

Return of Organization Exempt From Income Tax

2019

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.

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

A For the 2019 calendar year, or tax year beginning , 2019, and ending , 20	
B Check if applicable: <input checked="" type="checkbox"/> Address change <input type="checkbox"/> Name change <input type="checkbox"/> Initial return <input type="checkbox"/> Final return/terminated <input type="checkbox"/> Amended return <input type="checkbox"/> Application pending	C Name of organization THE MEDICAL CENTER OF PEACH COUNTY, INC. Doing business as THE MEDICAL CENTER OF PEACH COUNTY, NAVICENT HEALTH Number and street (or P.O. box if mail is not delivered to street address) Room/suite 777 HEMLOCK STREET, MSC 111 City or town, state or province, country, and ZIP or foreign postal code MACON, GA 31201
	D Employer identification number 45-3765471
	E Telephone number (478) 633-6968
	G Gross receipts \$ 20,808,665
	H(a) Is this a group return for subordinates? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No H(b) Are all subordinates included? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," attach a list. (see instructions)
	I Tax-exempt status: <input checked="" type="checkbox"/> 501(c)(3) <input type="checkbox"/> 501(c) () ◀ (insert no.) <input type="checkbox"/> 4947(a)(1) or <input type="checkbox"/> 527
J Website: ▶ WWW.NAVICENTHEALTH.ORG	
K Form of organization: <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Association <input type="checkbox"/> Other ▶	L Year of formation: 2011
M State of legal domicile: GA	

Part I Summary

Activities & Governance	1 Briefly describe the organization's mission or most significant activities: THE MISSION OF THE MEDICAL CENTER OF PEACH COUNTY, INC. IS TO PROVIDE ACCESS TO INPATIENT, OUTPATIENT, PHYSICIAN CARE, EMERGENCY AND (CONTINUED ON SCHEDULE O)		
	2 Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	3 Number of voting members of the governing body (Part VI, line 1a)	3	7
	4 Number of independent voting members of the governing body (Part VI, line 1b)	4	6
	5 Total number of individuals employed in calendar year 2019 (Part V, line 2a)	5	276
	6 Total number of volunteers (estimate if necessary)	6	30
	7a Total unrelated business revenue from Part VIII, column (C), line 12	7a	0
b Net unrelated business taxable income from Form 990-T, line 39	7b		
Revenue	8 Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
	9 Program service revenue (Part VIII, line 2g)	4,385,448	20,361,767
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	2,512	6,507
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)		0
	12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	4,387,960	20,808,665
	Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1–3)	
14 Benefits paid to or for members (Part IX, column (A), line 4)			
15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)		2,309,069	9,350,708
16a Professional fundraising fees (Part IX, column (A), line 11e)		0	0
b Total fundraising expenses (Part IX, column (D), line 25) ▶		0	0
17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)		2,787,483	10,642,616
18 Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)		5,096,552	19,993,324
19 Revenue less expenses. Subtract line 18 from line 12	(708,592)	815,341	
Net Assets or Fund Balances	20 Total assets (Part X, line 16)	Beginning of Current Year	End of Year
	21 Total liabilities (Part X, line 26)	27,419,609	23,771,187
	22 Net assets or fund balances. Subtract line 21 from line 20	38,669,459	34,205,696
		(11,249,850)	(10,434,509)

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
	CHRIS WILDE, EXECUTIVE VICE PRESIDENT/CFO Type or print name and title	

Paid Preparer Use Only	Print/Type preparer's name	Preparer's signature	Date	Check <input type="checkbox"/> if self-employed	PTIN
	W. EDWARD PHILLIPS				P00451499
	Firm's name ▶ DRAFFIN & TUCKER, LLP	Firm's EIN ▶	58-0914992		
	Firm's address ▶ PO BOX 71309, ALBANY, GA 31708-1309	Phone no.	(229) 883-7878		

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:
THE MEDICAL CENTER OF PEACH COUNTY (MCPC) PARTNERS WITH NAVICENT HEALTH, INC. TO OPERATE A 25-BED RURAL, CRITICAL ACCESS HOSPITAL AND PROVIDE EMERGENCY, SURGICAL, INPATIENT AND OUTPATIENT CARE FOR RESIDENTS OF PEACH AND SURROUNDING COUNTIES.

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 \$ 18,437,607 including grants of \$) (Revenue \$ 20,361,767)
MCPC IS A NON-PROFIT CRITICAL ACCESS HOSPITAL AFFILIATED WITH NAVICENT HEALTH, INC. MCPC PROVIDES EXPANDED SERVICES WITH INNOVATIVE TECHNOLOGY TO THE LOCAL COMMUNITY FURTHERING ITS MISSION TO IMPROVE RURAL HEATH CARE ACCESS. MCPC IS LICENSED FOR 25 BEDS.

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

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

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

4e Total program service expenses ▶ 18,437,607

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules (continued)

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

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		
b Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable		
c Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?		

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

		Yes	No
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return		
	2a 276		
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)	✓	
3a	Did the organization have unrelated business gross income of \$1,000 or more during the year?		✓
b	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation on Schedule O		
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?		✓
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?		✓
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		✓
c	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?		
6a	Does the organization have annual gross receipts that are normally greater than \$100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?		✓
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		
7	Organizations that may receive deductible contributions under section 170(c).		
a	Did the organization receive a payment in excess of \$75 made partly as a contribution and partly for goods and services provided to the payor?		✓
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		✓
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?		✓
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		✓
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		
8	Sponsoring organizations maintaining donor advised funds. Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?		
9	Sponsoring organizations maintaining donor advised funds.		
a	Did the sponsoring organization make any taxable distributions under section 4966?		
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?		
10	Section 501(c)(7) organizations. Enter:		
a	Initiation fees and capital contributions included on Part VIII, line 12	10a	
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b	
11	Section 501(c)(12) organizations. Enter:		
a	Gross income from members or shareholders	11a	
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b	
12a	Section 4947(a)(1) non-exempt charitable trusts. Is the organization filing Form 990 in lieu of Form 1041?	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	✓
b	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation on 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	✓
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	✓

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

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	7	
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain on Schedule O.			
b	Enter the number of voting members included on line 1a, above, who are independent	1b	6	
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2		<input checked="" type="checkbox"/>
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, trustees, or key employees to a management company or other person?	3		<input checked="" type="checkbox"/>
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4		<input checked="" type="checkbox"/>
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5		<input checked="" type="checkbox"/>
6	Did the organization have members or stockholders?	6	<input checked="" type="checkbox"/>	
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	<input checked="" type="checkbox"/>	
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	<input checked="" type="checkbox"/>	
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:			
a	The governing body?	8a	<input checked="" type="checkbox"/>	
b	Each committee with authority to act on behalf of the governing body?	8b		
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses on Schedule O	9		<input checked="" type="checkbox"/>

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		<input checked="" type="checkbox"/>
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	<input checked="" type="checkbox"/>	
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	<input checked="" type="checkbox"/>	
b	Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	<input checked="" type="checkbox"/>	
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	<input checked="" type="checkbox"/>	
13	Did the organization have a written whistleblower policy?	13	<input checked="" type="checkbox"/>	
14	Did the organization have a written document retention and destruction policy?	14	<input checked="" type="checkbox"/>	
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		<input checked="" type="checkbox"/>
b	Other officers or key employees of the organization	15b		<input checked="" type="checkbox"/>
	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		<input checked="" type="checkbox"/>
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 ► GA
- 18** Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A, if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.
 Own website Another's website Upon request Other (explain on Schedule O)
- 19** Describe on Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
- 20** State the name, address, and telephone number of the person who possesses the organization's books and records ►
 CHRIS WILDE, 777 HEMLOCK STREET, MACON, GA 31201, (478) 633-1452

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, and highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) KENNETH B BANKS SECRETARY	1.0 49.0			✓				0	605,385	177,436
(2) ROBERT C WILDE TREASURER	1.0 49.0	✓		✓				0	442,814	41,945
(3) LAURA T GENTRY AVP MEDICAL CENTER PEACH COUNTY	40.0 1.0				✓			154,814	0	24,890
(4) JR ALBERT JONES CERTIFIED RESPIRATORY THERAPIST	40.0 0.0					✓		104,285	0	10,832
(5) JIM MCLENDON VICE CHAIRMAN	1.0 0.0	✓		✓				0	0	0
(6) THOMAS M. GREEN CHAIRMAN	1.0 0.0	✓		✓				0	0	0
(7) AL WALDREP BOARD MEMBER	1.0 0.0	✓						0	0	0
(8) CRYSTAL BROWN, M.D. BOARD MEMBER	1.0 0.0	✓						0	0	0
(9) ISAAC CRUMBLY BOARD MEMBER	1.0 0.0	✓						0	0	0
(10) PAUL JONES BOARD MEMBER	1.0 0.0	✓						0	0	0
(11)										
(12)										
(13)										
(14)										

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			
(15)										
(16)										
(17)										
(18)										
(19)										
(20)										
(21)										
(22)										
(23)										
(24)										
(25)										
1b Subtotal							259,098	1,048,199	255,103	
c Total from continuation sheets to Part VII, Section A							0	0	0	
d Total (add lines 1b and 1c)							259,098	1,048,199	255,103	

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 **1**

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

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
PHARMD ON DEMAND, 1971 HOG MOUNTAIN RD., WATKINSVILLE, GA 30677	CONTRACT LABOR	409,902
FITZROY FLEX HEALTH, LLC, 830 HIGH STREET, MACON, GA 31201	CONTRACT LABOR-NURSING	393,375
HOUSTON PRIMARY CARE, INC, 1719 RUSSELL PKWY, SUITE 700, WARNER ROBINS, GA 31008	CONTRACT LABOR	343,212
PEACH EMERGENCY GROUP, LLC, PO BOX 677979, DALLAS, TX 75267-7979	CONTRACT LABOR	263,789
TWILIGHT CONSULTING & MGMT LLC, 431 LEAMINGTON LANE, MACON, GA 31220	CONSULTING	219,000

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 **8**

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					
	e Government grants (contributions)	1e					
	f All other contributions, gifts, grants, and similar amounts not included above	1f	440,391				
	g Noncash contributions included in lines 1a-1f	1g	\$				
	h Total. Add lines 1a-1f ▶		440,391				
Program Service Revenue			Business Code				
	2a PATIENT REVENUE	622110	20,305,347	20,305,347			
	b RENT - PROGRAM SERVICE	622110	27,172	27,172			
	c MISC - PROGRAM SERVICE	622110	29,248	29,248			
	d -----						
	e -----						
	f All other program service revenue		0	0	0	0	
g Total. Add lines 2a-2f ▶		20,361,767					
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts) ▶		6,507			6,507	
	4 Income from investment of tax-exempt bond proceeds ▶						
	5 Royalties ▶						
	6a Gross rents	6a	(i) Real				
			(ii) Personal				
	b Less: rental expenses	6b					
	c Rental income or (loss)	6c	0	0			
	d Net rental income or (loss) ▶						
	7a Gross amount from sales of assets other than inventory	7a	(i) Securities				
			(ii) Other				
	b Less: cost or other basis and sales expenses	7b					
	c Gain or (loss)	7c	0	0			
	d Net gain or (loss) ▶						
8a Gross income from fundraising events (not including \$ of contributions reported on line 1c). See Part IV, line 18	8a						
b Less: direct expenses	8b						
c Net income or (loss) from fundraising events ▶							
9a Gross income from gaming activities. See Part IV, line 19	9a						
b Less: direct expenses	9b						
c Net income or (loss) from gaming activities ▶							
10a Gross sales of inventory, less returns and allowances	10a						
b Less: cost of goods sold	10b						
c Net income or (loss) from sales of inventory ▶							
Miscellaneous Revenue			Business Code				
	11a -----						
	b -----						
	c -----						
	d All other revenue		0	0	0	0	
e Total. Add lines 11a-11d ▶		0					
12 Total revenue. See instructions ▶		20,808,665	20,361,767	0	6,507		

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.

	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21				
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees				
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	7,740,048	7,159,680	580,368	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	29,754	29,754		
9 Other employee benefits	1,012,940	1,012,690	250	
10 Payroll taxes	567,966	526,018	41,948	
11 Fees for services (nonemployees):				
a Management				
b Legal	44,438	0	44,438	
c Accounting				
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.)	4,678,009	4,606,741	71,268	0
12 Advertising and promotion	46,417	47	46,370	
13 Office expenses	127,459	79,461	47,998	
14 Information technology	469,026	469,026	0	
15 Royalties				
16 Occupancy	367,051	356,653	10,398	
17 Travel	14,733	7,479	7,254	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings				
20 Interest	630,771	630,771		
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	1,437,218	749,201	688,017	
23 Insurance	310,860	310,860		
24 Other expenses. Itemize expenses not covered above (List miscellaneous expenses on line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MEDICAL SUPPLIES	1,879,680	1,879,602	78	
b REPAIRS & MAINT	627,060	616,875	10,185	
c DUES & SUBSCRIPTIONS	6,612	663	5,949	
d SALES/USE TAX	1,607	1,321	286	
e All other expenses	1,675	765	910	0
25 Total functional expenses. Add lines 1 through 24e	19,993,324	18,437,607	1,555,717	0
26 Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

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

		(A) Beginning of year		(B) End of year
Assets	1 Cash—non-interest-bearing	2,641,391	1	1,263,342
	2 Savings and temporary cash investments		2	
	3 Pledges and grants receivable, net		3	
	4 Accounts receivable, net	4,153,348	4	3,880,416
	5 Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons	0	5	0
	6 Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B)	0	6	0
	7 Notes and loans receivable, net		7	
	8 Inventories for sale or use	225,957	8	218,416
	9 Prepaid expenses and deferred charges	25,000	9	74,535
	10a Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 28,516,755		
	b Less: accumulated depreciation	10b 11,070,237	18,612,650	10c 17,446,518
	11 Investments—publicly traded securities		11	
	12 Investments—other securities. See Part IV, line 11	0	12	0
	13 Investments—program-related. See Part IV, line 11	0	13	0
	14 Intangible assets		14	
	15 Other assets. See Part IV, line 11	1,761,263	15	887,960
16 Total assets. Add lines 1 through 15 (must equal line 33)	27,419,609	16	23,771,187	
Liabilities	17 Accounts payable and accrued expenses	711,725	17	699,212
	18 Grants payable		18	
	19 Deferred revenue		19	
	20 Tax-exempt bond liabilities		20	
	21 Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22 Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons	0	22	0
	23 Secured mortgages and notes payable to unrelated third parties		23	
	24 Unsecured notes and loans payable to unrelated third parties		24	
	25 Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17–24). Complete Part X of Schedule D	37,957,734	25	33,506,484
	26 Total liabilities. Add lines 17 through 25	38,669,459	26	34,205,696
Net Assets or Fund Balances	Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33.			
	27 Net assets without donor restrictions	(11,249,850)	27	(10,434,509)
	28 Net assets with donor restrictions		28	
	Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33.			
	29 Capital stock or trust principal, or current funds		29	
	30 Paid-in or capital surplus, or land, building, or equipment fund		30	
	31 Retained earnings, endowment, accumulated income, or other funds		31	
32 Total net assets or fund balances	(11,249,850)	32	(10,434,509)	
33 Total liabilities and net assets/fund balances	27,419,609	33	23,771,187	

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	20,808,665
2	Total expenses (must equal Part IX, column (A), line 25)	2	19,993,324
3	Revenue less expenses. Subtract line 2 from line 1	3	815,341
4	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	4	(11,249,850)
5	Net unrealized gains (losses) on investments	5	
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain on Schedule O)	9	0
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	10	(10,434,509)

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

SCHEDULE A
(Form 990 or 990-EZ)

Public Charity Status and Public Support

OMB No. 1545-0047

2019

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

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

▶ Attach to Form 990 or Form 990-EZ.

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

Name of the organization THE MEDICAL CENTER OF PEACH COUNTY, INC.	Employer identification number 45-3765471
--	--

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

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

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

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

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ►	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 Total. Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 Public support. Subtract line 5 from line 4						

Section B. Total Support

Calendar year (or fiscal year beginning in) ►	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 Total support. Add lines 7 through 10						
12 Gross receipts from related activities, etc. (see instructions)					12	
13 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here						<input type="checkbox"/>

Section C. Computation of Public Support Percentage

14 Public support percentage for 2019 (line 6, column (f) divided by line 11, column (f))	14	%
15 Public support percentage from 2018 Schedule A, Part II, line 14	15	%
16a 33 1/3% support test—2019. If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization	<input type="checkbox"/>	
b 33 1/3% support test—2018. If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and stop here. The organization qualifies as a publicly supported organization	<input type="checkbox"/>	
17a 10%-facts-and-circumstances test—2019. If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization	<input type="checkbox"/>	
b 10%-facts-and-circumstances test—2018. If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and stop here. Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization	<input type="checkbox"/>	
18 Private foundation. If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions	<input type="checkbox"/>	

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

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

Section A. Public Support

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

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2015	(b) 2016	(c) 2017	(d) 2018	(e) 2019	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 Total support. (Add lines 9, 10c, 11, and 12.)						
14 First five years. If the Form 990 is for the organization's first, second, third, fourth, or fifth tax year as a section 501(c)(3) organization, check this box and stop here ▶ <input type="checkbox"/>						

Section C. Computation of Public Support Percentage

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

Section D. Computation of Investment Income Percentage

17 Investment income percentage for 2019 (line 10c, column (f), divided by line 13, column (f))	17	%
18 Investment income percentage from 2018 Schedule A, Part III, line 17	18	%
19a 33 1/3% support tests—2019. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and stop here. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>		
b 33 1/3% support tests—2018. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and stop here. The organization qualifies as a publicly supported organization ▶ <input type="checkbox"/>		
20 Private foundation. If the organization did not check a box on line 14, 19a, or 19b, check this box and see instructions ▶ <input type="checkbox"/>		

Part IV Supporting Organizations

(Complete only if you checked a box in line 12 on 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.		
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).		
3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? If "Yes," answer (b) and (c) below.		
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.		
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.		
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.		
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.		
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.		
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).		
b Type I or Type II only. Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
c Substitutions only. Was the substitution the result of an event beyond the organization's control?		
6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? If "Yes," provide detail in Part VI .		
7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (as defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).		
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).		
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 .		
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 .		
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 .		
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 10b below.		
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.)		

Part IV Supporting Organizations (continued)

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

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.		
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.		

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).		

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally Integrated Supporting Organizations

1 Check the box next to the method that the organization used to satisfy the Integral Part Test during the year (see instructions).		
a <input type="checkbox"/> The organization satisfied the Activities Test. Complete line 2 below.		
b <input type="checkbox"/> The organization is the parent of each of its supported organizations. Complete line 3 below.		
c <input type="checkbox"/> The organization supported a governmental entity. Describe in Part VI how you supported a government entity (see instructions).		
2 Activities Test. Answer (a) and (b) below.		
a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? 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.		
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.		
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 .		
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.		

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

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

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

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

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

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

**SCHEDULE D
(Form 990)**

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 6, 7, 8, 9, 10, 11a, 11b, 11c, 11d, 11e, 11f, 12a, or 12b.
▶ Attach to Form 990.

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization THE MEDICAL CENTER OF PEACH COUNTY, INC.	Employer identification number 45-3765471
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Part I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts.

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

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

Part II Conservation Easements.

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

1 Purpose(s) of conservation easements held by the organization (check all that apply).
 Preservation of land for public use (for example, recreation or education) Preservation of a historically important land area
 Protection of natural habitat Preservation of a certified historic structure
 Preservation of open space

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 make 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 program
 - 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 on 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** Term 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 line 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		509,700		509,700
b Buildings		19,472,442	4,096,351	15,376,091
c Leasehold improvements				
d Equipment		8,504,150	6,973,886	1,530,264
e Other		30,463		30,463
Total. Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.)				17,446,518

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

Part X Other Liabilities.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) DUE TO MEDICAL CENTER OF CENTRAL GEORGIA	33,506,484
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. (Column (b) must equal Form 990, Part X, col. (B) line 25.) ▶	33,506,484

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

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 - Identifier	Explanation
<p>SCHEDULE D, PART X, LINE 2 - FIN 48 (ASC 740) FOOTNOTE</p>	<p>ON JANUARY 1, 2019, NAVICENT HEALTH BECAME PART OF ATRIUM HEALTH (THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY). FOLLOWING ARE EXCERPTS FROM FOOTNOTE 1 OF ATRIUM HEALTH'S AUDITED STATEMENTS FOR THE YEAR ENDED DECEMBER 31, 2019. THIS FOOTNOTE DISCUSSES NAVICENT'S RELATIONSHIP TO ATRIUM HEALTH AND ITS INCLUSION IN THE ATRIUM HEALTH AUDITED FINANCIAL STATEMENTS. AN ASC 740 DISCLOSURE WAS NOT CONSIDERED TO BE MATERIAL FOR FINANCIAL STATEMENT DISCLOSURE PURPOSES; HOWEVER, THE REQUIREMENTS OF ASC 740 WERE CONSIDERED. FOR THE COMPLETE FOOTNOTE, PLEASE SEE FOOTNOTE 1 BEGINNING ON PAGE 27 OF THE ATTACHED AUDITED FINANCIAL STATEMENTS.</p> <p>ATRIUM HEALTH IS ONE OF THE NATION'S LEADING AND MOST INNOVATIVE HEALTHCARE ORGANIZATIONS, PROVIDING A FULL SPECTRUM OF HEALTHCARE AND WELLNESS PROGRAMS THROUGHOUT THE SOUTHEAST REGION. ITS DIVERSE NETWORK OF CARE LOCATIONS INCLUDES ACADEMIC MEDICAL CENTERS, HOSPITALS, FREESTANDING EMERGENCY DEPARTMENTS, PHYSICIAN PRACTICES, SURGICAL AND REHABILITATION CENTERS, HOME HEALTH AGENCIES, NURSING HOMES AND BEHAVIORAL HEALTH CENTERS, AS WELL AS HOSPICE AND PALLIATIVE CARE SERVICES. ATRIUM HEALTH WORKS TO ENHANCE THE OVERALL HEALTH AND WELLBEING OF ITS COMMUNITIES THROUGH HIGH QUALITY PATIENT CARE, EDUCATION AND RESEARCH PROGRAMS, AND NUMEROUS COLLABORATIVE PARTNERSHIPS. ATRIUM HEALTH WAS ORGANIZED IN 1943 UNDER THE NORTH CAROLINA HOSPITAL AUTHORITIES ACT. IT IS A PUBLIC BODY AND A BODY CORPORATE AND POLITIC AND, THEREFORE, HAS BEEN DETERMINED BY THE INTERNAL REVENUE SERVICE TO BE EXEMPT FROM FEDERAL AND STATE INCOME TAXES. ATRIUM HEALTH IS HEADQUARTERED IN CHARLOTTE, NORTH CAROLINA.</p> <p>FOR FINANCIAL REPORTING PURPOSES, ATRIUM HEALTH IS DIVIDED INTO THE "PRIMARY ENTERPRISE", "DISCRETE COMPONENT UNITS," AND "FIDUCIARY ACTIVITIES." THE PRIMARY ENTERPRISE CONSISTS OF THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY (CMHA, D/B/A ATRIUM HEALTH) AND ALL AFFILIATES WHOSE ASSETS AND INCOME ATRIUM HEALTH CONTROLS WITHOUT LIMITATION.</p> <p>IN FEBRUARY 2018, ATRIUM HEALTH SIGNED A LETTER OF INTENT WITH NAVICENT HEALTH (NAVICENT), A NONPROFIT CORPORATION HEADQUARTERED IN MACON, GEORGIA, TO ENTER A STRATEGIC COMBINATION TO ENHANCE ACCESS, AFFORDABILITY, AND EQUITY OF CARE FOR INDIVIDUALS AND FAMILIES IN CENTRAL AND SOUTHERN GEORGIA. IN DECEMBER 2018, ATRIUM HEALTH AND NAVICENT SIGNED AN AGREEMENT AND MEMBER SUBSTITUTION (AGREEMENT), EFFECTIVE JANUARY 1, 2019, PURSUANT TO WHICH AHNH GEORGIA, INC., A NEWLY FORMED CONTROLLED AFFILIATE OF WHICH ATRIUM HEALTH IS THE SOLE MEMBER, BECAME THE SOLE CORPORATE MEMBER OF NAVICENT. THROUGH THIS AGREEMENT, NAVICENT BECAME A REGIONAL HUB IN, AND AN INTEGRAL PART OF ATRIUM HEALTH. ON THE EFFECTIVE DATE OF THE AGREEMENT, NAVICENT BECAME A COMPONENT UNIT OF ATRIUM HEALTH AND, BECAUSE A CONTROLLED SUBSIDIARY OF ATRIUM HEALTH IS THE SOLE MEMBER OF NAVICENT, ITS FINANCIAL INFORMATION IS BLENDED WITH THE PRIMARY ENTERPRISE AS OF AND FOR THE YEAR ENDED DECEMBER 31, 2019.</p>

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2019

Open to Public Inspection

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, question 20.**
 ▶ **Attach to Form 990.**
 ▶ **Go to www.irs.gov/Form990 for instructions and the latest information.**

Department of the Treasury
Internal Revenue Service

Name of the organization THE MEDICAL CENTER OF PEACH COUNTY, INC.	Employer identification number 45 3765471
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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	✓	
b If "Yes," was it a written policy?	✓	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. <input checked="" type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> Generally tailored to individual hospital facilities		
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing free care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>125</u> %	✓	
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: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input checked="" type="checkbox"/> Other <u>270</u> %	✓	
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	✓	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	✓	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	✓	
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		✓
6a Did the organization prepare a community benefit report during the tax year?	✓	
b If "Yes," did the organization make it available to the public?	✓	

7 Financial Assistance and Certain Other Community Benefits at Cost

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
Financial Assistance and Means-Tested Government Programs						
a Financial Assistance at cost (from Worksheet 1)			652,465	0	652,465	3.26
b Medicaid (from Worksheet 3, column a)			2,890,076	3,303,547	0	0.00
c Costs of other means-tested government programs (from Worksheet 3, column b)			0	0	0	0.00
d Total. Financial Assistance and Means-Tested Government Programs	0	0	3,542,541	3,303,547	652,465	3.26
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			0	0	0	0.00
f Health professions education (from Worksheet 5)			0	0	0	0.00
g Subsidized health services (from Worksheet 6)			0	0	0	0.00
h Research (from Worksheet 7)			0	0	0	0.00
i Cash and in-kind contributions for community benefit (from Worksheet 8)			0	0	0	0.00
j Total. Other Benefits	0	0	0	0	0	0.00
k Total. Add lines 7d and 7j	0	0	3,542,541	3,303,547	652,465	3.26

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

Cat. No. 50192T

Schedule H (Form 990) 2019

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					0	0.00
2 Economic development					0	0.00
3 Community support					0	0.00
4 Environmental improvements					0	0.00
5 Leadership development and training for community members					0	0.00
6 Coalition building					0	0.00
7 Community health improvement advocacy					0	0.00
8 Workforce development					0	0.00
9 Other					0	0.00
10 Total	0	0	0	0	0	0.00

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

- 1 Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15? **1**
- 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** 4,192,072
- 3 Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit. **3**
- 4 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.

	Yes	No
1		
2		
3		
5		
6		
7		
9a	✓	
9b	✓	

Section B. Medicare

- 5 Enter total revenue received from Medicare (including DSH and IME) **5** 5,533,143
- 6 Enter Medicare allowable costs of care relating to payments on line 5 **6** 5,598,514
- 7 Subtract line 6 from line 5. This is the surplus (or shortfall) **7** (65,371)
- 8 Describe in Part VI the extent to which any shortfall reported on 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** ✓
- 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** ✓

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)

1 MEDICAL CENTER OF PEACH COUNTY, INC.
 1960 HIGHWAY 247 CONNECTOR, BYRON, GA 31008
 WWW.NAVICENTHEALTH.ORG STATE LICENSE NO. :
 111-687

2

3

4

5

6

7

8

9

10

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

Part V Facility Information (continued)

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group MEDICAL CENTER OF PEACH COUNTY, 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?		✓
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		✓
3	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	✓	
If "Yes," indicate what the CHNA report describes (check all that apply):			
a	<input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
b	<input checked="" type="checkbox"/> Demographics of the community		
c	<input checked="" type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input checked="" type="checkbox"/> How data was obtained		
e	<input checked="" type="checkbox"/> The significant health needs of the community		
f	<input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
j	<input type="checkbox"/> Other (describe in Section C)		
4	Indicate the tax year the hospital facility last conducted a CHNA: <u>20 18</u>		
5	In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge 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	✓	
6a	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C		✓
6b	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		✓
7	Did the hospital facility make its CHNA report widely available to the public?	✓	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a	<input checked="" type="checkbox"/> Hospital facility's website (list url): <u>WWW.NAVICENTHEALTH.ORG/OUR-ANNUAL-REPORTS.HTML</u>		
b	<input type="checkbox"/> Other website (list url): _____		
c	<input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
d	<input type="checkbox"/> Other (describe in Section C)		
8	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	✓	
9	Indicate the tax year the hospital facility last adopted an implementation strategy: <u>20 18</u>		
10	Is the hospital facility's most recently adopted implementation strategy posted on a website?	✓	
a	If "Yes," (list url): <u>WWW.NAVICENTHEALTH.ORG/OUR-ANNUAL-REPORTS.HTML</u>		
b	If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?		
11	Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
12a	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?		✓
b	If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?		
c	If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$		

Part V Facility Information (continued)

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group MEDICAL CENTER OF PEACH COUNTY, INC.

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	✓	
a	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of <u>1</u> <u>2</u> <u>5</u> % and FPG family income limit for eligibility for discounted care of <u>2</u> <u>7</u> <u>0</u> %		
b	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
c	<input type="checkbox"/> Asset level		
d	<input checked="" type="checkbox"/> Medical indigency		
e	<input checked="" type="checkbox"/> Insurance status		
f	<input checked="" type="checkbox"/> Underinsurance status		
g	<input type="checkbox"/> Residency		
h	<input type="checkbox"/> Other (describe in Section C)		
14	Explained the basis for calculating amounts charged to patients?	✓	
15	Explained the method for applying for financial assistance? If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	✓	
a	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
b	<input checked="" type="checkbox"/> Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application		
c	<input checked="" type="checkbox"/> Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process		
d	<input type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
e	<input type="checkbox"/> Other (describe in Section C)		
16	Was widely publicized within the community served by the hospital facility? If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	✓	
a	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>(SEE STATEMENT)</u>		
b	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>(SEE STATEMENT)</u>		
c	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>(SEE STATEMENT)</u>		
d	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
e	<input checked="" type="checkbox"/> The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)		
f	<input checked="" type="checkbox"/> A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
g	<input checked="" type="checkbox"/> Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention		
h	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
i	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by Limited English Proficiency (LEP) populations		
j	<input type="checkbox"/> Other (describe in Section C)		

Part V Facility Information *(continued)*

Billing and Collections

Name of hospital facility or letter of facility reporting group MEDICAL CENTER OF PEACH COUNTY, INC.

		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?	✓	
18	Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:		
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	<input type="checkbox"/> Actions that require a legal or judicial process		
e	<input type="checkbox"/> Other similar actions (describe in Section C)		
f	<input checked="" type="checkbox"/> None of these actions or other similar actions were permitted		
19	Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?		✓
If "Yes," check all actions in which the hospital facility or a third party engaged:			
a	<input type="checkbox"/> Reporting to credit agency(ies)		
b	<input type="checkbox"/> Selling an individual's debt to another party		
c	<input type="checkbox"/> Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP		
d	<input type="checkbox"/> Actions that require a legal or judicial process		
e	<input type="checkbox"/> Other similar actions (describe in Section C)		
20	Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19 (check all that apply):		
a	<input checked="" type="checkbox"/> Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)		
b	<input checked="" type="checkbox"/> Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)		
c	<input checked="" type="checkbox"/> Processed incomplete and complete FAP applications (if not, describe in Section C)		
d	<input checked="" type="checkbox"/> Made presumptive eligibility determinations (if not, describe in Section C)		
e	<input type="checkbox"/> Other (describe in Section C)		
f	<input type="checkbox"/> None of these efforts were made		

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

Name of hospital facility or letter of facility reporting group MEDICAL CENTER OF PEACH COUNTY, INC.

		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	<input type="checkbox"/> The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period		
b	<input checked="" type="checkbox"/> 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	<input type="checkbox"/> 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	<input type="checkbox"/> 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	✓
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	✓
If "Yes," explain in Section C.			

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

Return Reference - Identifier	Explanation
SCHEDULE H, PART V, SECTION B, LINE 3E - THE SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY	<p>THE CHNA IDENTIFIED AND PRIORITIZED THE COMMUNITY'S SIGNIFICANT HEALTH NEEDS THROUGH A COMMUNITY SURVEY AND A KEY INFORMANT FOCUS GROUP. INDIVIDUALS' RATINGS FOR EACH CRITERIA WERE AVERAGED FOR EACH TESTED HEALTH ISSUE, AND THEN THESE COMPOSITE CRITERIA SCORES WERE AVERAGED TO PRODUCE AN OVERALL SCORE. THIS PROCESS YIELDED THE FOLLOWING PRIORITIZED LIST OF COMMUNITY HEALTH NEEDS:</p> <ol style="list-style-type: none"> 1. NUTRITION, PHYSICAL ACTIVITY & WEIGHT 2. DIABETES 3. HEART DISEASE & STROKE 4. ACCESS TO HEALTHCARE 5. MENTAL HEALTH 6. SUBSTANCE ABUSE 7. SEXUALLY TRANSMITTED DISEASES 8. INFANT HEALTH 9. RESPIRATORY DISEASES 10. KIDNEY DISEASE 11. INJURY & VIOLENCE 12. HIV/AIDS 13. CANCER 14. TOBACCO USE 15. POTENTIALLY DISABLING CONDITIONS 16. DEMENTIA, INCLUDING ALZHEIMER'S DISEASE
SCHEDULE H, PART V, SECTION B, LINE 5 - INPUT FROM PERSONS WHO REPRESENT BROAD INTERESTS OF COMMUNITY SERVED	<p>FACILITY NAME: THE MEDICAL CENTER OF PEACH COUNTY, INC.</p> <p>DESCRIPTION: A CHNA WAS PERFORMED IN 2018 ON BEHALF OF THE MEDICAL CENTER OF PEACH COUNTY, LLC BY PROFESSIONAL RESEARCH CONSULTANTS, INC. (PRC). PRC IS A NATIONALLY RECOGNIZED HEALTHCARE CONSULTING FIRM WHICH HAS CONDUCTED HUNDREDS OF COMMUNITY HEALTH NEEDS ASSESSMENTS SINCE 1994. THE SURVEY INCLUDED 200 SURVEYS AND 1 KEY INFORMANT FOCUS GROUPS WHICH INCLUDED PUBLIC HEALTH AND POLITICAL LEADERS, HEALTHCARE PROVIDERS AND OTHER COMMUNITY LEADERS. ADDITIONALLY, PUBLIC HEALTH, VITAL STATISTICS AND BENCHMARK DATA INCLUDING GEORGIA AND NATIONWIDE RISK FACTOR DATA AND HEALTHY PEOPLE 2020 WERE USED. PARTICIPANTS ALSO INCLUDED A PUBLIC HEALTH REPRESENTATIVE AND SEVERAL INDIVIDUALS WHO WORK WITH LOW INCOME, MINORITY AND OTHER MEDICALLY UNDERSERVED POPULATIONS. A VARIETY OF SECONDARY DATA SOURCES WERE CONSULTED TO COMPLEMENT THE ASSESSMENT INCLUDING THE CENTERS FOR DISEASE CONTROL AND PREVENTION, GEORGIA DEPARTMENT OF COMMUNITY HEALTH, US CENSUS DATA, US DEPARTMENT OF HEALTH AND HUMAN SERVICES, US DEPARTMENT OF LABOR, AND THE US DEPARTMENT OF JUSTICE (FBI).</p>
SCHEDULE H, PART V, SECTION B, LINE 11 - HOW HOSPITAL FACILITY IS ADDRESSING NEEDS IDENTIFIED IN CHNA	<p>FACILITY NAME: THE MEDICAL CENTER OF PEACH COUNTY, INC.</p> <p>DESCRIPTION: A WIDE RANGE OF PRIORITY HEALTH ISSUES WERE IDENTIFIED BY THE COMMUNITY REPRESENTATIVES IN THE 2018 CHNA. THE HOSPITAL WILL CONSIDER THE TOP HEALTH PRIORITIES IDENTIFIED THROUGH THE PROCESS AND THEIR OVERALL ALIGNMENT WITH THE HOSPITAL'S MISSION, GOALS AND STRATEGIC PRIORITIES. THE HOSPITAL WILL CONTINUE TO FOCUS ON DEVELOPING, SUPPORTING AND COLLABORATING ON STRATEGIES AND INITIATIVES TO IMPROVE HEALTHCARE ACCESS, AND HEALTH PROMOTION AND DISEASE PREVENTION. NAVICENT HEALTH WILL USE THE INFORMATION FROM THIS COMMUNITY HEALTH NEEDS ASSESSMENT TO DEVELOP IMPLEMENTATION STRATEGIES TO ADDRESS THE SIGNIFICANT HEALTH NEEDS IN THE COMMUNITY. WHILE THE HOSPITAL WILL NOT IMPLEMENT STRATEGIES FOR ALL OF THE HEALTH ISSUES LISTED ABOVE, THE RESULTS OF THIS PRIORITIZATION EXERCISE WILL BE USED TO INFORM THE DEVELOPMENT OF THE HOSPITAL'S ACTION PLAN TO GUIDE COMMUNITY HEALTH IMPROVEMENT EFFORTS IN THE COMING YEARS. THE IMPLEMENTATION STRATEGIES REPORT IS POSTED ON THE ORGANIZATION'S WEBSITE.</p>
SCHEDULE H, PART V, SECTION B, LINE 16A - FAP AVAILABLE WEBSITE	<p>WWW.NAVICENTHEALTH.ORG/FOR-PATIENTS-AND-VISITORS/FINANCIAL-AID-INFORMATION.HTML</p>
SCHEDULE H, PART V, SECTION B, LINE 16B - FAP APPLICATION FORM WEBSITE	<p>WWW.NAVICENTHEALTH.ORG/FOR-PATIENTS-AND-VISITORS/FINANCIAL-AID-INFORMATION.HTML</p>
SCHEDULE H, PART V, SECTION B, LINE 16C - PLAIN LANGUAGE FAP SUMMARY WEBSITE	<p>WWW.NAVICENTHEALTH.ORG/FOR-PATIENTS-AND-VISITORS/FINANCIAL-AID-INFORMATION.HTML</p>

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? 1

Name and address	Type of Facility (describe)
1 VALLEY MEDICAL CENTER 701 BLUEBIRD BLVD. FT. VALLEY, GA 31030	RURAL HEALTH CLINIC
2	
3	
4	
5	
6	
7	
8	
9	
10	

Provide the following information.

- 1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; 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 needs assessments 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.

Return Reference - Identifier	Explanation
SCHEDULE H, PART I, LINE 6A - NAME OF RELATED ORGANIZATION THAT PREPARED COMMUNITY BENEFIT REPORT	NAVICENT HEALTH
SCHEDULE H, PART I, LINE 7 - EXPLANATION OF COSTING METHODOLOGY USED FOR CALCULATING LINE 7 TABLE	THE DATA REPORTED IN PART 1, LINE 7 IS REPORTED AS INSTRUCTED BY THE CATHOLIC HEALTH ASSOCIATION'S "A GUIDE FOR PLANNING AND REPORTING COMMUNITY BENEFITS, 2008". THE COSTS WERE CALCULATED USING THE RATIO OF COSTS TO CHARGES USING WORKSHEET 2 IN THE INSTRUCTIONS TO FORM 990 SCHEDULE H.
SCHEDULE H, PART III, LINE 2 - METHODOLOGY USED TO ESTIMATE BAD DEBT	PATIENT CHARGES WRITTEN OFF AS BAD DEBT EXPENSES REPRESENT THE AMOUNT OF CHARGES CONSIDERED UNCOLLECTIBLE AFTER REASONABLE ATTEMPTS TO COLLECT HAVE BEEN MADE FOR THAT PORTION OF A PATIENT'S BILL THAT ARE NOT OTHERWISE PAID BY THIRD-PARTY INSURANCE, GOVERNMENT PROGRAMS, THE PATIENT OR THAT DO NOT QUALIFY FOR WRITE-OFF UNDER THE HOSPITAL'S FINANCIAL ASSISTANCE POLICY.
SCHEDULE H, PART III, LINE 4 - FOOTNOTE IN ORGANIZATION'S FINANCIAL STATEMENTS DESCRIBING BAD DEBT	ATRIUM HEALTH ISSUES CONSOLIDATED FINANCIAL STATEMENTS IN ACCORDANCE WITH GENERALLY ACCEPTED ACCOUNTING PRINCIPLES AS PRESCRIBED BY THE GOVERNMENTAL ACCOUNTING STANDARDS BOARD. THERE IS NO COMPREHENSIVE FOOTNOTE THAT ADDRESSES BAD DEBT EXPENSE. NET PATIENT ACCOUNT RECEIVABLES ARE IN FOOTNOTE 1(F) ON PAGE 26, FINANCIAL ASSISTANCE AND COMMUNITY BENEFIT COSTS ARE DISCUSSED IN FOOTNOTE 1(R) ON PAGE 29, AND THE USE OF ESTIMATES (WHICH INCLUDES THE USE OF ESTIMATES RELATED TO THE VALUATION OF ACCOUNTS RECEIVABLE, INCLUDING CONTRACTUAL ALLOWANCES AND PROVISIONS FOR BAD DEBTS) IS DISCUSSED IN FOOTNOTE 1(T) ON PAGE 30 OF THE AUDITED FINANCIAL ON STATEMENTS FOR THE CALENDAR YEAR ENDED DECEMBER 31, 2019.
SCHEDULE H, PART III, LINE 8 - DESCRIBE EXTENT ANY SHORTFALL FROM LINE 7 TREATED AS COMMUNITY BENEFIT AND COSTING METHOD USED	THE COSTING METHODOLOGY USES THE ESTIMATED COSTS INCLUDED IN THE COST REPORT WHICH ARE CALCULATED USING A DEPARTMENTAL SPECIFIC COST TO CHARGE RATIO AS COMPARED TO ACTUAL MEDICARE PAYMENTS. THE COSTS ARE ESTIMATED BECAUSE THE COST REPORT WAS FILED ON A 12 MONTH PERIOD ENDING 9/30/2019 AND A 3 MONTH PERIOD ENDING 12/31/2019.
SCHEDULE H, PART III, LINE 9B - DID COLLECTION POLICY CONTAIN PROVISIONS ON COLLECTION PRACTICES FOR PATIENTS WHO ARE KNOWN TO QUALIFY FOR ASSISTANCE	PATIENTS ARE NOTIFIED OF THE ORGANIZATION'S FINANCIAL ASSISTANCE POLICY PRIOR TO DISCHARGE. EACH BILLING STATEMENT CONTAINS A CONSPICUOUS NOTICE THAT FINANCIAL ASSISTANCE IS AVAILABLE TO INDIVIDUALS THAT QUALIFY. ONCE A PATIENT IS DETERMINED TO QUALIFY FOR FINANCIAL ASSISTANCE, IT IS NOTED IN THE PATIENT'S FINANCIAL RECORD AND ANY COLLECTION EFFORTS CEASE. ANY PREVIOUS AMOUNTS BILLED ARE WRITTEN-OFF (OR REFUNDED IF ANY PAYMENT WAS RECEIVED) AS PROVIDED IN THE FINANCIAL ASSISTANCE POLICY. THE ORGANIZATION REVIEWS THE FINANCIAL ACTIVITY ON OTHER ACCOUNTS TO DETERMINE IF THE ACCOUNTS SHOULD BE TURNED OVER TO OUTSIDE COLLECTIONS. IF A PATIENT ACCOUNT TURNED OVER TO COLLECTIONS IS LATER DETERMINED TO QUALIFY AS FINANCIAL ASSISTANCE, THE ACCOUNT IS BROUGHT BACK FROM COLLECTIONS AND THE ACCOUNT WRITTEN OFF.
SCHEDULE H, PART VI, LINE 2 - NEEDS ASSESSMENT	A COMMUNITY NEEDS ASSESSMENT WAS PERFORMED IN 2018 BEHALF OF THE MEDICAL CENTER OF PEACH COUNTY BY PROFESSIONAL RESEARCH CONSULTANTS, INC. (PRC). PRC IS A NATIONALLY RECOGNIZED CONSULTING FIRM. IN ADDITION, THE MEDICAL CENTER OF PEACH COUNTY REGULARLY SOLICITS FEEDBACK ON COMMUNITY HEALTH NEEDS FROM A VARIETY OF SOURCES INCLUDING MEDICAL STAFF MEMBERS AND COMMUNITY LEADERS AS PART OF ITS STRATEGIC PLANNING PROCESS.
SCHEDULE H, PART VI, LINE 3 - PATIENT EDUCATION	PATIENTS ARE INFORMED OF AVAILABLE ASSISTANCE BY THE FOLLOWING METHODS: THE PATIENT IS NOTIFIED UPON ADMISSION OF THE FINANCIAL ASSISTANCE POLICY; SIGNAGE AT ALL ACCESS POINTS INTO THE ORGANIZATION NOTIFIES PATIENTS AND GUESTS OF THE POLICY; AND ALL BILLINGS INCLUDE INFORMATION TO CONTACT THE BUSINESS OFFICE TO APPLY FOR ASSISTANCE. WE ALSO IDENTIFY ALL PATIENTS WITHOUT INSURANCE AND WORK WITH THEM TO OBTAIN MEDICAID COVERAGE IF POSSIBLE. THE ORGANIZATION'S WEBSITE NOTIFIES VISITORS OF AVAILABLE FINANCIAL ASSISTANCE. THE FAP, THE PLAIN LANGUAGE SUMMARY AND THE APPLICATION FOR ASSISTANCE ARE ALSO AVAILABLE ON THE ORGANIZATION'S WEBSITE.
SCHEDULE H, PART VI, LINE 4 - COMMUNITY INFORMATION	THE PRIMARY SERVICE AREA IS PEACH COUNTY. A RECENT ESTIMATE OF THE POPULATION FOR PEACH COUNTY IS 27,099 AS OF 2017. THERE ARE NO OTHER HOSPITALS IN THE COUNTY. MEDICAL CENTER OF PEACH COUNTY IS DESIGNATED A CRITICAL ACCESS HOSPITAL FOR MEDICARE PURPOSES.

Return Reference - Identifier	Explanation
SCHEDULE H, PART VI, LINE 5 - PROMOTION OF COMMUNITY HEALTH	THE ORGANIZATION IS PART OF A MULTI-ENTITY HEALTHCARE SYSTEM THAT PROVIDES MEDICAL SERVICES TO THE COMMUNITY. THE ORGANIZATION HAS A BOARD COMPRISED OF MEMBERS OF THE COMMUNITY. THE MEDICAL STAFF OF THE HOSPITAL IS OPEN TO ALL QUALIFIED PHYSICIAN APPLICANTS. ANY SURPLUS FUNDS ARE REINVESTED IN THE ORGANIZATION AND USED FOR PROGRAM SERVICES. AN EMERGENCY ROOM OPEN 24/7/365 IS AVAILABLE TO THE COMMUNITY.
SCHEDULE H, PART VI, LINE 6 - DESCRIPTION OF AFFILIATED GROUP	THE ORGANIZATION IS PART OF NAVICENT HEALTH, INC. AND AFFILIATED ENTITIES, A MULTI-ENTITY HEALTHCARE SYSTEM. ORGANIZATIONS IN THE SYSTEM INCLUDE: NAVICENT HEALTH, INC. WHICH SERVES AS THE PARENT ENTITY OF THE HEALTH SYSTEM. IT ALSO OPERATES CENTRAL GEORGIA REHABILITATION HOSPITAL, INC. THE MEDICAL CENTER OF CENTRAL GEORGIA, INC. IS A 637-BED GENERAL SHORT-TERM ACUTE CARE HOSPITAL FACILITY THAT IS DESIGNATED AS A LEVEL 1 TRAUMA CENTER AND MAGNET HOSPITAL FOR NURSING. HEALTH SERVICES OF CENTRAL GEORGIA, INC. PROVIDES FACULTY PHYSICIANS TO THE RESIDENCY TRAINING PROGRAMS OF THE MEDICAL CENTER OF CENTRAL GEORGIA AS WELL AS OTHER PHYSICIANS, NURSE PRACTITIONERS, AND PHYSICIAN ASSISTANTS. CENTRAL GEORGIA SENIOR HEALTH, INC. IS A LIFE PLAN COMMUNITY (CCRC) OFFERING INDEPENDENT LIVING, ASSISTED LIVING, MEMORY SUPPORT AND SKILLED NURSING. NAVICENT HEALTH BALDWIN, INC. IS A 140-LICENSED BED ACUTE CARE HOSPITAL AND 15-BED SKILLED NURSING FACILITY IN NEARBY BALDWIN COUNTY. THE MEDICAL CENTER OF PEACH COUNTY, INC. IS A 25-BED CRITICAL ACCESS HOSPITAL PRIMARILY SERVING THE RESIDENTS OF PEACH COUNTY, GEORGIA. NAVICENT HEALTH FOUNDATION, INC. PROVIDES FUNDRAISING AND SUPPORT FOR THE MEDICAL CENTER OF CENTRAL GEORGIA AND THE TAX-EXEMPT AFFILIATES WORKING WITH THE MEDICAL CENTER TO PROVIDE HEALTH CARE TO THE RESIDENTS OF CENTRAL GEORGIA.
SCHEDULE H, PART VI, LINE 7 - STATE FILING OF COMMUNITY BENEFIT REPORT	GA

**SCHEDULE J
(Form 990)**

Compensation Information

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

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

OMB No. 1545-0047

2019

Open to Public Inspection

Department of the Treasury
Internal Revenue Service

Name of the organization

THE MEDICAL CENTER OF PEACH COUNTY, INC.

Employer identification number

45-3765471

Part I Questions Regarding Compensation

- 1a** Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.
- | | |
|--|--|
| <input type="checkbox"/> First-class or charter travel | <input type="checkbox"/> Housing allowance or residence for personal use |
| <input type="checkbox"/> Travel for companions | <input type="checkbox"/> Payments for business use of personal residence |
| <input type="checkbox"/> Tax indemnification and gross-up payments | <input type="checkbox"/> Health or social club dues or initiation fees |
| <input type="checkbox"/> Discretionary spending account | <input type="checkbox"/> Personal services (such as maid, chauffeur, chef) |

b If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain

2 Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked on line 1a?

3 Indicate which, if any, of the following the organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.

- | | |
|--|--|
| <input type="checkbox"/> Compensation committee | <input type="checkbox"/> Written employment contract |
| <input type="checkbox"/> Independent compensation consultant | <input type="checkbox"/> Compensation survey or study |
| <input type="checkbox"/> Form 990 of other organizations | <input type="checkbox"/> Approval by the board or compensation committee |

4 During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:

- a** Receive a severance payment or change-of-control payment?
- b** Participate in, or receive payment from, a supplemental nonqualified retirement plan?
- c** Participate in, or receive payment from, an equity-based compensation arrangement?

If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.

Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.

5 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:

- a** The organization?
- b** Any related organization?

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?
- b** Any related organization?

If "Yes" on line 6a or 6b, describe in Part III.

7 For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described on lines 5 and 6? If "Yes," describe in Part III

8 Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III

9 If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?

	Yes	No
1a		
1b		
2		
3		
4a		✓
4b	✓	
4c		✓
5a		✓
5b		✓
6a		✓
6b		✓
7	✓	
8		✓
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 aren't listed on Form 990, Part VII.

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
1 ROBERT C WILDE TREASURER	(i)	0	0	0	0	0	0	0
	(ii)	441,990	0	824	11,077	30,869	484,760	0
2 KENNETH B BANKS SECRETARY	(i)	0	0	0	0	0	0	0
	(ii)	554,929	0	50,456	148,395	29,041	782,821	0
3 LAURA T GENTRY AVP MEDICAL CENTER PEACH COUNTY	(i)	154,258	0	555	3,924	20,966	179,704	0
	(ii)	0	0	0	0	0	0	0
4	(i)							
	(ii)							
5	(i)							
	(ii)							
6	(i)							
	(ii)							
7	(i)							
	(ii)							
8	(i)							
	(ii)							
9	(i)							
	(ii)							
10	(i)							
	(ii)							
11	(i)							
	(ii)							
12	(i)							
	(ii)							
13	(i)							
	(ii)							
14	(i)							
	(ii)							
15	(i)							
	(ii)							
16	(i)							
	(ii)							

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 - Identifier	Explanation
SCHEDULE J, PART I, LINE 3 - ARRANGEMENT USED TO ESTABLISH THE TOP MANAGEMENT OFFICIAL'S COMPENSATION	THE COMPENSATION COMMITTEE OF THE BOARD OF DIRECTORS OF NAVICENT HEALTH, INC. ENGAGES AN EXECUTIVE CONSULTING FIRM PERIODICALLY TO REVIEW AND PROVIDE RECOMMENDATIONS REGARDING TOTAL COMPENSATION AND BENEFITS FOR THE EXECUTIVE LEADERSHIP TEAM. BASE COMPENSATION, INCENTIVE COMPENSATION, AND BENEFITS ARE INCLUDED IN THE REVIEW. THE EXECUTIVE CONSULTANTS REVIEW ORGANIZATION STRUCTURE, INDIVIDUAL JOB DESCRIPTIONS, AND DISCUSS SCOPE OF LEADERSHIP AND SPAN OF CONTROL WITH HR, THE COO, AND THE CEO AS A PART OF THE PROCESS TO DETERMINE PROPER PLACEMENT OF THE PAY GRADE AND LEVEL OF PARTICIPATION IN INCENTIVE AND BENEFITS PROGRAMS. THE COMPENSATION COMMITTEE PERIODICALLY REAFFIRMS THE TOTAL COMPENSATION PHILOSOPHY WHICH TARGETS THE 75TH PERCENTILE OF TOTAL COMPENSATION FOR OUR LEADERSHIP TEAM. THE PEER GROUP USED IS NATIONAL HOSPITALS AND HEALTH SYSTEMS OF SIMILAR SIZE AND SCOPE. OUR HUMAN RESOURCES DEPARTMENT SURVEYS THOSE EMPLOYED OUTSIDE OF THE EXECUTIVE LEADERSHIP TEAM USING TOOLS THAT PROVIDE COMPARABLE DATA IN OUR MARKET AREA TO ENSURE THE COMPENSATION IS IN LINE WITH OTHER HEALTH CARE ORGANIZATIONS.
SCHEDULE J, PART I, LINE 4B - SUPPLEMENTAL NONQUALIFIED RETIREMENT PLAN	<p>MCCG HAD A SUPPLEMENTAL EXECUTIVE BENEFIT PROGRAM ("SEBP") FOR CERTAIN EXECUTIVES THAT WAS DESIGNED AS A LOAN REGIME SPLIT DOLLAR LIFE INSURANCE PROGRAM. THIS PROGRAM WAS EXPECTED TO PROVIDE DEATH AND OTHER BENEFITS TO EXECUTIVES AND TO PROVIDE REPAYMENT OF LIFE INSURANCE PREMIUMS TO THE ORGANIZATION.</p> <p>AS A RESULT OF ECONOMIC CONDITIONS, THE LIFE INSURANCE POLICIES DID NOT PERFORM AS ANTICIPATED. DURING 2009 MCCG SUSPENDED ALL PREMIUM PAYMENTS AND REEVALUATED THE EFFECTIVENESS OF THE PROGRAM FOR ALL CURRENT PARTICIPANTS. DURING CALENDAR YEAR 2009 THE MCCG BOARD OF DIRECTORS, AFTER CONSULTATION WITH COMPENSATION AND LEGAL ADVISERS, ADOPTED A RESOLUTION TO MAKE PAYMENTS TO THE RETIRED PARTICIPANTS IN THE SEBP. IN CONSIDERATION FOR THE RECEIPT OF SUCH PAYMENT, THE RETIRED EXECUTIVES SURRENDERED SUBSTANTIALLY ALL RIGHTS AND BENEFITS (OTHER THAN A SMALL DEATH BENEFIT) UNDER THE SEBP TO THE ORGANIZATION. SUBSEQUENTLY, A SIMILAR DECISION WAS MADE DURING FISCAL YEAR ENDED SEPTEMBER 30, 2011 FOR THE REMAINING (EMPLOYED) PARTICIPANTS WITH ANY PAYMENTS TO BE MADE DEPENDENT ON THE INDIVIDUAL CONTINUING TO PROVIDE SUBSTANTIAL SERVICES TO A SPECIFIED FUTURE DATE.</p> <p>IN ADDITION, MCCG AND ITS AFFILIATED ORGANIZATIONS ADOPTED A SERP PROGRAM FOR CERTAIN EXECUTIVES EFFECTIVE FOR SERVICES RENDERED ON OR AFTER JANUARY 1, 2010. THIS PROGRAM PROVIDES FOR ANNUAL ACCOUNT VESTING IF THE PARTICIPANT IS EMPLOYED ON DECEMBER 31 OF THE THIRD YEAR AFTER THE ACCOUNT IS CREATED. THE BENEFIT EQUALS THE ANNUAL INCREASE IN THE PRESENT VALUE OF A LIFETIME ANNUITY PAYABLE COMMENCING AT A SPECIFIED TARGETED FUTURE DATE. THE ANNUITY IS EQUAL TO A SPECIFIC PERCENTAGE OF FINAL AVERAGE EARNINGS (GENERALLY 60%) LESS (1) THE EXPECTED ANNUAL SEBP PAYMENT USED IN CALCULATING THE SEBP LUMP SUM PAYMENT, (2) THE ANNUAL BENEFIT PROVIDED UNDER THE DEFINED BENEFIT PLAN, AND (3) 100% OF THE PARTICIPANT'S SOCIAL SECURITY BENEFIT. DURING THE YEAR, THE FOLLOWING BENEFITS WERE ACCRUED: KEN BANKS \$111,854</p> <p>IN ADDITION, NAVICENT ADOPTED A RETENTION PAYMENT PLAN EFFECTIVE OCTOBER 1, 2011 DESIGNED TO ENCOURAGE DESIGNATED EMPLOYEES TO CONTINUE THEIR EMPLOYMENT. UNDER THE PLAN, NAVICENT HEALTH MAY SELECT A RETENTION CREDIT EQUAL TO A PERCENTAGE OF THE EXECUTIVE'S BASE SALARY. THE CREDIT IS REDUCED BY THE VALUE OF LIFE INSURANCE COVERAGE PROVIDED TO THE EXECUTIVE. IN GENERAL, THE PLAN IS SUBJECT TO VESTING AT THE END OF THE THIRD PLAN YEAR AFTER THE ACCOUNT WAS CREATED OR AGE 65 IF EARLIER, AND IS SUBJECT TO FORFEITURE IF THE EXECUTIVE VOLUNTARILY SEPARATES FROM SERVICE. DURING THE YEAR THE FOLLOWING BENEFITS ACCRUED UNDER THIS PLAN: KEN BANKS \$25,341</p> <p>IN ADDITION, NAVICENT ADOPTED A NONQUALIFIED, UNFUNDED DEFERRED COMPENSATION PLAN DESIGNED TO ATTRACT AND RETAIN QUALIFIED MANAGEMENT PERSONNEL. DURING THE YEAR THE FOLLOWING BENEFITS ACCRUED UNDER THIS PLAN: N/A</p>
SCHEDULE J, PART I, LINE 7 - NON-FIXED PAYMENTS	THIS PROGRAM IS ADMINISTERED BY THE CEO OF NAVICENT HEALTH, INC. THE DISCRETIONARY INCENTIVE PROGRAM WAS ESTABLISHED FOR REWARD AND RECOGNITION OF EXECUTIVES AND ORGANIZATIONAL LEADERS WHO GO ABOVE AND BEYOND THE SCOPE OF THEIR RESPONSIBILITIES.

**SCHEDULE O
(Form 990 or 990-EZ)**

Department of Treasury Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

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

- ▶ Attach to Form 990 or 990-EZ.
- ▶ Go to www.irs.gov/Form990 for the latest information.

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the Organization
THE MEDICAL CENTER OF PEACH COUNTY, INC.

Employer Identification Number
45-3765471

Return Reference - Identifier	Explanation																																													
FORM 990, PART I, LINE 1 - BRIEF MISSION	OTHER HEALTH CARE RELATED SERVICES TO PEACH COUNTY AND THE SURROUNDING COUNTIES WHICH ARE PRIMARILY RURAL.																																													
FORM 990, PART V, LINE 1A - FORMS 1099	ALL FORMS 1099 ARE ISSUED BY THE MEDICAL CENTER OF CENTRAL GEORGIA FOR THE HEALTHCARE SYSTEM.																																													
FORM 990, PART VI, LINE 6 - CLASSES OF MEMBERS OR STOCKHOLDERS	NAVICENT HEALTH, INC., A RELATED SECTION 501(C)(3) ORGANIZATION, IS THE SOLE MEMBER OF THE ORGANIZATION. THE MEMBER HAS THE RIGHT TO APPOINT AND REMOVE MEMBERS OF THE BOARD OF DIRECTORS OF THE ORGANIZATION. IN ADDITION, THE PRIOR APPROVAL OF THE BOARD OF DIRECTORS OF NAVICENT HEALTH IS REQUIRED FOR CHANGES IN GOVERNANCE, ORGANIZATIONAL STRUCTURE CHANGES (ORGANIZING A SUBSIDIARY OR ENTERING A JOINT VENTURE, LIQUIDATING OR DISSOLVING, MERGING OF CONSOLIDATING THE ENTITY), ADOPTING OR AMENDING CAPITAL OR OPERATING BUDGETS (OR SPENDING MORE THAN IS AUTHORIZED PURSUANT TO SUCH BUDGETS UNLESS PERMITTED BY A NAVICENT HEALTH APPROVED POLICY), APPOINTING OR REMOVING THE CEO, AND AMENDING OR TERMINATING ANY LEASE AGREEMENT.																																													
FORM 990, PART VI, LINE 7A - MEMBERS OR STOCKHOLDERS ELECTING MEMBERS OF GOVERNING BODY	NAVICENT HEALTH, INC., A RELATED SECTION 501(C)(3) ORGANIZATION, HAS THE RIGHT TO APPOINT AND REMOVE MEMBERS OF THE BOARD OF DIRECTORS OF THE ORGANIZATION. HOWEVER, ONE MEMBER OF THE BOARD OF DIRECTORS MUST BE A CURRENTLY SERVING MEMBER OF THE HOSPITAL AUTHORITY OF PEACH COUNTY AND TWO OTHER MEMBERS ARE TO BE NOMINATED BY THE HOSPITAL AUTHORITY OF PEACH COUNTY.																																													
FORM 990, PART VI, LINE 7B - DECISIONS REQUIRING APPROVAL BY MEMBERS OR STOCKHOLDERS	NAVICENT HEALTH, INC., A RELATED SECTION 501(C)(3) ORGANIZATION, HAS CERTAIN RESERVE POWERS AS WELL AS THE POWER TO APPOINT, APPROVE AND REMOVE BOARD MEMBERS OF THE MEDICAL CENTER OF PEACH COUNTY, INC.																																													
FORM 990, PART VI, LINE 11B - REVIEW OF FORM 990 BY GOVERNING BODY	FORM 990 WAS PREPARED BY HOSPITAL ACCOUNTING PERSONNEL FROM INFORMATION PROVIDED BY MANAGEMENT AND FROM INTERNAL FINANCIAL STATEMENTS. IT WAS REVIEWED IN DETAIL BY OUR OUTSIDE TAX ADVISOR (AN INDEPENDENT CPA) AND BY MANAGEMENT OF THE MEDICAL CENTER OF PEACH COUNTY, INC. A COPY OF FORM 990 WAS PROVIDED TO EACH BOARD MEMBER PRIOR TO FILING WITH THE INTERNAL REVENUE SERVICE.																																													
FORM 990, PART VI, LINE 12C - CONFLICT OF INTEREST POLICY	THE DEPARTMENT OF AUDIT AND COMPLIANCE ISSUES COI DISCLOSURE FORMS ANNUALLY TO OUR BOARD MEMBER, ADMINISTRATION AND DIRECTORS. AUDIT AND COMPLIANCE RECEIVES, REVIEWS AND DOCUMENTS ALL POTENTIAL CONFLICTS (PERCEIVED AND REAL). THE RESULTS ARE TAKEN TO THE COMPLIANCE COMMITTEE WHERE THE REAL CONFLICTS OF INTEREST ARE DISCUSSED AND A PLAN FOR CORRECTIVE ACTION IS DEVELOPED. IF NEEDED, CORRECTIVE ACTION RECOMMENDATIONS ARE TAKEN TO THE APPROPRIATE BOARD AND ADMINISTRATION FOR IMPLEMENTATION. ANY TIME A CHANGE IN A RELATIONSHIP OR NEW POTENTIAL CONFLICT EVOLVES, THE INDIVIDUAL MUST AMEND THEIR COI DISCLOSURE FORM. CONFLICTED INDIVIDUALS ARE PROHIBITED FROM PARTICIPATING IN DELIBERATIONS AND DECISIONS REGARDING SUCH TRANSACTIONS, BUT MAY PROVIDE INFORMATION IF REQUESTED BY THE COMPLIANCE COMMITTEE.																																													
FORM 990, PART VI, LINE 19 - REQUIRED DOCUMENTS AVAILABLE TO THE PUBLIC	THE MEDICAL CENTER OF PEACH COUNTY, INC. PROVIDES COPIES OF ITS GOVERNING AND OTHER CORPORATE DOCUMENTS UPON REQUEST.																																													
FORM 990, PART IX, LINE 11G - OTHER FEES FOR SERVICES	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;">(a) Description</th> <th style="text-align: center;">(b) Total Expenses</th> <th style="text-align: center;">(c) Program Service Expenses</th> <th style="text-align: center;">(d) Management and General Expenses</th> <th style="text-align: center;">(e) Fundraising Expenses</th> </tr> </thead> <tbody> <tr> <td>CONSULTATION FEES</td> <td style="text-align: right;">35,635</td> <td style="text-align: right;">2,000</td> <td style="text-align: right;">33,635</td> <td></td> </tr> <tr> <td>CREDENTIALING FEE EXPENSE</td> <td style="text-align: right;">8,357</td> <td style="text-align: right;">0</td> <td style="text-align: right;">8,357</td> <td></td> </tr> <tr> <td>CONTRACT SVCS-CORPORATE</td> <td style="text-align: right;">1,329,420</td> <td style="text-align: right;">1,329,420</td> <td></td> <td></td> </tr> <tr> <td>CONTRACT SERVICES</td> <td style="text-align: right;">2,095,884</td> <td style="text-align: right;">2,066,608</td> <td style="text-align: right;">29,276</td> <td></td> </tr> <tr> <td>CONTRACT LINEN SERV</td> <td style="text-align: right;">113,637</td> <td style="text-align: right;">113,637</td> <td style="text-align: right;">0</td> <td></td> </tr> <tr> <td>COLLECTION FEES</td> <td style="text-align: right;">22,330</td> <td style="text-align: right;">22,330</td> <td></td> <td></td> </tr> <tr> <td>CONTRACT PERSONNEL</td> <td style="text-align: right;">1,050,648</td> <td style="text-align: right;">1,050,648</td> <td style="text-align: right;">0</td> <td></td> </tr> <tr> <td>OTHER</td> <td style="text-align: right;">22,098</td> <td style="text-align: right;">22,098</td> <td style="text-align: right;">0</td> <td></td> </tr> </tbody> </table>	(a) Description	(b) Total Expenses	(c) Program Service Expenses	(d) Management and General Expenses	(e) Fundraising Expenses	CONSULTATION FEES	35,635	2,000	33,635		CREDENTIALING FEE EXPENSE	8,357	0	8,357		CONTRACT SVCS-CORPORATE	1,329,420	1,329,420			CONTRACT SERVICES	2,095,884	2,066,608	29,276		CONTRACT LINEN SERV	113,637	113,637	0		COLLECTION FEES	22,330	22,330			CONTRACT PERSONNEL	1,050,648	1,050,648	0		OTHER	22,098	22,098	0	
(a) Description	(b) Total Expenses	(c) Program Service Expenses	(d) Management and General Expenses	(e) Fundraising Expenses																																										
CONSULTATION FEES	35,635	2,000	33,635																																											
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CONTRACT LINEN SERV	113,637	113,637	0																																											
COLLECTION FEES	22,330	22,330																																												
CONTRACT PERSONNEL	1,050,648	1,050,648	0																																											
OTHER	22,098	22,098	0																																											
FORM 990, PART XII, LINE 2C - CHANGE OF OVERSIGHT PROCESS OR SELECTION PROCESS	AS A RESULT OF THE AFFILIATION OF NAVICENT HEALTH, INC. WITH ATRIUM HEALTH, THE SELECTION OF THE AUDITOR IS NOW DETERMINED BY THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY.																																													

**SCHEDULE R
(Form 990)**

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 33, 34, 35b, 36, or 37.
▶ Attach to Form 990.

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

OMB No. 1545-0047

2019

**Open to Public
Inspection**

Name of the organization

THE MEDICAL CENTER OF PEACH COUNTY, INC.

Employer identification number

45-3765471

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
(1) -----					
(2) -----					
(3) -----					
(4) -----					
(5) -----					
(6) -----					

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) NAVICENT HEALTH, INC (58-2149127) 777 HEMLOCK STREET, MSC 111, MACON, GA 31201	PARENT COMPANY/STRATEGIC & FINANCIAL MANAGEMENT	GA	501(C)(3)	12 TYPE III-FI	AHNN GEORGIA, INC.		✓
(2) CENTRAL GEORGIA SENIOR HEALTH, INC. (58-2345439) 777 HEMLOCK STREET, MSC 111, MACON, GA 31201	CONTINUING CARE RETIREMENT COMMUNITY	GA	501(C)(3)	12 TYPE II	NAVICENT HEALTH, INC.		✓
(3) MEDICAL CENTER OF CENTRAL GEORGIA, IINC (58-2149128) 777 HEMLOCK STREET, MSC 111, MACON, GA 31201	HOSPITAL	GA	501(C)(3)	3	NAVICENT HEALTH, INC.		✓
(4) HEALTH SERVICES OF CENTRAL GEORGIA, INC (58-2307485) 777 HEMLOCK STREET, MSC 111, MACON, GA 31201	HEALTHCARE SERVICES	GA	501(C)(3)	3	NAVICENT HEALTH, INC.		✓
(5) NAVICENT HEALTH BALDWIN, INC. (82-3914925) 777 HEMLOCK STREET, MSC 111, MACON, GA 31204	HOSPITAL	GA	501(C)(3)	3	NAVICENT HEALTH, INC.		✓
(6) AHNN GEORGIA, INC. (83-1707383) PO BOX 32861, CHARLOTTE, NC 28232-2861	SOLE MEMBER NAVICENT HEALTH	NC	501(C)(3)	7	THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY		✓
(7) THE CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY (58-0529945) 1000 BLYTHE BLVD., CHARLOTTE, NC 28203	HEALTHCARE	NC			N/A		✓

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

Cat. No. 50135Y

Schedule R (Form 990) 2019

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) (SEE STATEMENT)												
(2)												
(3)												
(4)												
(5)												
(6)												
(7)												

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
(1) (SEE STATEMENT)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									

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

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

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

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

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

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) Disproportionate allocations?		(i) Code V-UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
				Yes	No			Yes	No		Yes	No	
(1)													
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													
(11)													
(12)													
(13)													
(14)													
(15)													
(16)													

Part III

Identification of Related Organizations Taxable as a Partnership (continued)

(a) Name, address and EIN of related organization	(b) Primary Activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Predominant income related, unrelated, excluded from tax under sections 512-514	(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V - UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) SECURE HEALTH PLANS OF GEORGIA, LLC (58-2306549) 577 MULBERRY STREET, SUITE 1000, MACON, GA 31201	MANAGED CARE	GA	N/A	N/A	N/A	N/A			N/A			N/A
(2) CENTRAL GEORGIA PET, LLC (37-1464470) 1650 HARDEMAN AVE., MACON, GA 31201	MEDICAL IMAGING CENTER	GA	N/A	N/A	N/A	N/A			N/A			N/A
(3) COWLES CLINIC REALTY, LLC (81-0636590) 1000 COWLES CLINIC WAY #C100, GREENSBORO, GA 30642	REAL ESTATE	GA	N/A	N/A	N/A	N/A			N/A			N/A

Part IV**Identification of Related Organizations Taxable as a Corporation or Trust (continued)**

(a) Name, address and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C-corp, S-corp or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
(1) CENTRAL GEORGIA HEALTH VENTURES, INC. (58-2164989) 777 HEMLOCK STREET, MSC 111, MACON, GA 31201	HOME CARE MANAGEMENT SERVICE	GA	N/A	C CORPORATION	N/A	N/A	N/A		✓
(2) CENTRA PROFESSIONAL INDEMNITY, LTD. P.O. BOX 1363, GRAND CAYMAN, CJ	SELF-INSURANCE	CAYMAN ISLANDS	N/A	C CORPORATION	N/A	N/A	N/A		✓
(3) NAVICENT HEALTHPLAN, INC. (20-2467391) 777 HEMLOCK STREET, MSC 111, MACON, GA 31201	INSURANCE	GA	N/A	C CORPORATION	N/A	N/A	N/A		✓

Exempt Organization Declaration and Signature for Electronic Filing

For calendar year 2019, or tax year beginning _____, 2019, and ending _____, 20_____

2019

Department of the Treasury
Internal Revenue Service

For use with Forms 990, 990-EZ, 990-PF, 1120-POL, and 8868

Name of exempt organization

THE MEDICAL CENTER OF PEACH COUNTY, INC.

Employer identification number

45-3765471

Part I Type of Return and Return Information (Whole Dollars Only)

Check the box for the type of return being filed with Form 8453-EO and enter the applicable amount, if any, from the return. If you check the box on line 1a, 2a, 3a, 4a, or 5a below and the amount on that line of the return being filed with this form was blank, then leave line 1b, 2b, 3b, 4b, or 5b, whichever is applicable, blank (do not enter -0-). If you entered -0- on the return, then enter -0- on the applicable line below. Do not complete more than one line in Part I.

1a	Form 990 check here	<input checked="" type="checkbox"/>	b	Total revenue, if any (Form 990, Part VIII, column (A), line 12)	1b	20,808,665
2a	Form 990-EZ check here	<input type="checkbox"/>	b	Total revenue, if any (Form 990-EZ, line 9)	2b	
3a	Form 1120-POL check here	<input type="checkbox"/>	b	Total tax (Form 1120-POL, line 22)	3b	
4a	Form 990-PF check here	<input type="checkbox"/>	b	Tax based on investment income (Form 990-PF, Part VI, line 5)	4b	
5a	Form 8868 check here	<input type="checkbox"/>	b	Balance due (Form 8868, line 3c)	5b	

Part II Declaration of Officer

- 6 I authorize the U.S. Treasury and its designated Financial Agent to initiate an Automated Clearing House (ACH) electronic funds withdrawal (direct debit) entry to the financial institution account indicated in the tax preparation software for payment of the organization's federal taxes owed on this return, and the financial institution to debit the entry to this account. To revoke a payment, I must contact the U.S. Treasury Financial Agent at 1-888-353-4537 no later than 2 business days prior to the payment (settlement) date. I also authorize the financial institutions involved in the processing of the electronic payment of taxes to receive confidential information necessary to answer inquiries and resolve issues related to the payment.
- If a copy of this return is being filed with a state agency(ies) regulating charities as part of the IRS Fed/State program, I certify that I executed the electronic disclosure consent contained within this return allowing disclosure by the IRS of this Form 990/990-EZ/990-PF (as specifically identified in Part I above) to the selected state agency(ies).

Under penalties of perjury, I declare that I am an officer of the above named organization and that I have examined a copy of the organization's 2019 electronic return and accompanying schedules and statements, and, to the best of my knowledge and belief, they are true, correct, and complete. I further declare that the amount in Part I above is the amount shown on the copy of the organization's electronic return. I consent to allow my intermediate service provider, transmitter, or electronic return originator (ERO) to send the organization's return to the IRS and to receive from the IRS (a) an acknowledgement of receipt or reason for rejection of the transmission, (b) the reason for any delay in processing the return or refund, and (c) the date of any refund.

Sign Here Date EXECUTIVE VICE PRESIDENT/CFO
Signature of officer Title

Part III Declaration of Electronic Return Originator (ERO) and Paid Preparer (see instructions)

I declare that I have reviewed the above organization's return and that the entries on Form 8453-EO are complete and correct to the best of my knowledge. If I am only a collector, I am not responsible for reviewing the return and only declare that this form accurately reflects the data on the return. The organization officer will have signed this form before I submit the return. I will give the officer a copy of all forms and information to be filed with the IRS, and have followed all other requirements in Pub. 4163, Modernized e-File (MeF) Information for Authorized IRS e-file Providers for Business Returns. If I am also the Paid Preparer, under penalties of perjury I declare that I have examined the above organization's return and accompanying schedules and statements, and, to the best of my knowledge and belief, they are true, correct, and complete. This Paid Preparer declaration is based on all information of which I have any knowledge.

ERO's Use Only	ERO's signature	Date 11-10-20	Check if also paid preparer <input type="checkbox"/>	Check if self-employed <input type="checkbox"/>	ERO's SSN or PTIN
	Firm's name (or yours if self-employed), address, and ZIP code	EIN			
					Phone no.

Under penalties of perjury, I declare that I have examined the above return and accompanying schedules and statements, and, to the best of my knowledge and belief, they are true, correct, and complete. Declaration of preparer is based on all information of which the preparer has any knowledge.

Paid Preparer Use Only	Print/Type preparer's name W. EDWARD PHILLIPS	Preparer's signature	Date 11/10/2019	Check if self-employed <input type="checkbox"/>	PTIN P00451499
	Firm's name	Firm's EIN			58-0914992
	Firm's address	Phone no.			