOGNITION OF THE PROGRAM'S COMMIT MENT TO PROVIDING AND SUPPORTING QUALITY IMPROVEME

Form and Line Reference	Explanation
PART VI, LINE 5	NT AND PATIENT SAFETY EFFORTS FOR METABOLIC AND BARIATRIC SURGERY PATIENTS STROKE CAREALL FOUR MORTON PLANT MEASE HOSPITALS HAVE BEEN RECOGNIZED IN 2018 FOR PROVIDING QUALITY CARE TO STROKE PATIENTS WITH THE "GET WITH THE GUIDELINES" ACHIEVEMENT AWARDS FROM THE AMERICAN HEART ASSOCIATION/AMERICAN STROKE ASSOCIATION MORTON PLANT, MEASE COUNTRYSIDE, MEASE DUN EDIN AND MORTON PLANT NORTH BAY HOSPITALS ALL RECEIVED THE STROKE GOLD PLUS ACHIEVEMENT AW ARD MORTON PLANT, MEASE DUNEDIN AND MEASE COUNTRYSIDE ALSO RECEIVED TARGET STROKE HONOR RO LL ELITE RECOGNITION RESPONDING TO NEEDSMORTON PLANT MEASE IS COMMITTED TO PROVIDING FINA NCIAL AND OTHER SUPPORT TO NOT-FOR-PROFIT ORGANIZATIONS WHOSE MISSIONS ARE TO IMPROVE THE HEALTH AND WELL-BEING OF OUR COMMUNITY IN 2018, MORTON PLANT MEASE PROVIDED FUNDING TO FR EE CLINICS AND COMMUNITY BASED ORGANIZATIONS INCLUDING THE FOLLOWING CLEARWATER FREE CLIN ICMORTON PLANT MEASE PROVIDES $300,000 ANNUALLY TO SUPPORT ONGOING OPERATIONS INCLUDING ME DICATION ASSISTANCE AND AN ON-SITE ADVANCED REGISTERED NURSE PRACTITIONER LA CLINICA GUAD ALUPANALA CLINICA GUADALUPANA IS A FREE CLINIC THAT PROVIDES HEALTH CARE TO PINELLAS COUNT Y'S RAPIDLY GROWING HISPANIC COMMUNITY MORTON PLANT MEASE PROVIDES $60,000 ANNUALLY TO SU PPORT ONGOING OPERATIONS, WHICH INCLUDE SERVICES SUCH AS PRIMARY, GYNECOLOGICAL AND PEDIAT RIC CARE, FREE HEALTH SCREENINGS AND IMMUNIZATIONS WILLA CARSON HEALTH AND WELLNESS CENTE RTHE WILLA CARSON HEALTH AND WELLNESS CENTER IN CLEARWATER PROVIDES PREVENTATIVE HEALTH CA RE, WELLNESS AND EDUCATION SERVICES TO UNINSURED AND LOW-INCOME COMMUNITY MEMBERS AT NO CH ARGE MORTON PLANT MEASE PROVIDES $55,000 ANNUALLY TO SUPPORT ONGOING OPERATIONS SERVICES PROVIDED INCLUDE BLOOD PRESSURE TESTS, DIABETES SCREENINGS, LEAD SCREENINGS, PHYSICALS AN D TUBERCULOSIS (TB) TESTING HOMELESS EMPOWERMENT PROGRAMMORTON PLANT MEASE PROVIDES $158, 684 ANNUALLY TO SUPPORT THE HOMELESS EMPOWERMENT PROGRAM'S ON-SITE WELLNESS CLINIC OFFERIN G CHRONIC DISEASE SELF-MANAGEMENT PROGRAM WORKSHOPS, HEALTH AND WELLNESS NAVIGATOR SERVICE S TO EXPEDITE ACCESS TO PRIMARY CARE, DIAGNOSTIC, AND PHARMACEUTICAL SERVICES, AS WELL AS CRISIS INTERVENTION/STABILIZATION SERVICES FROM THE BEHAVIORAL HEALTH NAVIGATOR NORTH GRE ENWOOD COMMUNITY HEALTH FAIRIN AN EFFORT TO IMPROVE THE HEALTH OF THE RESIDENTS IN THE TRA DITIONALLY LOW-INCOME NEIGHBORHOOD OF NORTH GREENWOOD, BAYCARE AND MORTON PLANT MEASE PART NERED WITH MT OLIVE AME CHURCH TO HOST A FREE COMMUNITY HEALTH FAIR OUR FAITH COMMUNITY NURSES HELPED TO FACILITATE THE EVENT, BRINGING IN SERVICES AND HEALTH CARE PROVIDERS FROM THROUGHOUT BAYCARE AND THE COMMUNITY TO PROVIDE BLOOD PRESSURE SCREENINGS, BODY MASS INDE X/OBESITY SCREENINGS, TOTAL CHOLESTEROL TESTING, HEALTH RISK ASSESSMENTS, FLU VACCINES, DE PRESSION SCREENINGS AND MORE ENROLLMENT ASSISTANCE IN 2018, FOUR FINANCIAL ASSISTANCE TEAM MEMBERS AT MEASE COUNTRYSIDE SCREENED UNINSURED AND UNDER-INSURED ER PATIENTS AND INPATIE NTS AT THE BEDSIDE FOR MULTIPLE MEDICAID PROGRAMS AND COUNTY HEALTH CARE PLANS, THEN ASSIS TED WITH THE COMPLETION OF APPLICATIONS IN ADDITION TO PROVIDING EDUCATION AND CONTINUOUS SUPPORT THROUGH THE PROCESS THEIR EFFORTS LOGGED MORE THAN 2,300 HOURS OF BENEFIT FOR THE COMMUNITY SURROUNDING MEASE COUNTRYSIDE (CONT-D AFTER PART VI, LINE 7 NARRATIVE)

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 6	TRUSTEES OF MEASE HOSPITAL, INC IS PART OF BAYCARE HEALTH SYSTEM, INC ("BAYCARE"), A LEADING, NOT-FOR-PROFIT HEALTH CARE SYSTEM THAT CONNECTS INDIVIDUALS AND FAMILIES TO A WIDE RANGE OF SERVICES AT 14 HOSPITALS AND HUNDREDS OF OTHER CONVENIENT LOCATIONS THROUGHOUT THE TAMPA BAY AND WEST CENTRAL FLORIDA REGIONS INPATIENT AND OUTPATIENT SERVICES INCLUDE ACUTE CARE, PRIMARY CARE, IMAGING, LABORATORY, BEHAVIORAL HEALTH, HOME CARE AND URGENT CARE BAYCARE'S ANNUAL "REPORT TO THE COMMUNITY" CAN BE VIEWED AT HTTPS //BAYCARE ORG/ANNUAL-REPORT-2018 BAYCARE'S HOSPITALS ARE BARTOW REGIONAL MEDICAL CENTER, MEASE COUNTRYSIDE, MEASE DUNEDIN, MORTON PLANT, MORTON PLANT NORTH BAY, ST ANTHONY'S, ST JOSEPH'S, ST JOSEPH'S CHILDREN'S, ST JOSEPH'S WOMEN'S, ST JOSEPH'S HOSPITAL-NORTH, ST JOSEPH'S HOSPITAL-SOUTH, SOUTH FLORIDA BAPTIST, WINTER HAVEN AND WINTER HAVEN WOMEN'S *BAYCARE WAS FOUNDED IN 1997 WHEN SEVERAL OF THE AREA'S NOT-FOR-PROFIT HOSPITALS CAME TOGETHER TO CREATE A HEALTH SYSTEM THAT WOULD ENSURE HIGH-QUALITY HEALTH CARE FOR EVERYONE IN THE COMMUNITY, REGARDLESS OF THEIR ABILITY TO PAY TODAY, BAYCARE IS A $4 2 BILLION, INTEGRATED HEALTH DELIVERY SYSTEM WITH 28,400 EMPLOYEES IT PLAYS AN IMPORTANT ROLE AS AN ECONOMIC ENGINE, ANNUALLY GENERATING A $6 62 BILLION IMPACT ON THE REGION AND THE STATE IN 2018, BAYCARE SPENT $2 09 BILLION TO PAY FOR THE SALARY AND BENEFITS OF ITS EMPLOYEES AND INVESTED $309 MILLION IN CAPITAL RESOURCES BAYCARE'S CENTRALIZATION OF ADMINISTRATIVE FUNCTIONS IN A NUMBER OF AREAS, INCLUDING FINANCE, BUSINESS OFFICE, INFORMATION TECHNOLOGY, HUMAN RESOURCES, PERFORMANCE IMPROVEMENT, CLINICAL OUTCOMES, CARE MANAGEMENT, PLANNING, SUPPLY CHAIN AND MARKETING/COMMUNICATIONS, HAS PROVIDED A MANAGEMENT STRUCTURE THAT HELPS ITS HOSPITALS AND SERVICE LINES OPERATE MORE EFFICIENTLY AND CONTINUE STRIVING FOR CLINICAL EXCELLENCE BAYCARE'S FINANCIAL STABILITY ALSO HELPS ENSURE THAT ITS HOSPITALS REMAIN FOCUSED ON THEIR SHARED MISSION TO IMPROVE THE HEALTH OF ALL THEY SERVE THROUGH COMMUNITY-OWNED SERVICES THAT SET THE STANDARD FOR HIGH-QUALITY, COMPASSIONATE CARE, REGARDLESS OF PATIENTS' ABILITY TO PAY IN 2018, BAYCARE PROVIDED $462 MILLION IN TOTAL COMMUNITY BENEFIT, 11% OF BAYCARE'S REVENUES, WHICH INCLUDES $117 MILLION IN TRADITIONAL CHARITY CARE FOR UNINSURED PATIENTS, $311 MILLION IN MEDICAID AND OTHER INCOME-BASED PROGRAMS, AND $34 MILLION IN UNBILLED COMMUNITY SERVICES ALL OF THESE ARE MEASURED IN UNREIMBURSED COST *IN CERTAIN CASES, HOSPITAL LOCATIONS WITH THE SAME TAX IDENTIFICATION AND STATE LICENSE NUMBER ARE LISTED AS ONE FACILITY ON FORM 990, SCHEDULE H, CONSISTENT WITH IRS REPORTING GUIDELINES

990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
PART VI, LINE 7	TRUSTEES OF MEASE HOSPITAL, INC OPERATES IN THE STATE OF FLORIDA, WHICH DOES NOT REQUIRE A COMMUNITY BENEFIT REPORT TO BE FILED WITH THE STATE GOVERNMENT

Form and Line Reference	Explanation
PART VI, LINE 5 (CONT-D)	CLINICAL RESOURCE MANAGEMENTIN 2018, THE CLINICAL RESOURCE MANAGEMENT PROGRAM PROVIDED $96 0,522 IN SERVICES THIS PROGRAM INCLUDES PHARMACY, HOME HEALTH/DME, TRANSPORTATION, SKILLE D NURSING FACILITIES, ASSISTED LIVING FACILITIES AND OTHER DISCHARGE NEEDS FOR PATIENTS M ANY PATIENTS ARE EITHER UNINSURED, UNABLE TO APPROPRIATELY CARE FOR THEMSELVES OR DO NOT H AVE A CAREGIVER WOMEN'S & CHILDREN'S CARESERVING NORTH PINELLAS AND PASCO COUNTIES, THE WO MEN'S & CHILDREN'S CENTER AT MEASE COUNTRYSIDE HOSPITAL SEEKS TO COMBINE MODERN TECHNOLOGY WITH FAMILY-CENTERED CARE BIRTHING, CHILDCARE AND BREASTFEEDING CLASSES ARE OFFERED TO E XPECTANT PARENTS PRE-NATAL CARE FOR DRUG TREATMENT PATIENTSTO HELP ADDRESS THE SERIOUS ISS UE OF BABIES BORN TO DRUG-ADDICTED MOMS, MEASE COUNTRYSIDE OFFERS EXPECTANT MOMS ADDICTED TO DRUGS A PROGRAM THAT CROSSES THE CONTINUUM OF CARE FROM PRE-NATAL THROUGH THE HOSPITAL STAY SERVICES INCLUDE AN OCCUPATIONAL THERAPIST, SPECIALIZING IN NEONATES TO WORK ONE-ON- ONE WITH PARENTS TO ENHANCE BONDING AND TEACH PARENTING SKILLS SUCH AS SOOTHING TECHNIQUES FOR BABIES SUFFERING THE EFFECTS OF DRUG WITHDRAWAL BY PARTNERING WITH ST JOSEPH'S CHILD REN'S HOSPITAL, MEASE COUNTRYSIDE HAS CONTINUED ITS COMMITMENT TO STRENGTHEN AND ADVANCE C HILDREN'S CARE IN NORTH PINELLAS AND SOUTH PASCO COUNTIES BY PROVIDING MORE ACCESS IN THE LOCAL COMMUNITY TO INNOVATIVE AND HIGH TECH CARE IN A FAMILY-CENTERED SETTING THE PARTNER SHIP OFFERS - PEDIATRIC EMERGENCY SERVICES - LEVEL III NEONATAL INTENSIVE CARE UNITS - EN HANCED 15-BED, PRIVATE INPATIENT CHILDREN'S UNIT WITH A CHILD LIFE SPECIALIST WHO WORKS WI TH CHILDREN AND THEIR PARENTS TO BRING A SENSE OF NORMALCY TO THE EXPERIENCE OF HOSPITALIZ ATION - CHILDREN'S ADVOCACY PROVIDING EDUCATIONAL CLASSES AND COMMUNITY ACTIVITIES INCLUDI NG HOME SAFETY ASSESSMENTS, ASTHMA ASSESSMENTS, ASTHMA EDUCATION, CHILD PASSENGER SAFETY E DUCATION, BICYCLE AND PEDESTRIAN SAFETY EDUCATION, FALL PREVENTION EDUCATION, DROWNING PRE VENTION EDUCATION, FIRE/BURN AND POISONING PREVENTION EDUCATION AND BRINGING AWARENESS OF FLORIDA KIDCARE INSURANCE - ST JOSEPH'S CHILDREN'S SPECIALTY CENTER ON THE MEASE COUNTRYS IDE CAMPUS PROVIDES THE NORTH PINELLAS AND SOUTH PASCO COMMUNITIES GREATER ACCESS TO PHYSI CAL, OCCUPATIONAL, SPEECH, AND SENSORY THERAPY PROGRAMS, PEDIATRIC PHYSICIAN SPECIALTY SER VICES AND CONVENIENT, ON-SITE PEDIATRIC AND LABORATORY SERVICESMEASE DUNEDIN BEHAVIORAL HE ALTH CENTERTO PROVIDE ADDITIONAL ACCESS TO CONVENIENT, ACUTE INPATIENT MENTAL HEALTH SERVI CES, BAYCARE HEALTH SYSTEM AND MEASE DUNEDIN HOSPITAL HAVE A 32-BED SPECIALIZED INPATIENT BEHAVIORAL HEALTH CENTER THE BEHAVIORAL HEALTH CENTER FEATURES THREE SEPARATE UNITS ONE F OR ADULTS WITH 12 BEDS, ONE FOR CHILDREN AND ADOLESCENTS WITH 10 BEDS AND ONE FOR GERIATRI C PATIENTS WITH 10 BEDS COMMUNITY SCREENINGS & COMMUNITY EDUCATIONMORTON PLANT MEASE SCRE ENED COMMUNITY MEMBERS FOR SUCH DISEASES AND CONDITIONS AS HIGH BLOOD PRESSURE, SKIN CANCE R, MEMORY DISORDERS, SLEEP DISORDERS AND CARDIOVASCULAR DISEASE IN ADDITION, MORTON PLANT MEASE GAVE FREE ATHLETIC PHYSICALS TO PINELLAS COUNTY HIGH SCHOOL STUDENTS AT A SPORTS PH YSICAL EVENT OUR COMPREHENSIVE PHYSICALS INCLUDED CHECKS OF HEIGHT, WEIGHT, BLOOD PRESSUR E, VISION AND LUNGS, AS WELL AS A MUSCULOSKELETAL EXAM MEASE COUNTRYSIDE AND MEASE DUNEDI N PROVIDE FREE COMMUNITY HEALTH EDUCATION IN THE FORM OF SUPPORT GROUPS ON A WIDE VARIETY OF TOPICS FAITH COMMUNITY NURSINGFAITH COMMUNITY NURSING OFFERS A UNIQUE PARTNERSHIP BETW EEN MORTON PLANT MEASE AND THE FAITH COMMUNITIES IN PINELLAS AND PASCO COUNTIES OUR FAITH COMMUNITY NURSES AND HEALTH MINISTERS WORK TO IMPROVE THE HEALTH OF THEIR FAITH COMMUNITY BY ENCOURAGING PREVENTATIVE CARE AND REFERRING MEMBERS TO THE APPROPRIATE HEALTH RESOURCE S IN 2018, 131 NURSES HAD DIRECT CONTACT WITH FAITH COMMUNITY MEMBERS THEY CONDUCTED MOR E THAN 4,000 SCREENINGS AND HAD ALMOST 32,000 CLIENT ENCOUNTERS, VOLUNTEERING MORE THAN 16 ,000 HOURS WITHIN 67 LOCAL FAITH COMMUNITIES VIRTUAL ICUBAYCARE HEALTH SYSTEM AND THE MOR TON PLANT MEASE HOSPITALS HAVE TAKEN THE TREATMENT OF CRITICALLY ILL PATIENTS TO THE NEXT LEVEL WITH VIRTUAL ICU, A TELEMEDICINE-BASED PROGRAM COMBINING MEDICAL EXPERTISE, TECHNOL OGY AND EXPERIENCED CRITICAL CARE NURSES AND DOCTORS, VIRTUAL ICU IS AN ELECTRONIC PATIENT MONITORING SYSTEM THAT USES REMOTE COMPUTER TECHNOLOGY AND PHYSICIANS TO ENHANCE THE CARE OF CRITICALLY ILL PATIENTS VOLUNTEER ACTIVITIESIN 2018, 485 VOLUNTEERS PROVIDED 101,286 H OURS WHICH RESULTED IN 318,356 UNITS OF SERVICE FOR MEASE COUNTRYSIDE AND MEASE DUNEDIN HO SPITALS TO PROVIDE SERVICE TO MEET OUR COMMUNITY NEEDS THAT MIGHT OTHERWISE GO UNMET THES E SERVICES INCLUDE PATIENT WELCOME VISITS, SURGERY VISITOR ASSISTANCE, TRAM/SHUTTLE RIDES, DISCHARGE ASSISTS, VOLUNTEER CHAPLAIN VISITS AND PATIENT COMPANION VISITS IN ADDITION TO HOSPITAL SERVICES, THEY ALSO PROVIDED UNIQUE SUPPORT FOR CANCER PATIENTS AND THEIR FAMILI ES THROUGH AN ALL-DAY, FREE CELEBRATION PICNIC VO

Form and Line Reference	Explanation
PART VI, LINE 5 (CONT-D)	LUNTEERS PROVIDED 12,649 RIDES THROUGH CARELIFT, A FREE VAN TRANSPORTATION PROGRAM FOR PAT IENTS NEEDING RIDES TO AND FROM THE HOSPITALS AND OUTPATIENT SERVICES FOR APPOINTMENTS AND TREATMENTS MORTON PLANT MEASE AND ITS TEAM MEMBERS AND PHYSICIANS FROM THE TURLEY FAMILY HEALTH CENTER, ALONG WITH MORTON PLANT MEASE FAITH COMMUNITY NURSING AND PASTORAL CARE GAV E 47 FREE BACK-TO-SCHOOL PHYSICALS AND HANDED OUT 380 BACKPACKS FILLED WITH SCHOOL SUPPLIE S AT THE NORTH GREENWOOD BACK TO SCHOOL WELLNESS FAIR TEAM MEMBERS ALSO CONTRIBUTED TO TH E HEALTH OF THE COMMUNITY BY PARTNERING WITH TAMPA BAY TROOP SUPPORT TO COLLECT AND SHIP N EEDED ITEMS TO TROOPS OVERSEAS ITEMS DONATED INCLUDED BABY WIPES, PROTEIN BARS, SUNSCREEN , TRAIL MIX AND HAND SANITIZER

Additional Data

Software ID:

Software Version:

EIN: 59-0855412

Name: TRUSTEES OF MEASE HOSPITAL INC

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

Section A. Hospital Facilities (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? **1** Name, address, primary website address, and state license number		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	**Other (Describe)**	**Facility reporting group**
1	TRUSTEES OF MEASE HOSPITAL INC 3231 MCMULLEN BOOTH RD CLEARWATER, FL 33761 WWW BAYCARE ORG 4378	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
TRUSTEES OF MEASE HOSPITAL, INC	PART V, SECTION B, LINE 5 TO SOLICIT INPUT FROM KEY INFORMANTS, THOSE INDIVIDUALS WHO HAVE A BROAD INTEREST IN THE HEALTH OF THE COMMUNITY, AN ONLINE KEY INFORMANT SURVEY WAS ALSO IMPLEMENTED AS PART OF THIS PROCESS A LIST OF RECOMMENDED PARTICIPANTS WAS PROVIDED BY TRUSTEES OF MEASE HOSPITAL, THIS LIST INCLUDED NAMES AND CONTACT INFORMATION FOR PHYSICIANS, PUBLIC HEALTH REPRESENTATIVES, OTHER HEALTH PROFESSIONALS, SOCIAL SERVICE PROVIDERS, AND A VARIETY OF OTHER COMMUNITY LEADERS POTENTIAL PARTICIPANTS WERE CHOSEN BECAUSE OF THEIR ABILITY TO IDENTIFY PRIMARY CONCERNS OF THE POPULATIONS WITH WHOM THEY WORK, AS WELL AS OF THE COMMUNITY OVERALL KEY INFORMANTS WERE CONTACTED BY EMAIL, INTRODUCING THE PURPOSE OF THE SURVEY AND PROVIDING A LINK TO TAKE THE SURVEY ONLINE, REMINDER EMAILS WERE SENT AS NEEDED TO INCREASE PARTICIPATION IN ALL, 66 COMMUNITY STAKEHOLDERS IN THE TRUSTEES OF MEASE HOSPITAL SERVICE AREA TOOK PART IN THE ONLINE KEY INFORMANT SURVEY, AS OUTLINED ON PAGE 8 OF THE CHNA SEVERAL OF THE PARTICIPANTS RESPONDING TO THE SURVEY REPRESENT ORGANIZATIONS WHICH WORK WITH LOW-INCOME, MINORITY OR OTHER MEDICALLY UNDERSERVED POPULATIONS

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
TRUSTEES OF MEASE HOSPITAL, INC	PART V, SECTION B, LINE 6A CHNA WAS CONDUCTED WITH THE FOLLOWING HOSPITAL FACILITIES 1 ST ANTHONY'S HOSPITAL2 MORTON PLANT HOSPITAL ASSOCIATION3 TRUSTEES OF MEASE4 ST JOSEPH'S HOSPITAL5 SOUTH FLORIDA BAPTIST HOSPITAL

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
TRUSTEES OF MEASE HOSPITAL, INC	PART V, SECTION B, LINE 11 WHILE 14 AREAS OF OPPORTUNITY WERE IDENTIFIED WITHIN THE MEASE COUNTRYSIDE HOSPITAL AND MEASE DUNEDIN HOSPITAL SERVICE AREAS, CONCENTRATED EFFORTS WILL BE DEDICATED DURING THE 2017-2019 TIME PERIOD TO ADDRESSING THE FOLLOWING SIGNIFICANT HEAL TH NEEDS OF OUR COMMUNITY AS IDENTIFIED IN THE MOST RECENT CHNA - ACCESS TO HEALTHCARE SE RVICES - DIABETES - HEART DISEASE & STROKE - INFANT HEALTH - MENTAL HEALTH - SUBSTANCE ABU SE - NUTRITION, PHYSICAL ACTIVITY & WEIGHTPLEASE SEE THE ATTACHED IMPLEMENTATION PLAN FOR SPECIFIC ACTIVITIES THAT ARE UNDERWAY TO ADDRESS THESE SIGNIFICANT HEALTH NEEDS DURING THE 2017-2019 TIME PERIOD BASED ON THE SCOPE/SCALE OF THE ISSUE, MEASE COUNTRYSIDE AND MEASE DUNEDIN HOSPITALS' LEADERSHIP TEAM'S PERCEIVED ABILITY TO IMPACT THE ISSUE, THE AVAILABILI TY OF EXISTING COMMUNITY RESOURCES ALREADY IN PLACE TO ADDRESS THE ISSUE AND CONSIDERING C OMMUNITY STAKEHOLDER FEEDBACK, THE SIGNIFICANT HEALTH NEEDS IDENTIFIED DURING THE 2016 ASS ESSMENT THAT ARE NOT DIRECTLY REFERENCED IN THE 2017-2019 CHNA IMPLEMENTATION STRATEGY, AR E LISTED BELOW CANCER MEASE COUNTRYSIDE AND MEASE DUNEDIN HOSPITALS REMAIN COMMITTED TO SU PPORTING THOSE AFFECTED BY CANCER MEASE COUNTRYSIDE AND MEASE DUNEDIN HOSPITAL'S LEADERSH IP BELIEVES THAT EXISTING HOSPITAL INITIATIVES AND NEW EFFORTS OUTLINED HEREIN TO IMPROVE ACCESS TO HEALTH SERVICES WILL HAVE A POSITIVE IMPACT ON AIDING THOSE AFFECTED BY CANCER A ND THAT A SEPARATE SET OF INITIATIVES WAS NOT NECESSARY AT THIS TIME DEMENTIA (INCLUDING A LZHEIMER'S DISEASE) MEASE COUNTRYSIDE HOSPITAL AND MEASE DUNEDIN HOSPITAL HAVE LIMITED RES OURCES, SERVICES AND EXPERTISE AVAILABLE TO ADDRESS DEMENTIA (INCLUDING ALZHEIMER'S DISEAS E) WHILE THIS IS AN IMPORTANT ISSUE, OTHER COMMUNITY ORGANIZATIONS HAVE INFRASTRUCTURE AN D PROGRAMS IN PLACE TO BETTER MEET THIS NEED LIMITED RESOURCES AND LOWER PRIORITY EXCLUDE D THIS AS AN AREA CHOSEN FOR ACTION HIV/AIDS MEASE COUNTRYSIDE AND MEASE DUNEDIN HOSPITALS HAVE LIMITED RESOURCES, SERVICES AND EXPERTISE AVAILABLE TO ADDRESS HIV/AIDS OTHER COMMU NITY ORGANIZATIONS (INCLUDING RESOURCES WITHIN THE BAYCARE HEALTH SYSTEM) HAVE INFRASTRUCT URE IN PLACE TO BETTER MEET THIS NEED LIMITED RESOURCES EXCLUDED THIS AS AN AREA CHOSEN F OR ACTION INJURY & VIOLENCE MEASE COUNTRYSIDE AND MEASE DUNEDIN HOSPITAL'S LEADERSHIP BELI EVES THAT THIS PRIORITY AREA FALLS MORE WITHIN THE PURVIEW OF OTHER COMMUNITY ORGANIZATION S OTHER COMMUNITY ORGANIZATIONS HAVE INFRASTRUCTURE AND PROGRAMS IN PLACE TO BETTER MEET THIS NEED LIMITED RESOURCES EXCLUDED THIS AS AN AREA CHOSEN FOR ACTION ORAL HEALTH MEASE COUNTRYSIDE AND MEASE DUNEDIN HOSPITALS HAVE LIMITED RESOURCES, SERVICES AND EXPERTISE AVA ILABLE TO ADDRESS ORAL HEALTH OTHER COMMUNITY ORGANIZATIONS HAVE INFRASTRUCTURE AND PROGR AMS IN PLACE TO BETTER MEET THIS NEED LIMITED RESOURCES AND LOWER PRIORITY EXCLUDED THIS AS AN AREA CHOSEN FOR ACTION POTENTIALLY DISABLING CONDITIONS MEASE COUNTRYSIDE AND MEASE DUNEDIN HOSPITAL'S LEADERSHIP

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
TRUSTEES OF MEASE HOSPITAL, INC	BELIEVES THAT EFFORTS OUTLINED HEREIN TO IMPROVE ACCESS TO HEALTH SERVICES WILL HAVE A POS ITIVE IMPACT ON AIDING THOSE WITH POTENTIALLY DISABLING CONDITIONS AND THAT A SEPARATE SET OF INITIATIVES WAS NOT NECESSARY AT THIS TIME SEXUALLY TRANSMITTED DISEASES MEASE COUNTRY SIDE AND MEASE DUNEDIN HOSPITAL'S LEADERSHIP BELIEVES THAT THIS PRIORITY AREA FALLS MORE W ITHIN THE PURVIEW OF THE COUNTY HEALTH DEPARTMENT AND OTHER COMMUNITY ORGANIZATIONS LIMIT ED RESOURCES AND LOWER PRIORITY EXCLUDED THIS AS AN AREA CHOSEN FOR ACTION

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
TRUSTEES OF MEASE HOSPITAL, INC	PART V, SECTION B, LINE 13B PATIENTS MAY BE ELIGIBLE FOR FINANCIAL ASSISTANCE ON THE PORTION OF HOSPITAL BILLS EXCEEDING 25% OF ANNUAL INCOME

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
TRUSTEES OF MEASE HOSPITAL, INC	PART V, SECTION B, LINE 18E LIEN ACTION RELATED TO COLLECTIONS IS LIMITED TO PATIENTS INVOLVING AUTO LIABILITY INSURANCE

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	HTTPS //BAYCARE ORG/HOSPITALS/MEASE-COUNTRYSIDE-HOSPITAL/ABOUT-US/COMMUNITY-HEALTH-NEEDS

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 7B	HTTPS //BAYCARE ORG/HOSPITALS/MEASE-DUNEDIN-HOSPITAL/ABOUT-US/COMMUNITY-HEALTH-NEEDS

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Schedule I (Form 990)

Department of the Treasury
Internal Revenue Service

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

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

▶ **Attach to Form 990.**

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
TRUSTEES OF MEASE HOSPITAL INC

Employer identification number
59-0855412

Part I General Information on Grants and Assistance

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

2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States

Part II Grants and Other Assistance to Domestic Organizations and Domestic Governments.

Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than $5,000 Part II can be duplicated if additional space is needed

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

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

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

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
PART I, LINE 2	TRUSTEES OF MEASE HOSPITAL, INC IS COMMITTED TO ASSISTING NON-PROFIT ORGANIZATIONS WHOSE FOCUS IS TO IMPROVE THE HEALTH AND WELLNESS OF THE COMMUNITIES WE SERVE EACH CASH DONATION REQUEST IS REVIEWED BY TRUSTEES OF MEASE HOSPITAL, INC 'S SENIOR MANAGEMENT TEAM TO DETERMINE WHETHER THE ORGANIZATION IS ONE WE WANT TO DONATE TO, BASED ON THE ORGANIZATION'S MISSION, NON-PROFIT STATUS, AND USAGE OF FUNDS ONCE APPROVED, WE REQUIRE PROPER DOCUMENTATION FROM THE ORGANIZATION OF ITS NON-PROFIT STATUS, AND AS NEEDED, FOLLOW-UP WITH THE ORGANIZATION TO ENSURE THE ACTIVITY OCCURRED

Additional Data

Software ID:
Software Version:
EIN: 59-0855412
Name: TRUSTEES OF MEASE HOSPITAL 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
HOMELESS EMERGENCY PROJECT 1120 N BETTY LANE CLEARWATER, FL 33755	59-2729694	501(C)(3)	63,474				HOMELESS SHELTER FUNDING
LA CLINICA GUADALUPANA 1000 LAKEVIEW RD STE 4 CLEARWATER, FL 33756	59-3348864	501(C)(3)	24,000				MEDICAL CLINIC FUNDING

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
WILLA CARSON HLTH RESOURCE CTR 1108 N MLK AVE CLEARWATER, FL 33755	65-0743078	501(C)(3)	22,000				MEDICAL CLINIC FUNDING

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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
TRUSTEES OF MEASE HOSPITAL INC

Employer identification number
59-0855412

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropiate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a Complete Part III to provide any relevant information regarding these items			
	☐ First-class or charter travel	☑ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax idemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (e g , maid, chauffeur, chef)		
b	If any of the boxes 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	**1b**	Yes	
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, officers, including the CEO/Executive Director, regarding the items checked in line 1a?	**2**	Yes	
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director Check all that apply Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III			
	☐ Compensation committee	☐ Written employment contract		
	☐ Independent compensation consultant	☐ Compensation survey or study		
	☐ Form 990 of other organizations	☐ Approval by the board or compensation committee		
4	During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization			
a	Receive a severance payment or change-of-control payment?	**4a**		No
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**	Yes	
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		No
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III			
	Only 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.			
5	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of			
a	The organization?	**5a**		No
b	Any related organization?	**5b**		No
	If "Yes," on line 5a or 5b, describe in Part III			
6	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of			
a	The organization?	**6a**		No
b	Any related organization?	**6b**		No
	If "Yes," on line 6a or 6b, describe in Part III			
7	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described in lines 5 and 6? If "Yes," describe in Part III	**7**		No
8	Were any amounts reported on Form 990, Part VII, paid or accured pursuant to a contract that was subject to the initial contract exception described in Regulations section 53 4958-4(a)(3)? If "Yes," describe in Part III	**8**		No
9	If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53 4958-6(c)?	**9**		

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

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

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

(A) Name and Title	**(B)** Breakdown of W-2 and/or 1099-MISC compensation			**(C)** Retirement and other deferred compensation	**(D)** Nontaxable benefits	**(E)** Total of columns (B)(i)-(D)	**(F)** Compensation in column (B) reported as deferred on prior Form 990
	(i) Base compensation	**(ii)** Bonus & incentive compensation	**(iii)** Other reportable compensation				
See Additional Data Table							

Part III Supplemental Information

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

Return Reference	Explanation
PART I, LINE 1A	RONALD BEAMON RECEIVED A HOUSING ALLOWANCE IN THE AMOUNT OF $12,000 DURING 2018 WHICH WAS INCLUDED IN HIS TAXABLE WAGES

Return Reference	Explanation
PART I, LINE 3	THE FILING ORGANIZATION DOES NOT USE ANY OF THE OPTIONS LISTED IN SCHEDULE J, PART I, LINE 3 TO ESTABLISH THE COMPENSATION OF THE CEO/EXECUTIVE DIRECTOR HOWEVER, THE RELATED ORGANIZATION, BAYCARE HEALTH SYSTEM INC, USES COMPENSATION COMMITTEE, INDEPENDENT COMPENSATION CONSULTANT, WRITTEN EMPLOYMENT CONTRACT, COMPENSATION SURVEY OR STUDY AND APPROVAL BY THE BOARD OR COMPENSATION COMMITTEE AS A MEANS TO ESTABLISH THE CEO'S COMPENSATION OF THE FILING ORGANIZATION

Return Reference	Explanation
PART I, LINE 4B	GLENN WATERS - PARTICIPATED IN A SUPPLEMENTAL NONQUALIFIED DEFERRED COMPENSATION PLAN HE HAD $237,944 IN BENEFITS VEST IN 2018 THIS AMOUNT IS INCLUDED IN PART II (B)(III) OTHER COMPENSATION THE PLAN MADE CASH DISTRIBUTION OF $93,631 IN 2018 CARL TREMONTI - PARTICIPATED IN A SUPPLEMENTAL NONQUALIFIED DEFERRED COMPENSATION PLAN HE HAD $137,675 IN BENEFITS VEST IN 2018 THIS AMOUNT IS INCLUDED IN PART II (B) (III) OTHER COMPENSATION THE PLAN MADE CASH DISTRIBUTION OF $54,175 IN 2018 LOUIS GALDIERI - PARTICIPATED IN A SUPPLEMENTAL NONQUALIFIED DEFERRED COMPENSATION PLAN HE HAD $126,247 IN BENEFITS VEST IN 2018 THIS AMOUNT IS INCLUDED IN PART II (B)(III) OTHER COMPENSATION THE PLAN MADE CASH DISTRIBUTION OF $49,678 IN 2018

Additional Data

Software ID:

Software Version:

EIN: 59-0855412

Name: TRUSTEES OF MEASE HOSPITAL 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				
GLENN WATERS EX-OFFICIO TRUSTEE/EVP, COO BAYCARE	(I)	0	0	0	0	0	0	0
	(II)	922,335	352,137	274,564	18,822	41,172	1,609,030	14,747
CARL TREMONTI VP, CFO BAYCARE HOSP DIV TILL MAY	(I)	0	0	0	0	0	0	0
	(II)	404,412	128,903	164,893	13,750	12,577	724,535	49,498
RONALD BEAMON VP, CFO BAYCARE HOSP DIV EFF MAY	(I)	0	0	0	0	0	0	0
	(II)	220,342	54,022	36,000	7,903	13,682	331,949	0
LOUIS GALDIERI PRESIDENT TILL DECEMBER	(I)	0	0	0	0	0	0	0
	(II)	357,211	111,573	139,595	14,712	26,754	649,845	43,972
MATTHEW NOVAK PRESIDENT EFF DECEMBER	(I)	0	0	0	0	0	0	0
	(II)	226,377	74,801	14,336	47,888	21,303	384,705	0
JOHN POLLARD DIRECTOR, SURGICAL SVCS	(I)	175,803	19,324	157	9,603	25,771	230,658	0
	(II)	0	0	0	0	0	0	0
REBECCA SCHULKOWSKI DIR, OPERATIONS MEASE	(I)	167,078	12,778	145	1,838	29,182	211,021	0
	(II)	0	0	0	0	0	0	0
ROBIN LAPHAM DIRECTOR, PATIENT SVCS	(I)	168,217	22,176	1,875	9,245	21,458	222,971	0
	(II)	0	0	0	0	0	0	0
MOHSEN HABIB MANAGER PHARMACY	(I)	169,690	12,370	16,402	9,397	23,349	231,208	0
	(II)	0	0	0	0	0	0	0
MAIKEL BOLOS CLINICAL PHARMACIST	(I)	152,119	33,444	217	8,605	12,855	207,240	0
	(II)	0	0	0	0	0	0	0
RODNEY CAVALIER CLINICAL PHARMACIST	(I)	136,985	59,879	1,228	8,489	18,962	225,543	0
	(II)	0	0	0	0	0	0	0
RENEE BURDI DIR, PATIENT SVCS	(I)	149,675	19,839	9,813	7,297	23,736	210,360	0
	(II)	0	0	0	0	0	0	0
JOSEPH SCHUMACHER CLINICAL PHARMACIST	(I)	151,850	6,686	4,756	8,242	21,137	192,671	0
	(II)	0	0	0	0	0	0	0
KELLY CULLEN FORMER DIR, OPERATIONS	(I)	63,995	22,849	37,538	0	6,658	131,040	0
	(II)	0	0	0	0	0	0	0

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Schedule L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions with Interested Persons

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
TRUSTEES OF MEASE HOSPITAL INC

Employer identification number
59-0855412

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	(d) Corrected? 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? To	(d) Loan to or from the organization? From	(e) Original principal amount	(f) Balance due	(g) In default? Yes	(g) In default? No	(h) Approved by board or committee? Yes	(h) Approved by board or committee? No	(i) Written agreement? Yes	(i) Written agreement? No
Total				▶ $								

Part III Grants or Assistance Benefiting Interested Persons.

Complete if the organization answered "Yes" on Form 990, Part IV, line 27.

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

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
(1) VICKIE BURWELL	SEE PART V	80,147	COMPENSATION		No
(2) THOMAS DORIA	SEE PART V	382,957	COMPENSATION		No

Part V Supplemental Information

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

Return Reference	Explanation
SCHEDULE L, PART IV	VICKIE BURWELL IS A FAMILY MEMBER OF ANDY BURWELL, A DIRECTOR OF THE FILING ORGANIZATION VICKIE BURWELL WAS PAID REASONABLE COMPENSATION AS AN EMPLOYEE OF THE FILING ORGANIZATION THOMAS DORIA IS A FAMILY MEMBER OF LOUIS GALDIERI, A KEY EMPLOYEE OF THE FILING ORGANIZATION THOMAS DORIA WAS PAID REASONABLE COMPENSATION AS AN EMPLOYEE OF THE FILING ORGANIZATION

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SCHEDULE M (Form 990)

Department of the Treasury
Internal Revenue Service

Noncash Contributions

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
TRUSTEES OF MEASE HOSPITAL INC

Employer identification number
59-0855412

Part I Types of Property

		(a) Check if applicable	(b) Number of contributions or items contributed	(c) Noncash contribution amounts reported on Form 990, Part VIII, line 1g	(d) Method of determining noncash contribution amounts
1	Art—Works of art				
2	Art—Historical treasures				
3	Art—Fractional interests				
4	Books and publications				
5	Clothing and household goods	X		26,114	SALE PRICE
6	Cars and other vehicles				
7	Boats and planes				
8	Intellectual property				
9	Securities—Publicly traded				
10	Securities—Closely held stock				
11	Securities—Partnership, LLC, or trust interests				
12	Securities—Miscellaneous				
13	Qualified conservation contribution—Historic structures				
14	Qualified conservation contribution—Other				
15	Real estate—Residential				
16	Real estate—Commercial				
17	Real estate—Other				
18	Collectibles				
19	Food inventory				
20	Drugs and medical supplies				
21	Taxidermy				
22	Historical artifacts				
23	Scientific specimens				
24	Archeological artifacts				
25	Other ▶ (_____)				
26	Other ▶ (_____)				
27	Other ▶ (_____)				
28	Other ▶ (_____)				

			Yes	No
29	Number of Forms 8283 received by the organization during the tax year for contributions for which the organization completed Form 8283, Part IV, Donee Acknowledgement	29		0
30a	During the year, did the organization receive by contribution any property reported in Part I, lines 1 through 28, that it must hold for at least three years from the date of the initial contribution, and which is not required to be used for exempt purposes for the entire holding period?	30a		No
b	If "Yes," describe the arrangement in Part II			
31	Does the organization have a gift acceptance policy that requires the review of any nonstandard contributions?	31		No
32a	Does the organization hire or use third parties or related organizations to solicit, process, or sell noncash contributions?	32a		No
b	If "Yes," describe in Part II			
33	If the organization did not report an amount in column (c) for a type of property for which column (a) is checked, describe in Part II			

Part II **Supplemental Information.**

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

Return Reference	Explanation

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SCHEDULE O (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
TRUSTEES OF MEASE HOSPITAL INC

Employer identification number
59-0855412

990 Schedule O, Supplemental Information

Return Reference	Explanation
PART V, LINE 1A	EFFECTIVE 2018, THE TOTAL NUMBER FROM BOX 3 OF FORM 1096 IS REPORTED BY BAYCARE HEALTH SYSTEM, INC, EIN 59-2796965, A RELATED ORGANIZATION THAT PROCESSES FORMS 1099 FOR ITS AFFILIATES THIS IS A CHANGE FROM THE PRIOR YEAR REPORTING AS IT BETTER ALIGNS THE FORM 1096, BOX 3 REPORTING TO THE ISSUING EIN

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 6	THE SOLE MEMBER OF TRUSTEES OF MEASE HOSPITAL, INC IS MORTON PLANT MEASE HEALTH CARE, INC

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7A	THE BOARD SHALL CONSIST OF NO MORE THAN TWENTY-SIX (26) MEMBERS (EACH, A "TRUSTEE"), ALL OF WHOM SHALL BE APPOINTED BY THE MEMBER SUCH THAT AT ALL TIMES THE BOARD IS COMPRISED OF ALL OF THE MEMBERS OF THE BOARD OF DIRECTORS OF THE MEMBER

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B	THE TAXPAYER IS A PARTICIPANT, AS DEFINED IN THE SECOND RESTATED JOINT OPERATING AGREEMENT DATED AS OF MAY 23, 2006, AS AMENDED (THE "JOA") UNDER THE JOA, BAYCARE HEALTH SYSTEM, I NC IS RESPONSIBLE FOR THE OPERATIONS OF THE PARTICIPANTS THE JOA PARTICIPANTS INCLUDE TH E TAXPAYER AND OTHER HOSPITALS AND NON-HOSPITAL ORGANIZATIONS NOTICE OF THE JOA WAS PREVI OUSLY PROVIDED TO THE INTERNAL REVENUE SERVICE BY LETTER DATED JULY 1, 1997 THE MEMBER RE SERVES TO ITSELF THE FOLLOWING TWO CATEGORIES OF ACTIONS CLASS I MEMBER RESERVED RIGHTS A ND CLASS II MEMBER RESERVED RIGHTS A CLASS I MEMBER RESERVED RIGHTS 1 ADDITION, DELETI ON OR RECONFIGURATION OF SERVICES OF THE CORPORATION 2 ESTABLISHMENT OF OVERALL CAPITAL AND OPERATING BUDGETS AND STRATEGIC PLANS APPLICABLE TO THE CORPORATION, INCLUDING THE USE OF THE FUNDS OF THE CORPORATION 3 EXCLUSIVE AUTHORITY TO ENTER INTO MANAGED CARE CONTRA CTS ON BEHALF OF THE CORPORATION AND ITS SUBSIDIARIES AND AFFILIATES 4 APPROVAL OF CONTR ACTS ON BEHALF OF THE CORPORATION (BUT THE CLASS I MEMBER MAY ESTABLISH POLICIES FROM TIME TO TIME PROVIDING THAT ONLY SPECIFIC TYPES OF CONTRACTS OR CONTRACTS INVOLVING OBLIGATION S IN EXCESS OF SPECIFIED LEVELS NEED TO BE APPROVED BY THE CLASS I MEMBER) 5 AUTHORITY T O ESTABLISH FEES AND CHARGES ON BEHALF OF THE CORPORATION 6 DETERMINATION OF WHETHER THE CORPORATION SHOULD JOIN ANY NETWORKS OR ALTERNATIVE OR INTEGRATED DELIVERY SYSTEMS 7 ES TABLISHMENT OF EMPLOYMENT AND OTHER POLICIES APPLICABLE TO ALL PERSONNEL EMPLOYED BY THE C ORPORATION 8 APPROVAL OF THE PHILOSOPHY, MISSION STATEMENT AND PURPOSES OF THE CORPORATI ON 9 APPROVAL OF CHANGES IN THE ARTICLES OF INCORPORATION OR IN THE BYLAWS OF THE CORPOR ATION 10 APPROVAL OF THE MERGER, CONSOLIDATION, DISSOLUTION, SALE OR OTHER TRANSFER OF S UBSTANTIALLY ALL ASSETS OF THE CORPORATION, OR OTHER CHANGE IN CORPORATE FORM, CAUSING A F UNDAMENTAL REORGANIZATION OF THE CORPORATION 11 APPROVAL OF THE INCURRENCE OF INDEBTEDNE SS BY THE CORPORATION ABOVE CERTAIN LIMITS ESTABLISHED BY THE CLASS I MEMBER 12 APPROVAL OF THE ESTABLISHMENT OF ADDITIONAL AFFILIATES OR SUBSIDIARIES OF THE CORPORATION 13 ADO PTION OF STRATEGIC PLANS OR MAJOR CHANGES IN PROGRAMS OR SERVICES OF THE CORPORATION 14 APPROVAL OF THE PURCHASE, SALE, TRANSFER, OR OTHER ENCUMBRANCE OF ASSETS OF THE CORPORATIO N ABOVE SPECIFIED LEVELS ESTABLISHED BY THE CLASS I MEMBER B CLASS II MEMBER RESERVED RI GHTS 1 APPROVAL OF THE PHILOSOPHY, MISSION STATEMENT AND PURPOSES OF THE CORPORATION 2 APPROVAL OF THE MERGER, CONSOLIDATION, DISSOLUTION, SALE OR OTHER TRANSFER OF SUBSTANTIAL LY ALL ASSETS OF THE CORPORATION, OR OTHER CHANGE IN CORPORATE FORM, CAUSING A FUNDAMENTAL REORGANIZATION OF THE CORPORATION 3 WITH REGARD TO ANY ASSETS OF THE CORPORATION NO LON GER REQUIRED IN THE OPERATIONS OF THE CORPORATION, APPROVAL OF ANY SALE OR OTHER DISPOSITI ON OF ANY ASSETS NOT IN THE ORDINARY COURSE WHICH HAVE A VALUE IN EXCESS OF $3 MILLION, AN D WITH REGARD TO ALL OTHER ASS

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 7B	ETS OF THE CORPORATION USED IN THE OPERATIONS OF THE CORPORATION, APPROVAL OF ANY SALE OR OTHER DISPOSITION OF SUCH ASSETS NOT IN THE ORDINARY COURSE (BUT THE FOREGOING IS NOT INTE NDED TO LIMIT ANY TRANSFER OF THE LOCATION OF THE ASSETS FROM THE CORPORATION TO ANOTHER E NTITY IN CONNECTION WITH A DULY AUTHORIZED RECONFIGURATION OF SERVICES) 4 APPROVAL OF TH E CLOSURE OF A HOSPITAL FACILITY OF THE CORPORATION 5 CHANGE IN THE NAME OF A HOSPITAL F ACILITY OF THE CORPORATION 6 APPROVAL OF SUBSTANTIVE CHANGES IN THE BYLAWS OF THE ARTICL ES OF INCORPORATION OF THE CORPORATION

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 11B	THE FORM 990 IS PREPARED BY THE ORGANIZATION AND REVIEWED BY THE CFO, AS WELL AS THE ORGANIZATION'S PAID PREPARER PRIOR TO FILING WITH THE IRS, A FINAL COPY OF THE FORM 990 WAS PROVIDED TO THE ENTIRE BOARD VIA A WEB PORTAL

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	TRUSTEES OF MEASE HOSPITAL, INC HAS TWO SEPARATE CONFLICT OF INTEREST PROCEDURES, ONE THAT RELATES TO BOARD MEMBERS AND ANOTHER THAT RELATES TO NON-BOARD MEMBER EMPLOYEES BOTH GRO UPS ARE REQUIRED ON AN ANNUAL BASIS TO COMPLETE, SIGN AND FILE AN ANNUAL DISCLOSURE STATEM ENT DETAILING EXISTING OR POTENTIAL CONFLICTS OF INTERESTS DISCLOSURE REQUIREMENTS OF BOA RD AND COMMITTEE MEMBERS PRIOR TO ANY AND ALL BOARD OR COMMITTEE MEETINGS, EACH BOARD/COMM ITTEE MEMBER SHALL REVIEW THE MEETING AGENDA FOR ANY ACTUAL OR POTENTIAL CONFLICT OF INTER EST IN THE EVENT AN ACTUAL OR POTENTIAL CONFLICT OF INTEREST ASSOCIATED WITH ANY AGENDA I TEM IS CONCLUDED BY A BOARD/COMMITTEE MEMBER AFTER SUCH REVIEW, THE IMPACTED BOARD/COMMITT EE MEMBER SHALL INFORM THE BOARD/COMMITTEE CHAIRPERSON OF THE CONFLICT IN ADVANCE OF THE M EETING REQUIRED ACTION AFTER DISCLOSURE OF THE BOARD/COMMITTEE MEMBER'S ACTUAL OR POTENTI AL CONFLICT TO THE BOARD/COMMITTEE CHAIRPERSON AS SET FORTH ABOVE, THE FOLLOWING PROCEDURE S FOR ADDRESSING THE CONFLICT OF INTEREST WILL BE ADHERED TO BY EACH BOARD AND ALL COMMITT EES WITHOUT EXCEPTION 1 THE BOARD/COMMITTEE CHAIRPERSON SHALL, UPON DISCLOSURE BY AN IMP ACTED BOARD/COMMITTEE MEMBER, HAVE THE DISCRETION (BASED UPON THE SEVERITY OF THE ACTUAL O R POTENTIAL CONFLICT) TO EXCUSE THE IMPACTED BOARD/COMMITTEE MEMBER FROM THE BOARD/COMMITT EE DISCUSSIONS ON THAT AGENDA ITEM 2 REGARDLESS OF WHETHER THE IMPACTED BOARD/COMMITTEE MEMBER IS ASKED TO LEAVE THE ROOM DURING THE AGENDA ITEM DISCUSSION, THE BOARD/COMMITTEE C HAIRPERSON SHALL NOTIFY ALL BOARD/COMMITTEE MEMBERS OF THE ACTUAL OR POTENTIAL CONFLICT OF INTEREST SO EVERYONE IS AWARE OF THE SAID CONFLICT BEFORE ANY DISCUSSIONS AND/OR VOTE ON THE MATTER 3 THE BOARD OR COMMITTEE SHALL DETERMINE WHETHER THE BAYCARE ENTITY CAN OBTAI N A MORE ADVANTAGEOUS TRANSACTION OR ARRANGEMENT WITH REASONABLE EFFORTS FROM AN INDIVIDUA L OR ENTITY THAT WOULD NOT GIVE RISE TO A CONFLICT OF INTEREST 4 IF A MORE ADVANTAGEOUS TRANSACTION OR ARRANGEMENT IS NOT REASONABLY AVAILABLE, THE BOARD OR COMMITTEE SHALL DETER MINE WHETHER THE TRANSACTION OR ARRANGEMENT IS IN THE BAYCARE ENTITY'S BEST INTEREST, AND WHETHER THE TRANSACTION IS FAIR AND REASONABLE TO BAYCARE AN INTERESTED BOARD/COMMITTEE S HALL NOT VOTE, PARTICIPATE IN, INFLUENCE, OR ATTEMPT TO INFLUENCE ANY DETERMINATION OR PRO CEEDINGS AS REQUESTED BY THE BOARD/COMMITTEE CHAIRPERSON, THE INTERESTED BOARD/COMMITTEE MEMBER MAY, HOWEVER, RESPOND TO QUESTIONS POSED BY THE BOARD/COMMITTEE REGARDING THE CONTR ACT OR TRANSACTION ANY SUCH CONTRACT OR TRANSACTION MUST BE AUTHORIZED BY A VOTE OF AT LE AST TWO-THIRDS (2/3) OF THE BOARD/ COMMITTEE MEMBERS ENTITLED TO VOTE AT A MEETING AT WHIC H A QUORUM WAS PRESENT ANY INTERESTED BOARD/COMMITTEE MEMBER MAY NOT BE COUNTED IN DETERM INING THE EXISTENCE OF A QUORUM 5 THE MINUTES OF THE BOARD AND ALL COMMITTEES SHALL REFL ECT THE FOLLOWING A THE NAME(S) OF THE BOARD/COMMITTEE MEMBER(S) WHO DISCLOSED OR WAS OT HERWISE FOUND TO HAVE AN ACTUA

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 12C	L OR POSSIBLE CONFLICT OF INTEREST, THE NATURE OF THE ACTUAL OR POSSIBLE CONFLICT OF INTER EST, ANY ACTION TAKEN TO DETERMINE WHETHER A CONFLICT OF INTEREST WAS PRESENT, AND THE BOA RD/COMMITTEE CHAIRPERSON'S DECISION AS TO WHETHER A CONFLICT OF INTEREST, IN FACT, EXISTED B THE NAMES OF THE BOARD/COMMITTEE MEMBERS WHO WERE PRESENT FOR DISCUSSIONS AND VOTES R ELATING TO THE TRANSACTION OR ARRANGEMENT, THE CONTENT OF THE DISCUSSION, INCLUDING ANY AL TERNATIVES TO THE PROPOSED TRANSACTION OR ARRANGEMENT, AND A RECORD OF ANY VOTES TAKEN ON THE SUBJECT AT ISSUE C THE INTERESTED BOARD/COMMITTEE MEMBER'S REMOVAL FROM THE ROOM (IF REQUESTED BY THE CHAIRPERSON), EXCLUSION FROM VOTING AND PARTICIPATION IN DISCUSSIONS, AN D THE EXISTENCE OF A PROPER QUORUM FOR EMPLOYEES, THE REVIEW OF CONFLICTS OF INTEREST OR POTENTIAL CONFLICTS GOES TO THE CONFLICT OF INTEREST DETERMINATION COMMITTEE THIS COMMITT EE CONSISTS OF THE BAYCARE CHIEF COMPLIANCE OFFICER, THE CORPORATE RESPONSIBILITY OFFICERS , AND THE BAYCARE VICE PRESIDENT OF TEAM RESOURCES THIS COMMITTEE SHALL DETERMINE IF AN A CTUAL CONFLICT EXISTS AND ANY ACTION REQUIRED TO ADDRESS THE CONFLICT OF INTEREST SITUATIO N

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION B, LINE 15B	THE FILING ORGANIZATION DOES NOT DIRECTLY COMPENSATE SOME OF ITS TOP MANAGEMENT EMPLOYEES, RATHER COMPENSATION IS PAID BY A RELATED ORGANIZATION THAT ALSO FOLLOWS THE COMPENSATION POLICY OF THE COMPENSATION COMMITTEE THE INDEPENDENT COMPENSATION COMMITTEE IS APPOINTED BY THE BOARD OF DIRECTORS THE COMPENSATION COMMITTEE'S PURPOSE IS TO PROVIDE OVERSIGHT FOR THE ORGANIZATION'S EXECUTIVE COMPENSATION PROGRAM, REVIEW AND APPROVE COMPENSATION AND BENEFITS FOR ALL "DISQUALIFIED PERSONS" SUBJECT TO THE INTERMEDIATE SANCTIONS REGULATIONS ISSUED UNDER SECTION 4958 OF THE INTERNAL REVENUE CODE (INCLUDING THE CHIEF EXECUTIVE OFFICER, CHIEF OPERATING OFFICER & CHIEF FINANCIAL OFFICER, OTHER SYSTEM AND ENTITY EXECUTIVES, AND OTHER DISQUALIFIED PERSONS AS DEFINED IN THE INTERMEDIATE SANCTIONS REGULATIONS (I E , VOTING MEMBERS OF THE GOVERNING BODY, FAMILY MEMBERS, FORMER OFFICERS)), AND ESTABLISH THE COMPENSATION PHILOSOPHY FOR ALL OTHER EXECUTIVES THIS COMMITTEE ENGAGES NATIONALLY RECOGNIZED COMPENSATION CONSULTANTS TO ASSIST THEM IN REVIEW OF EXECUTIVE COMPENSATION THE COMPENSATION CONSULTANTS PROVIDE A REVIEW OF EACH VICE PRESIDENT AND ABOVE IN THE SYSTEM TO DETERMINE IF THAT EMPLOYEE'S COMPENSATION IS REASONABLE WHEN COMPARED AGAINST MARKET STANDARDS THE DATA REVIEWED COMES FROM COMPENSATION STUDIES THAT INCLUDE COMPARABLE COMPENSATION FOR SIMILARL QUALIFIED PERSONS IN FUNCTIONALLY COMPARABLE POSITIONS AT SIMILARLY SITUATED ORGANIZATIONS THE ORGANIZATION KEEPS CONTEMPORANEOUS MINUTES OF THE COMPENSATION COMMITTEES MEETINGS AND DECISIONS EXTERNAL CONSULTANTS REVIEW COMPENSATION EVERY OTHER YEAR WITH THE LAST REVIEW OCCURRING IN 2017 BUT THE COMPENSATION COMMITTEE REGULARLY MONITORS COMPENSATION AND ALL OTHER PROCEDURES ARE FOLLOWED ANNUALLY

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION C, LINE 19	TRUSTEES OF MEASE HOSPITAL, INC PUBLISHES ITS FINANCIAL STATEMENTS WITH THE AGENCY FOR HEALTH ADMINISTRATION GOVERNING DOCUMENTS ARE AVAILABLE VIA SUNBIZ ORG

990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART XI, LINE 9	CONTRIBUTIONS IN NET ASSETS -1,524,016 ROUNDING 4

990 Schedule O, Supplemental Information

Return Reference	Explanation
SECTION J	HTTPS //BAYCARE ORG/HOSPITALS/MEASE-COUNTRYSIDE-HOSPITAL/PATIENTS-AND-VI SITORS HTTPS //BAYCARE ORG/HOSPITALS/MEASE-DUNEDIN-HOSPITAL/PATIENTS-AND-VISITO RS

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SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

OMB No 1545-0047

2018

Open to Public Inspection

Name of the organization
TRUSTEES OF MEASE HOSPITAL INC

Employer identification number
59-0855412

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
(1)BAYCARE HEALTH SYSTEM INC 2985 DREW ST CLEARWATER, FL 33759 59-2796965	SUPPORT SRVCS	FL	501(C)(3)	12B	N/A		No
(2)MORTON PLANT HOSPITAL ASSOCIATION INC 300 PINELLAS STREET CLEARWATER, FL 33756 59-0624462	HEALTH SRVCS	FL	501(C)(3)	3	MPMHC	Yes	
(3)MORTON PLANT MEASE HEALTH SERVICES INC 8452 118TH AVE N LARGO, FL 33773 59-2600684	HEALTH SRVCS	FL	501(C)(3)	10	MPMHC	Yes	
(4)MORTON PLANT MEASE HEALTH CARE FOUND 1200 DRUID ROAD SOUTH CLEARWATER, FL 33756 59-1751535	FUNDRAISING	FL	501(C)(3)	12A	MPHATOM	Yes	
(5)MORTON PLANT MEASE HEALTH CARE INC 300 PINELLAS STREET CLEARWATER, FL 33756 59-2374556	SUPPORT SRVCS	FL	501(C)(3)	12B	N/A		No

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity? Yes	(i) No
(1)GLOBAL HEALTH CARE INC 8452 118TH AVENUE NORTH LARGO, FL 33773 59-1853449	HEALTH SRVCS	FL	MPHV	C				Yes	
(2)MFP INC 628 BYPASS ROAD CLEARWATER, FL 33764 59-2374569	COLLECTIONS	FL	MPHV	C				Yes	
(3)MORTON PLANT HEALTH VENTURES INC 8452 118TH AVENUE NORTH LARGO, FL 33773 59-2728600	HEALTH SRVCS	FL	MPMHC	C				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 orgranization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?			
a Receipt of **(i)** interest, **(ii)**annuities, **(iii)** royalties, or**(iv)** rent from a controlled entity	1a		No
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	Yes	
e Loans or loan guarantees by related organization(s)	1e		No
f Dividends from related organization(s)	1f		No
g Sale of assets to related organization(s)	1g		No
h Purchase of assets from related organization(s)	1h		No
i Exchange of assets with related organization(s)	1i		No
j Lease of facilities, equipment, or other assets to related organization(s)	1j	Yes	
k Lease of facilities, equipment, or other assets from related organization(s)	1k	Yes	
l Performance of services or membership or fundraising solicitations for related organization(s)	1l		No
m Performance of services or membership or fundraising solicitations by related organization(s)	1m	Yes	
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		No
r Other transfer of cash or property to related organization(s)	1r	Yes	
s Other transfer of cash or property from related organization(s)	1s	Yes	

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

(a) Name of related organization	(b) Transaction type (a-s)	(c) Amount involved	(d) Method of determining amount involved
(1)MORTON PLANT MEASE HEALTH SERVICES INC	K	101,255	FMV
(2)MORTON PLANT HOSPITAL ASSOCIATION INC	O	3,664,728	FMV
(3)MORTON PLANT MEASE HEALTH SERVICES INC	S	39,073	FMV
(4)MORTON PLANT MEASE HEALTH SERVICES INC	O	121,913	FMV
(5)MORTON PLANT HOSPITAL ASSOCIATION INC	R	141,896	FMV

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

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization See instructions regarding exclusion for certain investment partnerships

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners section 501(c)(3) organizations?		(f) Share of total income	(g) Share of end-of-year assets	(h) Disproprtionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
				Yes	No			Yes	No		Yes	No	

Part VII Supplemental Information

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

Return Reference	Explanation