

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

# Return of Organization Exempt From Income Tax

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

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

Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047  
**2021**  
Open to Public Inspection

**A For the 2021 calendar year, or tax year beginning 07-01-2021, and ending 06-30-2022**

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

**C** Name of organization  
The Medical Center Inc  
% MARIE GAFFNEY  
Doing business as  
PIEDMONT COLUMBUS REGIONAL - MIDTOWN  
Number and street (or P.O. box if mail is not delivered to street address) Room/suite  
710 Center Street  
City or town, state or province, country, and ZIP or foreign postal code  
Columbus, GA 31901

**D** Employer identification number  
58-1685139  
**E** Telephone number  
(706) 660-6103

**F** Name and address of principal officer:  
MR M SCOTT HILL  
710 Center Street  
Columbus, GA 31901

**H(a)** Is this a group return for subordinates?  Yes  No  
**H(b)** Are all subordinates included?  Yes  No  
If "No," attach a list. See instructions.  
**H(c)** Group exemption number ▶

**I** Tax-exempt status:  501(c)(3)  501(c) ( ) ◀ (insert no.)  4947(a)(1) or  527  
**J** Website: ▶ WWW.PIEDMONT.ORG

**G** Gross receipts \$ 553,926,472

**K** Form of organization:  Corporation  Trust  Association  Other ▶

**L** Year of formation: 1986

**M** State of legal domicile: GA

**Part I Summary**

**1** Briefly describe the organization's mission or most significant activities:  
TO PROMOTE THE HEALTH AND HEALING OF OUR PATIENTS AND TO COORDINATE DELIVERY OF CLINICAL CARE.

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

<b>3</b> Number of voting members of the governing body (Part VI, line 1a)	12
<b>4</b> Number of independent voting members of the governing body (Part VI, line 1b)	9
<b>5</b> Total number of individuals employed in calendar year 2021 (Part V, line 2a)	2,464
<b>6</b> Total number of volunteers (estimate if necessary)	9
<b>7a</b> Total unrelated business revenue from Part VIII, column (C), line 12	117,375
<b>7b</b> Net unrelated business taxable income from Form 990-T, Part I, line 11	0

	Prior Year	Current Year
<b>8</b> Contributions and grants (Part VIII, line 1h)	18,978,839	4,976,787
<b>9</b> Program service revenue (Part VIII, line 2g)	449,127,974	488,966,464
<b>10</b> Investment income (Part VIII, column (A), lines 3, 4, and 7d)	11,986,994	19,099,538
<b>11</b> Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	31,800,092	40,883,683
<b>12</b> Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	511,893,899	553,926,472
<b>13</b> Grants and similar amounts paid (Part IX, column (A), lines 1–3)	0	0
<b>14</b> Benefits paid to or for members (Part IX, column (A), line 4)	0	0
<b>15</b> Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	163,588,314	199,633,192
<b>16a</b> Professional fundraising fees (Part IX, column (A), line 11e)	0	0
<b>b</b> Total fundraising expenses (Part IX, column (D), line 25) ▶ 0		
<b>17</b> Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	294,610,946	317,079,062
<b>18</b> Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	458,199,260	516,712,254
<b>19</b> Revenue less expenses. Subtract line 18 from line 12	53,694,639	37,214,218
	Beginning of Current Year	End of Year
<b>20</b> Total assets (Part X, line 16)	425,123,531	341,366,797
<b>21</b> Total liabilities (Part X, line 26)	350,100,298	430,456,116
<b>22</b> Net assets or fund balances. Subtract line 21 from line 20	75,023,233	-89,089,319

**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: 2023-05-11  
MARIE GAFFNEY VP CORPORATE FINANCE  
Type or print name and title

**Paid Preparer Use Only**  
Print/Type preparer's name: Preparer's signature: Date: 2023-05-10  
Check  if self-employed PTIN: P01048557  
Firm's name ▶ KPMG LLP Firm's EIN ▶  
Firm's address ▶ 500 W 5TH ST STE 800 Winston Salem, NC 27101 Phone no. (336) 275-3394

**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:

TO PROVIDE HEALTHCARE MARKED BY COMPASSION AND SUSTAINABLE EXCELLENCE IN A PROGRESSIVE ENVIRONMENT, GUIDED BY PHYSICIANS, DELIVERED BY PROFESSIONALS, AND INSPIRED BY THE COMMUNITIES WE SERVE.

**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 \$ 480,648,783 including grants of \$ 0 ) (Revenue \$ 529,084,634 )  
See Additional Data

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

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

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

**4e** Total program service expenses ▶ 480,648,783

**Part IV Checklist of Required Schedules**

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

Part IV Checklist of Required Schedules (continued)

Table with 3 columns: Question/Description, Yes, No. Rows 22-38 covering various organizational requirements and schedules.

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 [checked]

Table with 3 columns: Question/Description, Yes, No. Rows 1a, 1b, 1c regarding Form 1096, Forms W-2G, and backup withholding rules.

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

Table with 5 main columns: Question ID, Question Text, Answer Field, Yes/No, and Other. Rows include questions 2a through 17 regarding employee reporting, federal employment tax returns, unrelated business gross income, foreign accounts, prohibited tax shelter transactions, charitable contributions, and various organizational requirements.

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



Section A. Governing Body and Management

Table with 3 columns: Question, Yes, No. Rows include: 1a (12), 1b (9), 2, 3, 4, 5, 6, 7a, 7b, 8a, 8b, 9.

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

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

Section C. Disclosure

- 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 Form 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.
19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
20 State the name, address, and telephone number of the person who possesses the organization's books and records:
MARIE GAFFNEY 2727 PACES FERRY RD BLDG 2 STE 70 ATLANTA, GA 30339 (470) 271-6007

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

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

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

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

- List all of the organization's **current** officers, directors, trustees (whether individuals or organizations), regardless of amount of compensation. Enter -0- in columns (D), (E), and (F) if no compensation was paid.
- List all of the organization's **current** key employees, if any. See the instructions for definition of "key employee."
- List the organization's five **current** highest compensated employees (other than an officer, director, trustee or key employee) who received reportable compensation (box 5 of Form W-2, Form 1099-MISC, and/or box 1 of Form 1099-NEC) of more than \$100,000 from the organization and any related organizations.
- List all of the organization's **former** officers, key employees, or highest compensated employees who received more than \$100,000 of reportable compensation from the organization and any related organizations.
- List all of the organization's **former directors or trustees** that received, in the capacity as a former director or trustee of the organization, more than \$10,000 of reportable compensation from the organization and any related organizations.

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

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below 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/1099-NEC)	(E) Reportable compensation from related organizations (W-2/1099-MISC/1099-NEC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
(1) MR MICHAEL MANDL BOARD MEMBER	1.0 54.0	X					0	1,529,720	193,580	
(2) Mr M Scott Hill Board Member & CEO CRHS	5.0 50.0	X		X			0	1,242,492	133,237	
(3) Mr Thomas Arnold TREASURER/CFO PHC	1.0 54.0			X			0	1,131,535	124,798	
(4) Dr Peter Jiang Physician	55.0 0.0					X	1,177,348	0	38,686	
(5) Ms Elizabeth Leddy SECRETARY/CLO PHC	1.0 54.0			X			0	883,982	140,202	
(6) Mr Michael McAnder FORMER TREASURER/CFO PHC	0.0 0.0					X	0	972,687	0	
(7) Dr Mukesh Kumar Physician	55.0 0.0					X	925,587	0	30,415	
(8) Dr Andrew Pippas Physician	55.0 0.0					X	905,036	0	36,090	
(9) Dr Suresh Nukala Physician	55.0 0.0					X	869,678	0	35,852	
(10) Dr Shania Seibles Physician	55.0 0.0					X	755,078	0	25,619	
(11) Dr Todd Jarrell MD Board Member	1.0 54.0	X					0	668,337	32,923	
(12) MR ALLEN HOLLADAY CFO	5.0 50.0					X	0	436,684	18,586	
(13) Mr William Tustin COO	5.0 50.0					X	405,576	0	33,780	
(14) Mr John Dale Hester BOARD MEMBER/Chair	1.0 3.0	X		X			0	0	0	
(15) Dr Shane Darrah MD Board Member	1.0 3.0	X					0	0	0	
(16) Mr Joey Loudermilk Board Member	1.0 3.0	X					0	0	0	
(17) Dr Susan McWhirter MD Board Member	1.0 3.0	X					0	0	0	

**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/1099-NEC)	(E) Reportable compensation from related organizations (W-2/1099-MISC/1099-NEC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
(18) Dr William Roundtree MD ..... Board Member	1.0 ..... 3.0	X						0	0	0
(19) Dr Beverly Townsend MD ..... Board Member	1.0 ..... 3.0	X						0	0	0
(20) Mr Travis Wade ..... Board Member	1.0 ..... 3.0	X						0	0	0
(21) MS REBECCA RUMER ..... BOARD MEMBER	1.0 ..... 3.0	X						0	0	0
(22) MR WARREN STEELE ..... BOARD MEMBER	1.0 ..... 3.0	X						0	0	0
<b>1b Sub-Total</b> . . . . .										
<b>c Total from continuation sheets to Part VII, Section A</b> . . . . .										
<b>d Total (add lines 1b and 1c)</b> . . . . .								5,038,303	6,865,437	843,768

**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 ▶ 182

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

**Section B. Independent Contractors**

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

(A) Name and business address	(B) Description of services	(C) Compensation
MEDICAL SOLUTIONS LLC, 1010 N 102ND ST OMAHA, NE 68114	NURSING SERVICES	15,462,138
MUSCOGEE HOSPITALIST SERVICES LLC, 710 CENTER ST COLUMBUS, GA 31909	HOSPITALIST SERVICES	8,649,841
AMSOL ANESTHETISTS OF GEORGIA LLC, 100 FIRST CT COLUMBUS, GA 31909	ANESTHESIA SERVICES	4,346,174
HMMG LLC, 6262 Veterans Pkwy COLUMBUS, GA 31909	Consulting Services	2,929,009
GA RADIOLOGY IMAGING CONSULTANTS SC, 710 Center St COLUMBUS, GA 31909	Imaging Services	2,654,673

**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 ▶ 28



**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	
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1a</b> Federated campaigns . . . . .	<b>1a</b>					
	<b>b</b> Membership dues . . . . .	<b>1b</b>					
	<b>c</b> Fundraising events . . . . .	<b>1c</b>					
	<b>d</b> Related organizations . . . . .	<b>1d</b>					
	<b>e</b> Government grants (contributions)	<b>1e</b>	4,976,787				
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above	<b>1f</b>					
	<b>g</b> Noncash contributions included in lines 1a - 1f:\$	<b>1g</b>					
	<b>h Total.</b> Add lines 1a-1f . . . . .			4,976,787			
<b>Program Service Revenue</b>	<b>2a</b> PATIENT SERVICE	Business Code 621110	488,849,089	488,849,089			
	<b>b</b> OUTSIDE LAB REVENUE	621500	117,375		117,375		
	<b>c</b>						
	<b>d</b>						
	<b>e</b>						
	<b>f</b> All other program service revenue.						
	<b>g Total.</b> Add lines 2a-2f. . . . .		488,966,464				
<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts) . . . . .		19,099,538			19,099,538	
	<b>4</b> Income from investment of tax-exempt bond proceeds . . . . .		0				
	<b>5</b> Royalties . . . . .		0				
	<b>6a</b> Gross rents	(i) Real	765,513				
		(ii) Personal					
		<b>b</b> Less: rental expenses	<b>6b</b>				
		<b>c</b> Rental income or (loss)	<b>6c</b>	765,513	0		
	<b>d</b> Net rental income or (loss) . . . . .			765,513		765,513	
	<b>7a</b> Gross amount from sales of assets other than inventory	(i) Securities					
		(ii) Other					
		<b>b</b> Less: cost or other basis and sales expenses	<b>7b</b>				
		<b>c</b> Gain or (loss)	<b>7c</b>				
	<b>d</b> Net gain or (loss) . . . . .			0			
	<b>8a</b> Gross income from fundraising events (not including \$ _____ of contributions reported on line 1c). See Part IV, line 18 . . . . .						
		<b>8a</b>		0			
<b>b</b> Less: direct expenses . . . . .		<b>8b</b>		0			
<b>c</b> Net income or (loss) from fundraising events . . . . .			0				
<b>9a</b> Gross income from gaming activities. See Part IV, line 19 . . . . .							
	<b>9a</b>		0				
	<b>b</b> Less: direct expenses . . . . .	<b>9b</b>		0			
<b>c</b> Net income or (loss) from gaming activities . . . . .			0				
<b>10a</b> Gross sales of inventory, less returns and allowances . . . . .							
	<b>10a</b>		0				
	<b>b</b> Less: cost of goods sold . . . . .	<b>10b</b>		0			
<b>c</b> Net income or (loss) from sales of inventory . . . . .			0				
<b>11a</b> OTHER REVENUE		Business Code 900099	40,118,170	40,118,170			
<b>b</b>							
<b>c</b>							
<b>d</b> All other revenue . . . . .							
<b>e Total.</b> Add lines 11a-11d . . . . .			40,118,170				
<b>12 Total revenue.</b> See instructions . . . . .			553,926,472	528,967,259	117,375	19,865,051	

**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
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21 . . . . .	0			
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22 . . . . .	0			
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16. . . . .	0			
<b>4</b> Benefits paid to or for members . . . . .	0			
<b>5</b> Compensation of current officers, directors, trustees, and key employees . . . . .	401,173	332,974	68,199	
<b>6</b> Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) . . . . .	0			
<b>7</b> Other salaries and wages . . . . .	168,755,156	140,066,779	28,688,377	
<b>8</b> Pension plan accruals and contributions (include section 401 (k) and 403(b) employer contributions) . . . . .	0			
<b>9</b> Other employee benefits . . . . .	21,244,845	17,633,221	3,611,624	
<b>10</b> Payroll taxes . . . . .	9,232,018	7,662,575	1,569,443	
<b>11</b> Fees for services (non-employees):				
<b>a</b> Management . . . . .	98,764		98,764	
<b>b</b> Legal . . . . .	0			
<b>c</b> Accounting . . . . .	0			
<b>d</b> Lobbying . . . . .	0			
<b>e</b> Professional fundraising services. See Part IV, line 17	0			
<b>f</b> Investment management fees . . . . .	0			
<b>g</b> Other (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O)	14,307,539	14,307,539		
<b>12</b> Advertising and promotion . . . . .	44		44	
<b>13</b> Office expenses . . . . .	1,283,734	1,274,020	9,714	
<b>14</b> Information technology . . . . .	0			
<b>15</b> Royalties . . . . .	0			
<b>16</b> Occupancy . . . . .	11,365,811	10,911,179	454,632	
<b>17</b> Travel . . . . .	86,709	56,435	30,274	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials . . . . .	0			
<b>19</b> Conferences, conventions, and meetings . . . . .	0			
<b>20</b> Interest . . . . .	5,686,270	5,515,682	170,588	
<b>21</b> Payments to affiliates . . . . .	0			
<b>22</b> Depreciation, depletion, and amortization . . . . .	12,066,645	11,342,647	723,998	
<b>23</b> Insurance . . . . .	4,925,730	4,630,186	295,544	
<b>24</b> Other expenses. Itemize expenses not covered above (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
<b>a</b> MEDICAL SUPPLIES & DRUGS	116,923,104	116,923,104		
<b>b</b> INTERCOMPANY ALLOCATIONS	67,341,444	67,341,444		
<b>c</b> BAD DEBT EXPENSE	47,669,813	47,669,813		
<b>d</b> PHYSICIAN SUPPORT	29,618,968	29,618,968		
<b>e</b> All other expenses	5,704,487	5,362,217	342,270	
<b>25</b> Total functional expenses. Add lines 1 through 24e	516,712,254	480,648,783	36,063,471	0
<b>26</b> Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720).				

**Part X Balance Sheet**

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

		(A) Beginning of year		(B) End of year
<b>Assets</b>	<b>1</b> Cash—non-interest-bearing . . . . .	325,952	<b>1</b>	325,807
	<b>2</b> Savings and temporary cash investments . . . . .	0	<b>2</b>	0
	<b>3</b> Pledges and grants receivable, net . . . . .	0	<b>3</b>	0
	<b>4</b> Accounts receivable, net . . . . .	76,426,318	<b>4</b>	146,912,021
	<b>5</b> 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	<b>5</b>	0
	<b>6</b> 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	<b>6</b>	0
	<b>7</b> Notes and loans receivable, net . . . . .	0	<b>7</b>	0
	<b>8</b> Inventories for sale or use . . . . .	9,729,630	<b>8</b>	10,136,831
	<b>9</b> Prepaid expenses and deferred charges . . . . .	5,586,177	<b>9</b>	6,435,788
	<b>10a</b> Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	<b>10a</b> 217,235,976		
	<b>b</b> Less: accumulated depreciation	<b>10b</b> 55,431,442	148,212,183	<b>10c</b> 161,804,534
	<b>11</b> Investments—publicly traded securities . . . . .	148,757,413	<b>11</b>	0
	<b>12</b> Investments—other securities. See Part IV, line 11 . . . . .	0	<b>12</b>	0
	<b>13</b> Investments—program-related. See Part IV, line 11 . . . . .	11,365,439	<b>13</b>	12,852,377
	<b>14</b> Intangible assets . . . . .	0	<b>14</b>	0
	<b>15</b> Other assets. See Part IV, line 11 . . . . .	24,720,419	<b>15</b>	2,899,439
<b>16 Total assets.</b> Add lines 1 through 15 (must equal line 33) . . . . .	425,123,531	<b>16</b>	341,366,797	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses . . . . .	56,249,404	<b>17</b>	163,549,111
	<b>18</b> Grants payable . . . . .	0	<b>18</b>	0
	<b>19</b> Deferred revenue . . . . .	0	<b>19</b>	0
	<b>20</b> Tax-exempt bond liabilities . . . . .	287,112,381	<b>20</b>	178,606,343
	<b>21</b> Escrow or custodial account liability. Complete Part IV of Schedule D	0	<b>21</b>	0
	<b>22</b> 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	<b>22</b>	0
	<b>23</b> Secured mortgages and notes payable to unrelated third parties . . . . .	0	<b>23</b>	0
	<b>24</b> Unsecured notes and loans payable to unrelated third parties . . . . .	0	<b>24</b>	0
	<b>25</b> 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	6,738,513	<b>25</b>	88,300,662
	<b>26 Total liabilities.</b> Add lines 17 through 25 . . . . .	350,100,298	<b>26</b>	430,456,116
<b>Net Assets or Fund Balances</b>	<b>Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/> and complete lines 27, 28, 32, and 33.</b>			
	<b>27</b> Net assets without donor restrictions . . . . .	75,023,233	<b>27</b>	-89,089,319
	<b>28</b> Net assets with donor restrictions . . . . .	0	<b>28</b>	0
	<b>Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/> and complete lines 29 through 33.</b>			
	<b>29</b> Capital stock or trust principal, or current funds . . . . .		<b>29</b>	
	<b>30</b> Paid-in or capital surplus, or land, building or equipment fund . . . . .		<b>30</b>	
	<b>31</b> Retained earnings, endowment, accumulated income, or other funds		<b>31</b>	
<b>32</b> Total net assets or fund balances . . . . .	75,023,233	<b>32</b>	-89,089,319	
<b>33</b> Total liabilities and net assets/fund balances . . . . .	425,123,531	<b>33</b>	341,366,797	

**Part XI Reconciliation of Net Assets**

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	553,926,472
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	516,712,254
<b>3</b>	Revenue less expenses. Subtract line 2 from line 1	<b>3</b>	37,214,218
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	<b>4</b>	75,023,233
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	29,510,325
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	-63,684,875
<b>9</b>	Other changes in net assets or fund balances (explain in Schedule O)	<b>9</b>	-167,152,220
<b>10</b>	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	<b>10</b>	-89,089,319

**Part XII Financial Statements and Reporting**

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

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

		Yes	No
<b>2a</b>			No
<b>2b</b>	Yes		
<b>2c</b>	Yes		
<b>3a</b>			No
<b>3b</b>			

## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 58-1685139

**Name:** The Medical Center Inc

Form 990 (2021)

---

**Form 990, Part III, Line 4a:**

THE MEDICAL CENTER ("TMC") IS A 583-BED FACILITY THAT SERVES THE CITY OF COLUMBUS IN MUSCOGEE COUNTY, GEORGIA, AND 20 OTHER COUNTIES IN GEORGIA AND 2 IN EAST ALABAMA. OUR PRIMARY CARE AND SPECIALTY PHYSICIANS ON THE MEDICAL STAFF MEET THE PROFESSIONAL CLINICAL NEEDS OF CHILDREN, ADULTS, AND SENIORS WITHIN THE CITY AND THE GREATER COLUMBUS MARKET, REGARDLESS OF ANY INDIVIDUAL'S ABILITY TO PAY FOR SERVICES. FOR THE YEAR ENDED JUNE 30, 2022, THE HOSPITAL HAD 14,916 IN-PATIENT ADMISSIONS WITH A TOTAL OF 92,097 DAYS OF IN-PATIENT HOSPITALIZATION. ER VISITS TOTALED 82,254 AND OUTPATIENT VISITS TOTALED 133,280. SURGICAL SERVICES WERE PROVIDED TO 8,459 PATIENTS.

---

**SCHEDULE A**  
**(Form 990)**

Department of the Treasury  
Internal Revenue Service

**Public Charity Status and Public Support**

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

OMB No. 1545-0047

**2021**

**Open to Public Inspection**

<b>Name of the organization</b> The Medical Center Inc	<b>Employer identification number</b> 58-1685139
---	---

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

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

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

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

**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 failed to qualify under the tests listed below, please complete Part III.)

**Section A. Public Support**

Calendar year (or fiscal year beginning in) ▶		(a) 2017	(b) 2018	(c) 2019	(d) 2020	(e) 2021	(f) Total
<b>1</b>	Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grant.") . . .						
<b>2</b>	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . . .						
<b>3</b>	The value of services or facilities furnished by a governmental unit to the organization without charge..						
<b>4</b>	<b>Total.</b> Add lines 1 through 3						
<b>5</b>	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) . . .						
<b>6</b>	<b>Public support.</b> Subtract line 5 from line 4.						

**Section B. Total Support**

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

**Section C. Computation of Public Support Percentage**

<b>14</b>	Public support percentage for 2021 (line 6, column (f) divided by line 11, column (f)) . . . . .	<b>14</b>	
<b>15</b>	Public support percentage for 2020 Schedule A, Part II, line 14 . . . . .	<b>15</b>	
<b>16a</b>	<b>33 1/3% support test—2021.</b> If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and <b>stop here.</b> The organization qualifies as a publicly supported organization . . . . . ▶ <input type="checkbox"/>		
<b>b</b>	<b>33 1/3% support test—2020.</b> 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 <b>stop here.</b> The organization qualifies as a publicly supported organization . . . . . ▶ <input type="checkbox"/>		
<b>17a</b>	<b>10%-facts-and-circumstances test—2021.</b> 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 <b>stop here.</b> 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>b</b>	<b>10%-facts-and-circumstances test—2020.</b> 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 <b>stop here.</b> 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>18</b>	<b>Private foundation.</b> 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) 2017	(b) 2018	(c) 2019	(d) 2020	(e) 2021	(f) Total
<b>1</b>	Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.") .						
<b>2</b>	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						
<b>3</b>	Gross receipts from activities that are not an unrelated trade or business under section 513 . . . . .						
<b>4</b>	Tax revenues levied for the organization's benefit and either paid to or expended on its behalf. . .						
<b>5</b>	The value of services or facilities furnished by a governmental unit to the organization without charge						
<b>6</b>	<b>Total.</b> Add lines 1 through 5						
<b>7a</b>	Amounts included on lines 1, 2, and 3 received from disqualified persons						
<b>b</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.						
<b>c</b>	Add lines 7a and 7b. . . . .						
<b>8</b>	<b>Public support.</b> (Subtract line 7c from line 6.)						

**Section B. Total Support**

Calendar year (or fiscal year beginning in) ►		(a) 2017	(b) 2018	(c) 2019	(d) 2020	(e) 2021	(f) Total
<b>9</b>	Amounts from line 6. . . . .						
<b>10a</b>	Gross income from interest, dividends, payments received on securities loans, rents, royalties and income from similar sources. . .						
<b>b</b>	Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975.						
<b>c</b>	Add lines 10a and 10b.						
<b>11</b>	Net income from unrelated business activities not included on line 10b, whether or not the business is regularly carried on.						
<b>12</b>	Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.) . . . . .						
<b>13</b>	<b>Total support.</b> (Add lines 9, 10c, 11, and 12.) . . . . .						

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

**Section C. Computation of Public Support Percentage**

<b>15</b>	Public support percentage for 2021 (line 8, column (f) divided by line 13, column (f)) . . . . .	<b>15</b>	
<b>16</b>	Public support percentage from 2020 Schedule A, Part III, line 15 . . . . .	<b>16</b>	

**Section D. Computation of Investment Income Percentage**

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

**19a 33 1/3% support tests—2021.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . .

**b 33 1/3% support tests—2020.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3% and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization . . . . .

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



**Part IV Supporting Organizations**

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

**Section A. All Supporting Organizations**

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

**Part IV Supporting Organizations** (continued)

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

**Section B. Type I Supporting Organizations**

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

**Section C. Type II Supporting Organizations**

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

**Section D. All Type III Supporting Organizations**

		Yes	No
<b>1</b>	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?		
<b>2</b>	Were any of the organization's officers, directors, or trustees either (i) appointed or elected by the supported organization (s) or (ii) serving on the governing body of a supported organization? <i>If "No," explain in Part VI how the organization maintained a close and continuous working relationship with the supported organization(s).</i>		
<b>3</b>	By reason of the relationship described in line 2 above, did the organization's supported organizations have a significant voice in the organization's investment policies and in directing the use of the organization's income or assets at all times during the tax year? <i>If "Yes," describe in Part VI the role the organization's supported organizations played in this regard.</i>		

**Section E. Type III Functionally-Integrated Supporting Organizations**

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

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

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

<b>Section A - Adjusted Net Income</b>		(A) Prior Year	(B) Current Year (optional)
<b>1</b>	Net short-term capital gain	<b>1</b>	
<b>2</b>	Recoveries of prior-year distributions	<b>2</b>	
<b>3</b>	Other gross income (see instructions)	<b>3</b>	
<b>4</b>	Add lines 1 through 3	<b>4</b>	
<b>5</b>	Depreciation and depletion	<b>5</b>	
<b>6</b>	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)	<b>6</b>	
<b>7</b>	Other expenses (see instructions)	<b>7</b>	
<b>8</b>	<b>Adjusted Net Income</b> (subtract lines 5, 6 and 7 from line 4)	<b>8</b>	
<b>Section B - Minimum Asset Amount</b>		(A) Prior Year	(B) Current Year (optional)
<b>1</b>	Aggregate fair market value of all non-exempt-use assets (see instructions for short tax year or assets held for part of year):	<b>1</b>	
<b>a</b>	Average monthly value of securities	<b>1a</b>	
<b>b</b>	Average monthly cash balances	<b>1b</b>	
<b>c</b>	Fair market value of other non-exempt-use assets	<b>1c</b>	
<b>d</b>	<b>Total</b> (add lines 1a, 1b, and 1c)	<b>1d</b>	
<b>e</b>	<b>Discount</b> claimed for blockage or other factors ( <i>explain in detail in Part VI</i> ):		
<b>2</b>	Acquisition indebtedness applicable to non-exempt use assets	<b>2</b>	
<b>3</b>	Subtract line 2 from line 1d	<b>3</b>	
<b>4</b>	Cash deemed held for exempt use. Enter 0.015 of line 3 (for greater amount, see instructions).	<b>4</b>	
<b>5</b>	Net value of non-exempt-use assets (subtract line 4 from line 3)	<b>5</b>	
<b>6</b>	Multiply line 5 by 0.035	<b>6</b>	
<b>7</b>	Recoveries of prior-year distributions	<b>7</b>	
<b>8</b>	<b>Minimum Asset Amount</b> (add line 7 to line 6)	<b>8</b>	
<b>Section C - Distributable Amount</b>			Current Year
<b>1</b>	Adjusted net income for prior year (from Section A, line 8, Column A)	<b>1</b>	
<b>2</b>	Enter 85% of line 1	<b>2</b>	
<b>3</b>	Minimum asset amount for prior year (from Section B, line 8, Column A)	<b>3</b>	
<b>4</b>	Enter greater of line 2 or line 3	<b>4</b>	
<b>5</b>	Income tax imposed in prior year	<b>5</b>	
<b>6</b>	<b>Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions)	<b>6</b>	
<b>7</b>	<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)

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

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

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

<b>Facts And Circumstances Test</b>

**SCHEDULE D**  
(Form 990)  
  
Department of the Treasury  
Internal Revenue Service

# Supplemental Financial Statements

OMB No. 1545-0047  
**2021**  
**Open to Public Inspection**

▶ **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](http://www.irs.gov/Form990) for instructions and the latest information.**

**Name of the organization**  
The Medical Center Inc

**Employer identification number**  
58-1685139

**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
<b>1</b> Total number at end of year . . . . .		
<b>2</b> Aggregate value of contributions to (during year)		
<b>3</b> Aggregate value of grants from (during year)		
<b>4</b> Aggregate value at end of year . . . . .		

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

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

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

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

Preservation of land for public use (e.g., recreation or education)       Preservation of an historically important land area

Protection of natural habitat       Preservation of a certified historic structure

Preservation of open space

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

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

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

**Part IV Escrow and Custodial Arrangements.**

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

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

**Part V Endowment Funds.**

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

	(a) Current year	(b) Prior year	(c) Two years back	(d) Three years back	(e) Four years back
<b>1a</b> Beginning of year balance . . . . .	613,831	613,831	613,831	613,831	613,831
<b>b</b> Contributions . . . . .					
<b>c</b> Net investment earnings, gains, and losses					
<b>d</b> Grants or scholarships . . . . .					
<b>e</b> Other expenditures for facilities and programs . . . . .					
<b>f</b> Administrative expenses . . . . .					
<b>g</b> End of year balance . . . . .	613,831	613,831	613,831	613,831	613,831

- 2** Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
- a** Board designated or quasi-endowment ▶ 0 %
  - b** Permanent endowment ▶ 0 %
  - c** Term endowment ▶ 100.000 %
- 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 |
|--|---------------|----|
| <b>(i)</b> Unrelated organizations . . . . .   | <b>3a(i)</b>  | No |
| <b>(ii)</b> Related organizations . . . . .  | <b>3a(ii)</b> | No |
| <b>b</b> If "Yes" on 3a(ii), are the related organizations listed as required on Schedule R? . . . . . | <b>3b</b>     |    |
- 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
<b>1a</b> Land . . . . .		0		0
<b>b</b> Buildings . . . . .		110,348,853	14,381,265	95,967,588
<b>c</b> Leasehold improvements		5,202,200	4,483,350	718,850
<b>d</b> Equipment . . . . .		75,869,759	33,398,476	42,471,283
<b>e</b> Other . . . . .		25,815,164	3,168,351	22,646,813
<b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10(c).) . . . ▶				161,804,534

**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)		
(C)		
(D)		
(E)		
(F)		
(G)		
(H)		
(H)		
<b>Total.</b> (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)		
(10)		
<b>Total.</b> (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)	
(10)	
<b>Total.</b> (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	0
(2) RECOUPMENTS PAYABLE	25,248,786
(3) INTERCOMPANY PAYABLE	63,051,876
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col.(B) line 25.)	88,300,662

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



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

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

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

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

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

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

**Part XIII Supplemental Information**

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

Return Reference	Explanation
See Additional Data Table	

**Part XIII** Supplemental Information *(continued)*

Return Reference	Explanation

## Additional Data

**Software ID:**

**Software Version:**

**EIN:** 58-1685139

**Name:** The Medical Center Inc

## Supplemental Information

Return Reference	Explanation
SCHEDULE D, PART V, LINE 4	OPERATIONS OF THE MEDICAL CENTER - TO BE USED FOR THE PEDIATRIC INTENSIVIST AND PET.

## Supplemental Information

Return Reference	Explanation
SCHEDULE D, PART X, LINE 2: ASC 740 FOOTNOTE (FKA FIN 48)	PHC ACCOUNTS FOR INCOME TAXES UNDER THE PROVISIONS OF ASC 740, INCOME TAXES (ASC 740). UNDER THE REQUIREMENTS OF ASC 740, TAX-EXEMPT ORGANIZATIONS MAY BE REQUIRED TO RECORD AN OBLIGATION AS THE RESULT OF A TAX POSITION THEY HAVE HISTORICALLY TAKEN ON VARIOUS UNCERTAIN TAX EXPOSURE ITEMS. THERE WERE NO MATERIAL UNCERTAIN TAX POSITIONS AT JUNE 30, 2022 AND 2021.

**SCHEDULE H  
(Form 990)**  
  
Department of the Treasury  
Internal Revenue Service

# Hospitals

OMB No. 1545-0047  
**2021**  
Open to Public Inspection

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

**Name of the organization**  
The Medical Center Inc

**Employer identification number**  
58-1685139

**Part I Financial Assistance and Certain Other Community Benefits at Cost**

	Yes	No
<b>1a</b> Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a . . . . .	Yes	
<b>1b</b> If "Yes," was it a written policy? . . . . .	Yes	
<b>2</b> 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		
<b>3</b> 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. <b>a</b> Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing <i>free</i> care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input checked="" type="checkbox"/> Other <u>300</u> %	Yes	
<b>b</b> Did the organization use FPG as a factor in determining eligibility for providing <i>discounted</i> care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: . . . . . <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input checked="" type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____ %	Yes	
<b>c</b> 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.		
<b>4</b> 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"? . . . . .	Yes	
<b>5a</b> Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year? . . . . .	Yes	
<b>b</b> If "Yes," did the organization's financial assistance expenses exceed the budgeted amount? . . . . .		No
<b>c</b> 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? . . . . .		
<b>6a</b> Did the organization prepare a community benefit report during the tax year? . . . . .	Yes	
<b>b</b> If "Yes," did the organization make it available to the public? . . . . .	Yes	

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

**7 Financial Assistance and Certain Other Community Benefits at Cost**

<b>Financial Assistance and Means-Tested Government Programs</b>	<b>(a)</b> Number of activities or programs (optional)	<b>(b)</b> Persons served (optional)	<b>(c)</b> Total community benefit expense	<b>(d)</b> Direct offsetting revenue	<b>(e)</b> Net community benefit expense	<b>(f)</b> Percent of total expense
<b>a</b> Financial Assistance at cost (from Worksheet 1) . . . . .			14,801,327		14,801,327	3.160 %
<b>b</b> Medicaid (from Worksheet 3, column a) . . . . .			16,602,214	17,134,052		
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b) . . . . .			8,016,709	13,271,791		
<b>d Total</b> Financial Assistance and Means-Tested Government Programs . . . . .			39,420,250	30,405,843	14,801,327	3.160 %
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4). . . . .			222,898		222,898	0.050 %
<b>f</b> Health professions education (from Worksheet 5) . . . . .			2,569,100		2,569,100	0.550 %
<b>g</b> Subsidized health services (from Worksheet 6) . . . . .						
<b>h</b> Research (from Worksheet 7) . . . . .						
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8) . . . . .						
<b>j Total.</b> Other Benefits . . . . .			2,791,998		2,791,998	0.600 %
<b>k Total.</b> Add lines 7d and 7j . . . . .			42,212,248	30,405,843	17,593,325	3.760 %

**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
<b>1</b> Physical improvements and housing						
<b>2</b> Economic development						
<b>3</b> Community support						
<b>4</b> Environmental improvements						
<b>5</b> Leadership development and training for community members						
<b>6</b> Coalition building						
<b>7</b> Community health improvement advocacy						
<b>8</b> Workforce development						
<b>9</b> Other						
<b>10 Total</b>						

**Part III Bad Debt, Medicare, & Collection Practices**

**Section A. Bad Debt Expense**

		Yes	No
<b>1</b> Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?		<b>1</b> Yes	
<b>2</b> Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.	<b>2</b>		
<b>3</b> 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.	<b>3</b> 10,206,198		
<b>4</b> Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

**Section B. Medicare**

<b>5</b> Enter total revenue received from Medicare (including DSH and IME)	<b>5</b> 79,711,175
<b>6</b> Enter Medicare allowable costs of care relating to payments on line 5	<b>6</b> 66,985,517
<b>7</b> Subtract line 6 from line 5. This is the surplus (or shortfall)	<b>7</b> 12,725,658
<b>8</b> Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: <input type="checkbox"/> Cost accounting system <input checked="" type="checkbox"/> Cost to charge ratio <input type="checkbox"/> Other	

**Section C. Collection Practices**

<b>9a</b> Did the organization have a written debt collection policy during the tax year?	<b>9a</b> Yes
<b>b</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	<b>9b</b> Yes

**Part IV Management Companies and Joint Ventures**

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

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

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

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

1

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

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

**Part V Facility Information** (continued)

**Section B. Facility Policies and Practices**

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

Name of hospital facility or letter of facility reporting group \_\_\_\_\_

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

		Yes	No
<b>Community Health Needs Assessment</b>			
<b>1</b>	Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? . . . . .		No
<b>2</b>	Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C. . . . .		No
<b>3</b>	During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12. . . . . If "Yes," indicate what the CHNA report describes (check all that apply):	Yes	
	<b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
	<b>b</b> <input checked="" type="checkbox"/> Demographics of the community		
	<b>c</b> <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		
	<b>d</b> <input checked="" type="checkbox"/> How data was obtained		
	<b>e</b> <input checked="" type="checkbox"/> The significant health needs of the community		
	<b>f</b> <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
	<b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
	<b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
	<b>i</b> <input type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
	<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
<b>4</b>	Indicate the tax year the hospital facility last conducted a CHNA: 20 <u>21</u>		
<b>5</b>	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 . . . . .	Yes	
<b>6 a</b>	Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C . . . . .	Yes	
<b>b</b>	Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?" If "Yes," list the other organizations in Section C. . . . .		No
<b>7</b>	Did the hospital facility make its CHNA report widely available to the public? . . . . . If "Yes," indicate how the CHNA report was made widely available (check all that apply):	Yes	
	<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>SEE PART V</u>		
	<b>b</b> <input type="checkbox"/> Other website (list url): _____		
	<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
	<b>d</b> <input checked="" type="checkbox"/> Other (describe in Section C)		
<b>8</b>	Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11. . . . .	Yes	
<b>9</b>	Indicate the tax year the hospital facility last adopted an implementation strategy: 20 <u>22</u>		
<b>10</b>	Is the hospital facility's most recently adopted implementation strategy posted on a website? . . . . . If "Yes" (list url): <u>SEE PART V</u>	Yes	
	<b>a</b>		
	<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? . . . . .		
<b>11</b>	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.		
<b>12a</b>	Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? . . . . .		No
<b>12b</b>	If "Yes" on line 12a, did the organization file Form 4720 to report the section 4959 excise tax? . . . . .		
	<b>c</b> If "Yes" on line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? \$ _____		



**Part V Facility Information** (continued)

**Financial Assistance Policy (FAP)**

THE MEDICAL CENTER INC

Name of hospital facility or letter of facility reporting group

		Yes	No
Did the hospital facility have in place during the tax year a written financial assistance policy that:			
<b>13</b>	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care? If "Yes," indicate the eligibility criteria explained in the FAP:	Yes	
<b>a</b>	<input checked="" type="checkbox"/> Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 300. _____% and FPG family income limit for eligibility for discounted care of 300. _____%		
<b>b</b>	<input type="checkbox"/> Income level other than FPG (describe in Section C)		
<b>c</b>	<input type="checkbox"/> Asset level		
<b>d</b>	<input type="checkbox"/> Medical indigency		
<b>e</b>	<input checked="" type="checkbox"/> Insurance status		
<b>f</b>	<input type="checkbox"/> Underinsurance discount		
<b>g</b>	<input type="checkbox"/> Residency		
<b>h</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>14</b>	Explained the basis for calculating amounts charged to patients? . . . . .	Yes	
<b>15</b>	Explained the method for applying for financial assistance? . . . . . If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):	Yes	
<b>a</b>	<input checked="" type="checkbox"/> Described the information the hospital facility may require an individual to provide as part of his or her application		
<b>b</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		
<b>c</b>	<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		
<b>d</b>	<input checked="" type="checkbox"/> Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications		
<b>e</b>	<input type="checkbox"/> Other (describe in Section C)		
<b>16</b>	Was widely publicized within the community served by the hospital facility? . . . . . If "Yes," indicate how the hospital facility publicized the policy (check all that apply):	Yes	
<b>a</b>	<input checked="" type="checkbox"/> The FAP was widely available on a website (list url): <u>SEE PART V</u>		
<b>b</b>	<input checked="" type="checkbox"/> The FAP application form was widely available on a website (list url): <u>SEE PART V</u>		
<b>c</b>	<input checked="" type="checkbox"/> A plain language summary of the FAP was widely available on a website (list url): <u>SEE PART V</u>		
<b>d</b>	<input checked="" type="checkbox"/> The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)		
<b>e</b>	<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)		
<b>f</b>	<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)		
<b>g</b>	<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		
<b>h</b>	<input checked="" type="checkbox"/> Notified members of the community who are most likely to require financial assistance about availability of the FAP		
<b>i</b>	<input checked="" type="checkbox"/> The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations		
<b>j</b>	<input type="checkbox"/> Other (describe in Section C)		

**Part V Facility Information** (continued)

**Billing and Collections**

THE MEDICAL CENTER INC

**Name of hospital facility or letter of facility reporting group**

**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? . . . . .

	Yes	No
<b>17</b>	Yes	

**18** Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:

- a  Reporting to credit agency(ies)
- b  Selling an individual's debt to another party
- c  Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP
- d  Actions that require a legal or judicial process
- e  Other similar actions (describe in Section C)
- f  None of these actions or other similar actions were permitted

**19** Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP? . . . . .

<b>19</b>		No
-----------	--	----

If "Yes," check all actions in which the hospital facility or a third party engaged:

- a  Reporting to credit agency(ies)
- b  Selling an individual's debt to another party
- c  Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP
- d  Actions that require a legal or judicial process
- e  Other similar actions (describe in Section C)

**20** Indicate which efforts the hospital facility or other authorized party made before initiating any of the actions listed (whether or not checked) in line 19. (check all that apply):

- a  Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs (if not, describe in Section C)
- b  Made a reasonable effort to orally notify individuals about the FAP and FAP application process (if not, describe in Section C)
- c  Processed incomplete and complete FAP applications (if not, describe in Section C)
- d  Made presumptive eligibility determinations (if not, describe in Section C)
- e  Other (describe in Section C)
- f  None of these efforts were made

**Policy Relating to Emergency Medical Care**

**21** Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? . . . . .

<b>21</b>	Yes	
-----------	-----	--

If "No," indicate why:

- a  The hospital facility did not provide care for any emergency medical conditions
- b  The hospital facility's policy was not in writing
- c  The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- d  Other (describe in Section C)

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

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

THE MEDICAL CENTER INC

**Name of hospital facility or letter of facility reporting group** \_\_\_\_\_

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

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

If "Yes," explain in Section C.

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

If "Yes," explain in Section C.

	Yes	No
<b>23</b>		No
<b>24</b>		No

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

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

Form and Line Reference	Explanation
See Add'l Data	

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

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

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

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

**Part VI Supplemental Information**

Provide the following information.

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

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 1: REQUIRED DESCRIPTIONS	SCHEDULE H, PART I, LINE 6A PUBLIC AVAILABILITY OF COMMUNITY BENEFIT REPORT We regularly report to the community our community benefit activities in several ways. Each year, we prepare a systemwide community benefit report that is available to the public through publication on our website. We also make available our IRS Form 990 Schedule H on our website and provide copies to anyone upon request. We also provide information on community benefit programming to local, state, and federal lawmakers through our government affairs office and online at piedmont.org.

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART I, LINE 7(F)	PERCENT OF TOTAL EXPENSE THE DENOMINATOR USED FOR THE CALCULATION OF COLUMN (F), PERCENT OF TOTAL EXPENSE, WAS THE AMOUNT OF TOTAL FUNCTIONAL EXPENSES ON FORM 990, PART IX, LINE 25, COLUMN (A) OF \$516,712,254, LESS BAD DEBT EXPENSE OF \$47,669,813 FROM FORM 990, PART IX, LINE 24(C).

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART I, LINE 7	FINANCIAL ASSISTANCE AND CERTAIN OTHER COMMUNITY BENEFITS AT COST A RATIO OF PATIENT CARE COST TO CHARGES, CONSISTENT WITH WORKSHEET 2, WAS USED TO REPORT THE AMOUNTS IN PART I, LINES 7A-7D. FOR AMOUNTS ON LINES 7E-7K, ACTUAL EXPENSES FOR EACH COMMUNITY BENEFIT ACTIVITY ARE TRACED AND REPORTED USING THE ORGANIZATION'S COST ACCOUNTING SYSTEM.



**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART III, LINES 2-4	<p>BAD DEBT EXPENSE CALCULATION AND FOOTNOTE The provision for bad debts is based upon leadership's assessment of historical and expected net collections considering business and economic conditions, trends in health care coverage and other collection indicators. Periodically, leadership assesses the adequacy of the allowance for doubtful accounts based upon historical write-off experience by payor category. The results of the review are then used to make any modifications to the provision for bad debts to establish an appropriate allowance for uncollectible receivables. THE AMOUNT REPORTED ON PART III, LINE 3, WAS DETERMINED BY TAKING THE AVERAGE ACCEPTANCE RATE FOR ALL CHARITY CARE APPLICATIONS RECEIVED DURING THE YEAR MULTIPLIED BY THE NUMBER OF DENIALS THAT WERE ATTRIBUTABLE TO INSUFFICIENT INFORMATION. THAT TOTAL WAS THEN ADJUSTED DOWNWARD FOR THE ORGANIZATION'S USE OF PRESUMPTIVE ELIGIBILITY WHEN DETERMINING ITS COMMUNITY BENEFITS. BAD DEBT EXPENSE FOOTNOTE FROM CONSOLIDATED, AUDITED FINANCIAL STATEMENTS: THE PROVISION FOR BAD DEBTS IS BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS CONSIDERING BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN HEALTH CARE COVERAGE, AND OTHER COLLECTION INDICATORS. PERIODICALLY, MANAGEMENT ASSESSES THE ADEQUACY OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS BASED UPON HISTORICAL WRITE-OFF EXPERIENCE BY PAYOR CATEGORY. THE RESULTS OF THIS REVIEW ARE THEN USED TO MAKE ANY MODIFICATIONS TO THE PROVISION FOR BAD DEBT TO ESTABLISH AN APPROPRIATE ALLOWANCE FOR UNCOLLECTIBLE RECEIVABLES. THE MEDICAL CENTER PROVIDES CARE TO PATIENTS WHO MEET CERTAIN CRITERIA UNDER ITS CHARITY CARE POLICY WITHOUT CHARGE OR AT AMOUNTS LESS THAN ITS ESTABLISHED RATES. AMOUNTS DETERMINED TO QUALIFY AS CHARITY CARE ARE NOT REPORTED AS REVENUE.</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART III, LINE 8	<p>The amount reported on Part III, Line 6, was calculated in accordance with Schedule H instructions by utilizing our allowable Medicare cost as reported in the Medicare cost report, which is based on a cost to charge ratio. However, the allowable costs in the Medicare cost report do not reflect the actual cost of providing care to patients since the Medicare cost report excludes many direct patient care costs that are essential to provide quality healthcare for Medicare patients. For example, certain coverage fees to physicians, cost of Medicare C and D, and other similar direct patient care expenses are specifically excluded from allowable cost in the Medicare Cost Report. IRS Revenue Ruling 69-545 provides, in part, that hospitals serving patients with governmental health insurance, such as Medicare, is an indication we operate to promote health in the community. Our policy is to treat Medicare patients, regardless of the extent to which Medicare pays for the treatment. For many services, Medicare's reimbursement is less than the cost of the care provided, resulting in shortfalls that are to be absorbed by us in honor of our commitment to treat elderly patients. Many of these patients live on a low, fixed income, and would qualify for financial assistance or other means-tested programs, absent from their enrollment in Medicare.</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART III, LINE 9(B)	COLLECTION PRACTICES INITIAL SCREENINGS OF ALL INPATIENT, EMERGENCY, AND SURGERY ENCOUNTERS, AS WELL AS MOST OUTPATIENT VISITS, ARE CONDUCTED BY FINANCIAL COUNSELORS IN ORDER TO IDENTIFY ANY AVAILABLE INSURANCE OR OTHER COVERAGE FOR EACH PATIENT. COUNSELORS CONTACT PATIENTS AND THEIR FAMILIES DIRECTLY, EITHER IN PERSON OR BY LETTER, TO ASSIST THE FAMILY IN IDENTIFYING ANY PROGRAMS FOR WHICH THE PATIENT/SERVICE MAY QUALIFY (INCLUDING MEDICAID, STATE CHILDREN'S HEALTH INSURANCE PROGRAM ("SCHIP"), PRIVATE OR GOVERNMENT INSURANCE COVERAGE, AND CHARITY ASSISTANCE). IF THE FAMILY CANNOT BE TIMELY LOCATED OR IS UNCOOPERATIVE, RELATED ACCOUNTS ARE TRANSFERRED TO AN INTERNAL COLLECTION DEPARTMENT FOR FURTHER ATTEMPTS TO OBTAIN PAYMENT OR, IF THE PATIENT MAY QUALIFY FOR ASSISTANCE, TO SECURE A FINANCIAL ASSISTANCE APPLICATION. THE ORGANIZATION'S DEBT COLLECTION POLICY AND PROCEDURES PROHIBIT ANY COLLECTION EFFORTS FOR THE PORTION OF A PATIENT ACCOUNT BALANCE THAT QUALIFIES FOR FINANCIAL ASSISTANCE UNDER THE ORGANIZATION'S CHARITY CARE POLICY.

Form and Line Reference	Explanation
<p>SCHEDULE H, PART VI, LINE 2: NEEDS ASSESSMENT</p>	<p>As a designated 501(c)(3) nonprofit hospital, we are required by the Internal Revenue System to conduct a triennial community health needs assessment (CHNA), in accordance with regulations put forth by the IRS following the 2010 Patient Protection and Affordable Care Act (ACA). Through this assessment, we hope to better understand local health challenges, identify health trends in our community, determine gaps in the current health delivery system and craft a plan to address those gaps and the identified health needs. In FY22, we conducted our fourth triennial CHNA. FY22 also marked the third year of our FY19 Implementation Strategy. The CHNA was led by the Piedmont Healthcare community benefits team and consulting organization Public Goods Group, with input and direction from Piedmont leadership and Piedmont Healthcare's Department of External Affairs. Process The CHNA started with a definition of our community, which is our home county due to the impact of our tax-exempt status. Property taxes make up the largest segment of a hospital's tax exemption, which impacts county revenues. Because of this, we aim to ensure that we are providing ample benefit to our county and its residents. Additionally, we take into consideration patient origin, especially that of our lower-income patients such as those who qualify for financial assistance or receive insurance coverage through Medicaid. Our secondary communities are considered the areas in which we have the highest concentration of patients fitting that criterion, including ones from nearby communities. Once we established our primary and secondary communities, we then conducted an analysis of available public health data. This included resources from: US Census, US Health and Human Services' Community Health Status Indicators, US Department of Agriculture, Economic Research Service, National Center for Education Statistics, Kaiser Family Foundation's State Health Facts, American Heart Association, County Health Rankings and Georgia Online Analytical Statistical Information System (OASIS). All figures within the CHNA were for 2017, unless otherwise noted. Health indicators are estimates provided by County Health Rankings and hospital data were internally sourced. We then interviewed key stakeholders who have a particular expertise or knowledge of our communities. Specifically, we interviewed representatives of local and regional public health entities, minority populations, faith-based communities, local business owners, the philanthropic community, mental health agencies, elected officials and individuals representing our most vulnerable patients. An internal survey was also conducted throughout the health care system for both clinical and non-clinical employees. Information was gathered on knowledge and understanding of community benefit and current programs, as well as suggestions for how we can better serve our patients and communities. Approximately 1,053 employees spanning the system responded. Additionally, we conducted a community-based survey that was widely advertised to the community. Once both qualitative and quantitative data was gathered, we authored the preliminary report, which was then vetted and reviewed by hospital and health system leadership. In this report, we identified several key community health needs that emerged during the assessment process. The chosen priorities were recommended by the community benefit department with sign-off from hospital and board leadership. The following criteria were used to establish the priorities: - The number of persons affected; - The seriousness of the issue; - Whether the health need particularly affected persons living in poverty or reflected health disparities; and, - Availability of community and/or hospital resources to address the need. All priorities are viewed through the lens of health disparities, with particular attention paid to improving outcomes for those most vulnerable due to income and race. The priorities we chose reflected a collective agreement on what hospital leadership, staff and the community felt was most important and within our ability to positively impact the issue. Once priorities were approved by the board of directors, we then authored the CHNA and presented our findings and recommendations to the hospital's board of directors for their input and approval. Our priorities A key component of the CHNA is to identify the top health priorities we will address over fiscal years 2023, 2024, and 2025. These priorities will guide our community benefit work. They are, in no order: - Ensure affordable access to health, mental, and dental care for all community members, and especially those that are low income and/or uninsured - Reduce preventable instances of and deaths from cancer - Decrease preventable instances of diabetes and decrease the number of patients with uncontrolled diabetes - Decrease the impact of deaths from stroke - Reduce rates of obesity and increase access to health</p>

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 2: NEEDS ASSESSMENT	<p>hy foods and recreational activities With each priority, we work to achieve greater health equity by reducing the impact of poverty and other socioeconomic indicators. This means t hat health equity is built into each priority, which is demonstrated through our implement ation strategies. Our subsequent implementation strategy was developed in partnership with hospital leadership and community stakeholders to address the identified priorities in ou r FY22 community health needs assessment. The implementation strategy was designed to be e xecuted over a three-year period and included specific metrics by which we would be able t o evaluate our work and its impact. The implementation strategy was developed by utilizing community feedback from the assessment in partnership with the system community benefits department, our leadership, and our board of directors. We included proven and successful interventions and programming, investing further in work we felt was successful in address ing unmet health needs.</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 3: PATIENT EDUCATION OF ASSISTANCE ELIGIBILITY	<p>We understand that not everyone can pay their hospital bill due to their insurance status or a limited income, and because of this, we offer financial assistance to qualifying patients. Notification about financial assistance includes, but is not limited to, a dedicated contact number, notices in patient bills, and posted notices in key areas of the hospital. These locations are the emergency room, admitting and registration departments, our business office, and patient financial services offices that are located on site. We also publish and widely publicize a plain language summary of this financial assistance care policy on our website, as well as the full policy. Referral of patients for financial assistance may be made by any staff or medical staff member at the hospital, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors. A request for financial assistance may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws. Additionally, we provide copies of our financial assistance policy to our partner clinics and others who work closely with low-income populations. We help our partners in understanding the policy, how it relates to their populations, and receive feedback in ways our financial assistance programming could be improved.</p>

Form and Line Reference	Explanation
<p>SCHEDULE H, PART VI, LINE 4: COMMUNITY INFORMATION</p>	<p>While Piedmont Columbus serves patients from all over southwest Georgia, we consider our community to be Muscogee County. We do this in recognition of the direct impact of our tax- exempt status on county residents. In Muscogee County, an average 195,739 people lived in the 216.44 square mile area each year between 2015 and 2019. The population density for this area, estimated at 904 persons per square mile, is much greater than the state average population density of 181 people per square mile and the national average population density of 92 persons per square mile. The ZIP code with the highest concentration of people was 31906, where 30 percent of the county's population called home. Muscogee is mostly urban, as 97 percent of community members live within an urban setting. The ZIP code with the highest concentration of the rural population was 31801 and, like in most of Georgia, rural populations in Muscogee are overwhelmingly white. Muscogee County is growing, having seen a 9 percent increase in total population between 2010 and 2020. About 14 percent of the population were veterans in 2020, and more than half were between the ages of 35 and 54. Eighteen percent of the population - about 34,150 people - lived with a disability. Most of that population were 65 or older. About 25 percent of the population were 17 or younger, 13 percent were over the age of 65, and the remaining population were between the ages of 18-64. Between 2015 to 2019, about 40 percent of all Muscogee County residents were white, 46 percent were black or African American, 7.6 percent were Hispanic/Latino, 2.5 percent were Asian, and the remaining were comprised of other races. About 5 percent of the population were born outside of the US and 2.2 percent of the total population did not have citizenship status in 2020. In 2020, 12 percent of the population had no form of insurance. In 2020, 18 percent of nonelderly adults were uninsured, as compared to 5.11 percent of those under age 18 and 1 percent for those 65 and older. As with other indicators, race matters. Approximately 18 percent of Hispanic/Latino populations were uninsured, 12 percent of Asians were uninsured, 13 percent of blacks or African Americans were uninsured, and 9.14 percent of whites were uninsured. Of employers in the community, the largest sector by employment size is retail trade, which employed 13,570 community members at an average annual wage of \$27,310 in 2019 according to the US Department of Commerce. Administrative and support and waste management and remediation services was the second largest sector, with 12,488 people employed at an average annual wage of \$20,111. Transportation and warehousing were the third largest sector, with 10,566 people employed at an average annual wage of \$28,159. According to the 2015-2019 American Community Survey, 122,444 people in the community were part of the labor force, and only 3,500 -- about 4.5 percent -- were unemployed as of January 2022. This figure has steadily decreased since last year, when in January 2021, 5.9 percent of the labor force was unemployed. When looking back further, the rate is nearly three times less than the unemployment rate in 2012. In 2020, approximately 21 percent of the county lived at or below the Federal Poverty Level (FPL). By far, the poorest ZIP code within Muscogee County is 31903, where 42 percent of the population lived in poverty in 2020. In Muscogee County, like most of the state, minorities are more likely to live in poverty. For example, in 2020, 27 percent of blacks or African Americans and 19 percent of Hispanic/Latino populations in Muscogee County were living at or below poverty, as compared to 13 percent of whites. Of the 75,984 total occupied households in Muscogee County between 2015 and 2019, 26,767 community members -- about 37 percent -- lived in cost burdened households, in which housing costs were 30 percent or more of total household income. Approximately 18 percent of households had costs that exceeded 50 percent of the household income, which places the household in significant financial strain. In Muscogee County, in 2019, 11 of the county's 53 census tracts were food deserts. About 46,281 people lived within these census tracts. These tracts almost directly correspond with census tracts demonstrating retailers who are authorized to take SNAP benefits. In Muscogee County, like with most of the state, those retailers tend to be convenience and discount stores that carry limited, if any, healthy foods. Increasingly, discount stores like Dollar General do have some sort of produce section, but that is inconsistent among communities. Low food access is defined as living more than 0.5 mile from the nearest supermarket, supercenter, or large grocery store. This indicator is relevant because it highlights populations and geographic areas facing food insecurity. According to the 2019 Food Access Research Atlas database, about 30 percent of the total population in the county</p>

Form and Line Reference	Explanation
<p>SCHEDULE H, PART VI, LINE 4: COMMUNITY INFORMATION</p>	<p>have low food access, meaning about 57,404 county residents may struggle to access healthy foods. This is between the state and national rates of 30.89 percent and 22.22 percent, respectively. ZIP code 31905 has the worst rate of low food access at 99.4 percent. In 2019, about 79 percent of adults aged 18 or older saw a doctor for a routine check-up the previous year, a measure that is likely over-reported and is lower than both state and national averages. For Medicare recipients, this number drops to 74 percent of adult beneficiaries, which is below both state and national averages. Routine check-ups are a critical component to maintaining good health and identifying conditions that can be treated affordably in a community-based setting. Absent that, even simple-to-treat conditions can escalate to deeper issues, eventually requiring more intensive care, later stage diagnoses, or reduced life expectancy. Heart disease is a leading cause of death for both women and men in Muscogee County. In 2020, the age-adjusted death rate was 262.9 deaths for every 100,000 people, which is far worse than both state and national rates, which were 72.4 and 91.5 heart-related deaths per 100,000 people, respectively. Even so, this rate has steadily declined over the last few years. Between 2016 and 2020, there were 507 deaths due to stroke, representing an age-adjusted death rate of 50 deaths per every 100,000 people. Men are more likely to die from stroke than women, as are black populations. The hospitalization rate for heart disease and stroke among Medicare recipients have steadily decreased over the last five years. The cardiovascular disease hospitalization rate in 2018 was 8.9 hospitalizations per every 1,000 Medicare beneficiaries, which is better than state and national rates of 12.2 and 11.8, respectively. The hospitalization rate for stroke, though, is above state and national rates, with 9.7 hospitalizations per every 1,000 Medicare beneficiaries, as compared to the state rate of 9.3 and the national rate of 8.4. Although heart disease leads in county deaths, cancer remains a critical issue within the community. The cancer incidence rate for Muscogee County each year, on average between 2014 and 2018, was 490.4 per every 100,000 people, which equates to a diagnosis rate of an average 1,001 new cases each year. In 2019, 17,911 of adults aged 20 and older had diabetes, equaling 12.1 percent of the county's population, which is higher than the state rate of 9.8 percent. Diabetes is a prevalent problem in the US, often indicating an unhealthy lifestyle, and puts individuals at risk for further health issues. This rate has remained somewhat steady over the years. For example, ten years earlier, in 2009, the diabetes diagnosis rate was 11.2 percent. Chronic kidney disease, also called chronic kidney failure, involves a gradual loss of kidney function. Your kidneys filter wastes and excess fluids from your blood, which are then removed in your urine. Advanced chronic kidney disease can cause dangerous levels of fluid, electrolytes and wastes to build up in your body. In 2019, 3.6 percent of the county's population had a diagnosis of kidney disease, a rate worse than the state and national percentages of 3.22 percent and 3.1 percent, respectively. In 2019, 31 percent of adults 18 and older of the total population reported having high cholesterol, which is on par with state and national rates. Too much cholesterol puts you at risk for heart disease and stroke, two of the main causes of death within the county. In 2019, 39.1 percent of adults 18 and older had a diagnosis of high blood pressure. This is higher than the state and national rates of 35.5 percent and 32.6 percent, respectively. High blood pressure can damage your arteries by making them less elastic, which decreases the flow of blood and oxygen to your heart and leads to heart disease.</p>



990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
<p>SCHEDULE H, PART VI, LINE 5: PROMOTION OF COMMUNITY HEALTH</p>	<p>In FY22, we actively promoted the health of our community through community-based health screenings, our mobile unit, educational activities, community-building activities, the operation of a 24-hour emergency department available to the entire community, the operation of an emergency room open to all members of the community without regard to ability to pay, a governance board composed of community members, use of surplus revenue for facilities improvement, patient care, and medical training, education, and research, the provision of inpatient hospital care for all persons in the community able to pay, including those covered by Medicare and Medicaid, and an open medical staff with privileges available to all qualifying physicians. Please note that all community benefit activities are conducted in partnership with Piedmont Columbus Northside (Hughston Hospital, Inc.). It's important to note that COVID-19 continued to have a significant impact on our proactive community benefit programs. We created programming responsive to the pandemic, including our migration to online platforms for vital community-based programming. Even so, many programs are still on hold due to pandemic concerns. We prioritized increasing access to care by utilizing a patient and family advisory council to provide meaningful input on critical areas of consideration. Piedmont Columbus Regional created a Steering Committee with the goal to increase access to care by assisting with clinical policies and guidelines for the operations of the mobile unit, which provides access to healthcare for our indigent population Monday through Friday at various locations throughout the community to identify and treat targeted health risk. The steering committee focuses on key components to increase access to care for our most high-risk populations identified in the CHNA. We host our weekly clinics at Safe House and Valley Rescue to target our indigent population. We provide education to assist with vaccine hesitancy and offer vaccines (flu and COVID) at our clinics. In addition, Safe House Victory along with several other community partners are included in our monthly schedule. The Mobile Unit Steering Committee decided to use funds from a community grant to provide medication to our patients while our social worker links them to a medical home. During clinical visits, the MU team consists of a RN, LCSW a Family Practice Resident and a Pharm D Resident under the medical direction of Dr. Greg Foster. In FY22, the mobile unit served 1833 indigent patients, including 84 patients from Valley Rescue and 324 patients from Safe House. We provided 73 COVID-19 and seven Influenza vaccines. We also treated 64 patients who have visited the emergency room at least three times over the last 12 months. Our goal was to move most of their care to an appropriate community-based setting. Piedmont Columbus Regional has partnered with the Mayor's Commission to interface with the various populations in our community to continue to provide access to healthcare by highlighting our mobile unit clinic days. We provide various health education focusing on our CHNA priority areas. The local news media outlet has provided public service announcements highlighting the mobile unit's schedule. We continued distribution of our previously published brochure titled "Lung Cancer Screening, Shared Decision-Making Guide." This detailed instructional guide explains the who, what, and why about our Low-Dose CT Scan Lung Cancer Screening. In FY22, we screened 571 patients for lung cancer. We partnered with the West Central Georgia Cancer Coalition for another community-wide Drive-Thru Colorectal Cancer Screening, utilizing education events within the community to distribute 108 stool screening kits to community members. Of those, 55 were returned and one was positive (and that community member received appropriate follow-up care). By increasing the community knowledge of signs and symptoms, by utilizing the stroke survival campaign of F.A.S.T. with emphasis on "T" for time to call 911, as EMS is the preferred mode of arrival for stroke patients. In FY22, approximately 77 percent of all stroke patients arrived via EMS, a significant jump from FY20, when only 62 percent arrived at the ER via EMS. Piedmont Columbus Regional's Community Outreach department has partnered with The Food Mill District to host two Mobile Market Day community events. The Food Mill travels along with the mobile unit to provide healthy fruits and vegetables to our targeted populations identified in the CHNA. Discounted fresh fruit and vegetables along with educational materials are distributed while we provide blood pressure clinics and lectures. Additionally, we partnered with the Food Mill Mobile Van to provide fresh fruits and vegetables to low-income patients with fifty percent discount for SNAP participants. The communities targeted were identified in the CHNA.</p>

**990 Schedule H, Supplemental Information**

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 6: AFFILIATED HEALTH CARE SYSTEM	<p>We are part of Piedmont Healthcare, a regional not-for-profit organization and the parent company of 19 hospitals, the Piedmont Physicians Group, the Piedmont Heart Institute, the Piedmont Clinic and the Piedmont Healthcare Foundation. Our community relations team works directly with the community. Our community benefit department oversees the community benefit activities on behalf of all hospitals throughout the system, and this includes conducting the triennial CHNA and subsequent implementation strategy, ensuring the financial assistance policy is communicated to the community, maintaining the community benefit webpage, authoring the community benefit annual report, preparing board materials, developing and executing the community benefit grants program and compiling all community benefit figures. Each hospital and certain departments of Piedmont Healthcare execute community benefit programming, such as our revenue department, which oversees the financial assistance program.</p>

## 990 Schedule H, Supplemental Information

Form and Line Reference	Explanation
SCHEDULE H, PART VI, LINE 7: STATE OF FILING OF COMMUNITY BENEFIT REPORT	We are not required to file a community benefit report; however, we are required to file with the Georgia Department of Community Health information on our indigent and charity care, as well as our Medicaid and Medicare shortfalls.

**Additional Data****Software ID:****Software Version:****EIN:** 58-1685139**Name:** The Medical Center Inc**Form 990 Schedule H, Part V Section A. Hospital Facilities**

<b>Section A. Hospital Facilities</b>  (list in order of size from largest to smallest—see instructions) How many hospital facilities did the organization operate during the tax year? <b>1</b>		Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (Describe)	Facility reporting group
1	THE MEDICAL CENTER INC 710 CENTER STREET COLUMBUS, GA 31901 WWW.PIEDMONT.ORG 106-701	X	X		X			X		NURSING HOME	

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

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

Form and Line Reference	Explanation
THE MEDICAL CENTER, INC.:	Schedule H, PART V, SECTION B, LINE 5: COMMUNITY REPRESENTATION AS PART OF OUR PROCESS, WE INTERVIEWED NEARLY 245 STAKEHOLDERS, POLICY MAKERS AND LAWMAKERS REPRESENTING PUBLIC HEALTH, LOW-INCOME POPULATIONS, MINORITIES, CHRONIC CONDITIONS, OLDER ADULTS, AND OUR COMMUNITIES. THESE INCLUDED 37 STAKEHOLDERS WITHIN THE MUSCOGEE COMMUNITY, WHO GAVE THEIR PERSPECTIVES ON COMMUNITY HEALTH THROUGH THE LENS OF THEIR ROLE WITHIN THE COMMUNITY. THESE INTERVIEWS WERE CONDUCTED FOR PEOPLE REPRESENTING THE ENTIRE REGION. SPECIFICALLY, WE INTERVIEWED REPRESENTATIVES OF LOCAL AND REGIONAL PUBLIC HEALTH ENTITIES, MINORITY POPULATIONS, FAITH-BASED COMMUNITIES, LOCAL BUSINESS OWNERS, THE PHILANTROPIC COMMUNITY, MENTAL HEALTH AGENCIES, ELECTED OFFICIALS AND INDIVIDUALS REPRESENTING OUR MOST VULNERABLE PATIENTS. THE PIEDMONT HEALTHCARE BOARD OF DIRECTORS AND LEADERSHIP FROM ALL 19 HOSPITALS WERE ACTIVELY INFORMED AND ENGAGED THROUGHOUT THIS PROCESS.
SCHEDULE H, PART V, LINE 6A: COMMUNITY HEALTH NEEDS ASSESSMENT	THE COMMUNITY HEALTH NEEDS ASSESSMENT WAS CONDUCTED FOR PIEDMONT COLUMBUS REGIONAL HEALTHCARE SYSTEM, FEIN 58-1719994, WHICH INCLUDES THE MEDICAL CENTER, INC. (FEIN 58-1685139) AND HUGHSTON HOSPITAL, INC. (FEIN 33-1216751).

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

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, LINE 7A: COMMUNITY HEALTH NEEDS ASSESSMENT WEBSITE	<a href="https://www.piedmont.org/media/file/community-benefit-needs-assessment-pcr.pdf">HTTPS://WWW.PIEDMONT.ORG/MEDIA/FILE/COMMUNITY-BENEFIT-NEEDS-ASSESSMENT-PCR .PDF</a>
SCHEDULE H, PART V, LINE 7D: PUBLIC AVAILABILITY OF CHNA	IN ADDITION TO MAKING ITS CHNA AVAILABLE ON ITS WEBSITE AND BY REQUEST, THE MEDICAL CENTER SENT COPIES TO EACH PARTICIPANT IN THE CHNA PROCESS, DISTRIBUTED THE ASSESSMENTS TO COMMUNITY CENTERS AND OTHER LOCATIONS THAT PRIMARILY SERVE AN UNINSURED POPULATION, SENT COPIES TO LEGISLATIVE AND ELECTED OFFICIALS, AND WIDELY DISTRIBUTED THE ASSESSMENTS TO OTHER PIEDMONT HEALTHCARE HOSPITALS.

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

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, LINE 10A: IMPLEMENTATION STRATEGIES WEBSITE	THE BOARD OF DIRECTORS FOR THE MEDICAL CENTER APPROVED ITS IMPLEMENTATION STRATEGY FOR THE THREE-YEAR PERIOD BEGINNING WITH FY23 ON OCTOBER 5, 2022, WITHIN THE GRACE PERIOD FOLLOWING THE APPROVAL OF THE NEW COMMUNITY HEALTH NEEDS ASSESSMENT. THE FOLLOWING LINK IS FOR THE IMPLEMENTATION STRATEGY EFFECTIVE THROUGH JUNE 30, 2025. <a href="https://www.piedmont.org/media/file/community-benefit-implementation-strategy-pcr.pdf">HTTPS://WWW.PIEDMONT.ORG/MEDIA/FILE/COMMUNITY-BENEFIT-IMPLEMENTATION-STRATEGY-PCR.PDF</a>
SCHEDULE H, PART V, LINE 11: ADDRESSING COMMUNITY HEALTH NEEDS	DURING FY22, THE MEDICAL CENTER CONDUCTED ITS FOURTH CNHA, AGAIN BY ASSESSING PUBLICLY AVAILABLE DATA, INTERVIEWING COMMUNITY MEMBERS AND STAKEHOLDERS, CONDUCTING FOCUS GROUPS OF VULNERABLE POPULATIONS, INTERVIEWING PIEDMONT BOARD MEMBERS, AND SURVEYING PIEDMONT EMPLOYEES. THROUGH THIS PROCESS, THE MEDICAL CENTER DETERMINED AND PRIORITIZED THE COMMUNITY HEALTH NEEDS IT WOULD ADDRESS BASED ON THE NUMBER OF PERSONS AFFECTED, THE SERIOUSNESS OF THE ISSUE, WHETHER THE HEALTH NEED AFFECTED VULNERABLE POPULATIONS, AND THE AVAILABILITY OF COMMUNITY AND HOSPITAL RESOURCES NECESSARY TO ADDRESS THE ISSUE. ALL PRIORITIES ARE VIEWED THROUGH THE LENS OF HEALTH DISPARITIES, WITH PARTICULAR ATTENTION PAID TO IMPROVING OUTCOMES FOR THOSE MOST VULNERABLE DUE TO INCOME AND RACE. BASED ON THE CHNA, THE MEDICAL CENTER IS CURRENTLY FOCUSING ON: (1) ENSURING AFFORDABLE ACCESS TO HEALTH, MENTAL, AND DENTAL CARE FOR ALL COMMUNITY MEMBERS, AND ESPECIALLY THOSE THAT ARE LOW INCOME AND/OR UNINSURED (2) REDUCING PREVENTABLE INSTANCES OF, AND DEATHS FROM, CANCER (3) DECREASING PREVENTABLE INSTANCES OF DIABETES AND DECREASING THE NUMBER OF PATIENTS WITH UNCONTROLLED DIABETES (4) DECREASING THE IMPACT OF DEATHS FROM STROKE (5) REDUCING RATES OF OBESITY AND INCREASING ACCESS TO HEALTHY FOODS AND RECREATIONAL ACTIVITIES

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

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

Form and Line Reference	Explanation
SCHEDULE H, PART V, LINE 16A: FINANCIAL ASSISTANCE POLICY WEBSITE	FINANCIAL ASSISTANCE POLICY - <a href="https://www.piedmont.org/media/file/financial-assistance-policy.pdf">HTTPS://WWW.PIEDMONT.ORG/MEDIA/FILE/FINANCIAL-ASSISTANCE-POLICY.PDF</a> FINANCIAL ASSISTANCE APPLICATION - <a href="https://www.piedmont.org/media/file/financial-assistance-application.pdf">HTTPS://WWW.PIEDMONT.ORG/MEDIA/FILE/FINANCIAL-ASSISTANCE-APPLICATION.PDF</a> FINANCIAL ASSISTANCE PLAIN LANGUAGE SUMMARY - <a href="https://www.piedmont.org/media/file/financial-assistance-plain-language-summary-english.pdf">HTTPS://WWW.PIEDMONT.ORG/MEDIA/FILE/FINANCIAL-ASSISTANCE-PLAIN-LANGUAGE-SUMMARY-ENGLISH.PDF</a>



**Schedule J**  
(Form 990)

**Compensation Information**

OMB No. 1545-0047

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](http://www.irs.gov/Form990) for instructions and the latest information.

**2021**

**Open to Public Inspection**

Department of the Treasury  
Internal Revenue Service

Name of the organization  
The Medical Center Inc

Employer identification number  
58-1685139

**Part I Questions Regarding Compensation**

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

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

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

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

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

**Part III Supplemental Information**

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

Return Reference	Explanation
SCHEDULE J, PART I, LINE 3: COMPENSATION OF THE CEO/EXECUTIVE DIRECTOR	THE COMPENSATION FOR THE PRESIDENT/CEO OF THE MEDICAL CENTER IS SET BY THE ENTITY'S PARENT, PIEDMONT HEALTHCARE, INC. PLEASE SEE THE SCHEDULE O NARRATIVE FOR FORM 990, PART VI, SECTION B, LINE 15A & 15B FOR ADDITIONAL INFORMATION.

**Part III** Supplemental Information

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

Return Reference	Explanation
SCHEDULE J, PART I, LINE 4A: SEVERANCE PAYMENTS	MICHAEL MCANDER RECEIVED A SEVERANCE PAYMENT DURING CALENDAR YEAR 2021 IN THE AMOUNT OF \$972,687.

**Part III** Supplemental Information

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

Return Reference	Explanation
SCHEDULE J, PART I, LINE 4B: SUPPLEMENTAL COMPENSATION INFORMATION	THE FOLLOWING INDIVIDUALS RECEIVED PAYMENTS FROM THEIR SUPPLEMENTAL EXECUTIVE RETIRMENT PLANS: M. SCOTT HILL \$93,908 THOMAS ARNOLD \$93,750 MICHAEL MANDL AND ELIZABETH LEDDY PARTICIPATED IN SUPPLEMENTAL NONQUALIFIED RETIREMENT PLANS BUT DID NOT RECEIVE A CURRENT YEAR PAYMENT.

**Additional Data**

**Software ID:**  
**Software Version:**  
**EIN:** 58-1685139  
**Name:** The Medical Center Inc

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

(A) Name and Title		(B) Breakdown of W-2, 1099-MISC compensation, and/or 1099-NEC			(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				
1Mr M Scott Hill Board Member & CEO CRHS	(i)	0	0	0	0	0	0	0
	(ii)	617,248	337,175	288,069	111,308	21,929	1,375,729	93,908
1Dr Todd Jarrell MD Board Member	(i)	0	0	0	0	0	0	0
	(ii)	583,845	0	84,492	17,400	15,523	701,260	0
2Mr William Tustin COO	(i)	309,955	86,288	9,333	13,556	20,224	439,356	0
	(ii)	0	0	0	0	0	0	0
3Dr Andrew Pippas Physician	(i)	630,410	0	274,626	17,400	18,690	941,126	0
	(ii)	0	0	0	0	0	0	0
4Dr Peter Jiang Physician	(i)	630,779	0	546,569	17,400	21,286	1,216,034	0
	(ii)	0	0	0	0	0	0	0
5Dr Suresh Nukala Physician	(i)	441,525	0	428,153	17,400	18,452	905,530	0
	(ii)	0	0	0	0	0	0	0
6Dr Mukesh Kumar Physician	(i)	595,069	0	330,518	17,400	13,015	956,002	0
	(ii)	0	0	0	0	0	0	0
7Dr Shania Seibles Physician	(i)	544,994	0	210,084	17,400	8,219	780,697	0
	(ii)	0	0	0	0	0	0	0
8Mr Michael McAnder FORMER TREASURER/CFO PHC	(i)	0	0	0	0	0	0	0
	(ii)	0	0	972,687	0	0	972,687	0
9Mr Thomas Arnold TREASURER/CFO PHC	(i)	0	0	0	0	0	0	0
	(ii)	589,164	343,028	199,343	111,150	13,648	1,256,333	93,750
10Ms Elizabeth Leddy SECRETARY/CLO PHC	(i)	0	0	0	0	0	0	0
	(ii)	500,109	317,466	66,407	122,353	17,849	1,024,184	0
11MR MICHAEL MANDL BOARD MEMBER	(i)	0	0	0	0	0	0	0
	(ii)	874,041	548,422	107,257	180,936	12,644	1,723,300	0
12MR ALLEN HOLLADAY CFO	(i)	0	0	0	0	0	0	0
	(ii)	328,410	89,304	18,970	17,400	1,186	455,270	0

**SCHEDULE O**  
(Form 990)Department of the Treasury  
Internal Revenue Service**Supplemental Information to Form 990 or 990-EZ**Complete to provide information for responses to specific questions on  
Form 990 or 990-EZ or to provide any additional information.

▶ Attach to Form 990 or 990-EZ.

▶ Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No. 1545-0047

**2021****Open to Public  
Inspection**Name of the organization  
The Medical Center Inc

Employer identification number

58-1685139

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
FORM 990, PART V, LINE 1A: NUMBER OF FORMS 1099 FILED	ALL CALENDAR YEAR 2021 FORMS 1099 WERE FILED ON BEHALF OF THE MEDICAL CENTER BY ITS SOLE MEMBER, PIEDMONT HEALTHCARE, INC. (EIN 58-1503902), PURSUANT TO AN AGREEMENT WITH THE IRS TO FILE ALL FORMS 1099 FOR THE PIEDMONT HEALTHCARE SYSTEM ON A COMBINED BASIS.

# 990 Schedule O, Supplemental Information

Return Reference	Explanation
FORM 990, PART VI, SECTION A, LINE 6: ORGANIZATION'S SOLE MEMBER	PIEDMONT HEALTHCARE, INC. (EIN 58-1503902) IS THE SOLE MEMBER OF The Medical Center, INC.



**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, SECTION A, LINE 7A: ELECTION OF GOVERNING BODY	THE BOARD OF PIEDMONT HEALTHCARE, PIEDMONT COLUMBUS REGIONAL HEALTH SYSTEM'S SOLE MEMBER, APPOINTS THE MEMBERS OF THE BOARD OF DIRECTORS OF THE MEDICAL CENTER, INC.

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, SECTION A, LINE 7B: DECISIONS OF GOVERNING BODY	THE MEDICAL CENTER'S BOARD POLICIES AND DECISIONS MUST BE FILED, IMMEDIATELY AFTER ADOPTION, WITH THE SECRETARY OF THE PIEDMONT HEALTHCARE BOARD OF DIRECTORS. SUCH POLICIES AND DECISIONS OF THE MEDICAL CENTER BOARD OF DIRECTORS ARE NOT SUBJECT TO THE APPROVAL OF OR RATIFICATION BY THE PIEDMONT HEALTHCARE BOARD, BUT SHOULD THE NEED ARISE, THEY MAY BE RESCINDED BY THE PIEDMONT HEALTHCARE BOARD THROUGH A MAJORITY VOTE OF ITS DIRECTORS.

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, SECTION B, LINE 11B: 990 REVIEW PROCESS	INFORMATION NEEDED TO PREPARE THE MEDICAL CENTER'S FORM 990 IS COMPILED BY INDIVIDUALS IN THE ORGANIZATION'S FINANCE DEPARTMENT. THE INFORMATION IS REVIEWED BY TMC'S CONTROLLER AND VP/CFO. THE 990 IS THEN PREPARED INTERNALLY BY PIEDMONT HEALTHCARE, INC.'S TAX DEPARTMENT AND SUBMITTED TO AN EXTERNAL TAX PREPARER FOR REVIEW. PRIOR TO FILING, COPIES OF FORM 990 ARE PROVIDED TO THE BOARD OF DIRECTORS OF PIEDMONT HEALTHCARE, INC., THE ORGANIZATION'S SINGLE MEMBER, FOR BOARD REVIEW.

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, SECTION B, LINE 12C: CONFLICT OF INTEREST POLICY	COMPLIANCE WITH THE ORGANIZATION'S CONFLICT OF INTEREST POLICY IS MONITORED AND ENFORCED BY ORGANIZATION MANAGEMENT IN COORDINATION WITH PIEDMONT HEALTHCARE'S CHIEF COMPLIANCE OFFICER. ALL SENIOR LEADERS, BOARD MEMBERS, PHYSICIAN EMPLOYEES, NURSE PRACTITIONERS/PHYSICIAN ASSISTANTS AND EMPLOYEES AND NON-EMPLOYEES ENGAGED IN RESEARCH ARE REQUIRED TO ANNUALLY DISCLOSE ALL MATTERS WHICH COULD POTENTIALLY CONSTITUTE A CONFLICT OF INTEREST. MATTERS DISCLOSED UNDER THE POLICY MUST BE REVIEWED IN WRITING BY THE PIEDMONT HEALTHCARE CONFLICT OF INTEREST COMMITTEE IN ORDER TO DETERMINE WHETHER A CONFLICT EXISTS AND, IF SO, WHETHER TO ELIMINATE OR MANAGE THE CONFLICT. ALL BOARD MEMBERS AND EMPLOYEES OF THE MEDICAL CENTER ARE PROVIDED TRAINING ON CONFLICT OF INTEREST ISSUES, INCLUDING REPORTING REQUIREMENTS, AT NEW EMPLOYEE ORIENTATION AND AT LEAST ANNUALLY THEREAFTER. NONCOMPLIANCE WITH THE CONFLICT OF INTEREST POLICY MUST BE REPORTED TO PIEDMONT HEALTHCARE'S CHIEF COMPLIANCE OFFICER FOR INVESTIGATION, AND REMEDIAL STEPS MUST BE TAKEN AS APPROPRIATE UNDER THE PIEDMONT HEALTHCARE DISCIPLINARY POLICIES.

**990 Schedule O, Supplemental Information**

Return Reference	Explanation
<p>FORM 990, PART VI, SECTION B, LINE 15A, 15B: EXECUTIVE COMPENSATION</p>	<p>COMPENSATION FOR EXECUTIVES OF THE MEDICAL CENTER IS SET BY THE BOARD OF DIRECTORS OF PIEDMONT HEALTHCARE, INC. THE PIEDMONT HEALTHCARE, INC., BOARD OF DIRECTOR'S EXECUTIVE PERFORMANCE AND COMPENSATION COMMITTEE ("THE COMMITTEE") IS COMPOSED OF AT LEAST THREE MEMBERS OF THE PHC BOARD OF DIRECTORS, SERVING TERMS OF THREE YEARS, AND THE MAJORITY OF WHICH ARE COMMUNITY DIRECTORS WHO GENERALLY DO NOT HAVE CONFLICTS OF INTEREST RELATED TO FULFILLMENT OF THE DUTIES AS OUTLINED BELOW. THE COMMITTEE OVERSEES EXECUTIVE PERFORMANCE AND COMPENSATION ON BEHALF OF THE PHC BOARD, SUBJECT TO THE ULTIMATE AUTHORITY AND OVERSIGHT OF THE BOARD. THE COMMITTEE ALSO FORMULATES POLICIES AND MAKES DECISIONS IN ORDER TO ENSURE A HIGH LEVEL OF EXECUTIVE PERFORMANCE. THE COMMITTEE IS AUTHORIZED TO ACT ON BEHALF OF THE PHC BOARD AS SET OUT IN ITS CHARTER, AND THE COMMITTEE IS ALSO CHARGED WITH PROVIDING RECOMMENDATIONS AND PERIODIC REPORTS TO THE PHC BOARD REGARDING EXECUTIVE PERFORMANCE AND COMPENSATION. ALL DECISIONS AND COMPARABILITY DATA ARE DOCUMENTED IN THE COMMITTEE MEETING MINUTES. FUNCTIONS OF THE COMMITTEE - ASSESS AND IMPLEMENT POLICIES REGARDING PERFORMANCE, COMPENSATION AND BENEFITS OF THE PRESIDENT/CEO AND OTHER EXECUTIVES AS DETERMINED BY THE COMMITTEE - SELECT AN EXECUTIVE COMPENSATION CONSULTANT WHO REPORTS TO THE COMMITTEE - ANNUALLY REVIEW THE PRESIDENT/CEO SUCCESSION PLAN - FORMULATE AND IMPLEMENT ANNUAL PERFORMANCE OBJECTIVES FOR THE PRESIDENT/CEO, AND REVIEW AND APPROVE ANNUALLY RECOMMENDATIONS FROM THE PRESIDENT/CEO RELATING TO COMPENSATION, PERFORMANCE OBJECTIVES, AND SUCCESSION PLANS FOR EVP EXECUTIVES - ANNUALLY ASSESS PRESIDENT/CEO PERFORMANCE; IF NECESSARY, IMPLEMENT ACTION PLAN WITH PRESIDENT/CEO INPUT TO IMPROVE HIS/HER PERFORMANCE; ADJUST COMPENSATION AS APPROPRIATE; THE COMMITTEE CHAIR SHALL CONSULT WITH THE PHC GOVERNANCE COMMITTEE CHAIR AND THE PHC BOARD CHAIR AND SHALL COORDINATE THE ANNUAL PERFORMANCE REVIEW OF THE PHC PRESIDENT/CEO, UNLESS THE PHC BOARD CHAIR HAS A REAL OR PERCEIVED CONFLICT OF INTEREST, IN WHICH CASE THE COMMITTEE CHAIR SHALL DETERMINE THE PROPER REVIEW PROCESS - REVIEW AND APPROVE LONG-TERM AND SHORT-TERM GOALS TO BE USED IN CONNECTION WITH EVP COMPENSATION PROGRAMS AS RECOMMENDED BY THE PRESIDENT/CEO AND VALIDATED BY THE COMPENSATION CONSULTANT - PERIODICALLY REVIEW COMPENSATION, IF ANY, FOR THE PHC BOARD CHAIR AND ALL BOARD CHAIRS OF THE PHC SUBSIDIARIES - ESTABLISH OTHER POLICIES AND PROCEDURES, AND PERFORM OTHER TASKS, RELATED TO EXECUTIVE PERFORMANCE AND COMPENSATION, INCLUDING BUT NOT LIMITED TO, APPROVAL OF EXECUTIVE EMPLOYMENT CONTRACTS AND BENEFITS - PERIODICALLY REPORT SIGNIFICANT DECISIONS AND ANY ADDITIONAL REQUESTED INFORMATION TO THE PHC BOARD.</p>

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART VI, SECTION C, LINE 19: DOCUMENTS AND POLICIES	GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS ARE AVAILABLE UPON REQUEST. THESE DOCUMENTS SHOULD BE REQUESTED FROM PIEDMONT HEALTHCARE, INC.'S LEGAL COUNSEL.

**990 Schedule O, Supplemental Information**

<b>Return Reference</b>	<b>Explanation</b>
FORM 990, PART XI, LINE 9: CHANGES IN NET ASSETS	INTERCOMPANY TRANSFER (\$167,269,595) BOOK/TAX DIFFERENCES \$ 117,375 ----- ----- TOTAL (\$167,152,220)

**SCHEDULE R  
(Form 990)**

**Related Organizations and Unrelated Partnerships**

OMB No. 1545-0047

**2021**

**Open to Public  
Inspection**

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

Department of the Treasury  
Internal Revenue Service

Name of the organization  
The Medical Center Inc

**Employer identification number**

58-1685139

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
See Additional Data Table							



**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	
<b>(1)</b> GA SURGICAL CTR ON PEACHTREE 2061 PEACHTREE RD STE 100 ATLANTA, GA 30309 58-2394271	SURGERY	GA	NA	NONE	0	0		No	0		No	
<b>(2)</b> ORTHOATLANTA SURGERY CENTER FAYETTEVILLE 900 CIRCLE 75 PKWY SE STE 1700 ATLANTA, GA 30339 20-2961633	SURGERY	GA	NA	NONE	0	0		No	0		No	
<b>(3)</b> ATHENS ASC HOLDINGS LLC 2142 W BROAD ST BLDG 100 STE 100 ATHENS, GA 30606 45-4014891	SURGERY	GA	NA	NONE	0	0		No	0		No	
<b>(4)</b> COLUMBUS DIAGNOSTIC IMAGING CTR 116 INTRACOASTAL POINTE DR 300 JUPITER, FL 33477 26-2291768	IMAGING	GA	NA	NONE	0	0		No	0		No	
<b>(5)</b> THE SURGERY CTR LLC 100 FIRST COURT COLUMBUS, GA 31909 58-2520623	SURGERY	GA	NA	NONE	0	0		No	0		No	
<b>(6)</b> PIEDMONT ENCOMPASS REHAB HOSPITALS LLC 9001 LIBERTY PKWY BIRMINGHAM, AL 35242 85-3544795	HEALTHCARE	DE	NA	NONE	0	0		No	0		No	
<b>(7)</b> COLISEUM SAME DAY SURGERY CTR LP 340 HOSPITAL DR MACON, GA 31217 62-1805346	SURGERY	GA	NA	NONE	0	0		No	0		No	

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Direct controlling entity	(e) Type of entity (C corp, S corp, or trust)	(f) Share of total income	(g) Share of end-of-year assets	(h) Percentage ownership	(i) Section 512(b)(13) controlled entity?	
								Yes	No
See Additional Data Table									

**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
<b>1</b> 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?		
<b>a</b> Receipt of <b>(i)</b> interest, <b>(ii)</b> annuities, <b>(iii)</b> royalties, or <b>(iv)</b> rent from a controlled entity . . . . .	<b>1a</b>	No
<b>b</b> Gift, grant, or capital contribution to related organization(s) . . . . .	<b>1b</b>	No
<b>c</b> Gift, grant, or capital contribution from related organization(s) . . . . .	<b>1c</b>	No
<b>d</b> Loans or loan guarantees to or for related organization(s) . . . . .	<b>1d</b>	No
<b>e</b> Loans or loan guarantees by related organization(s) . . . . .	<b>1e</b>	No
<b>f</b> Dividends from related organization(s) . . . . .	<b>1f</b>	No
<b>g</b> Sale of assets to related organization(s) . . . . .	<b>1g</b>	No
<b>h</b> Purchase of assets from related organization(s) . . . . .	<b>1h</b>	No
<b>i</b> Exchange of assets with related organization(s) . . . . .	<b>1i</b>	No
<b>j</b> Lease of facilities, equipment, or other assets to related organization(s) . . . . .	<b>1j</b>	No
<b>k</b> Lease of facilities, equipment, or other assets from related organization(s) . . . . .	<b>1k</b>	No
<b>l</b> Performance of services or membership or fundraising solicitations for related organization(s) . . . . .	<b>1l</b>	No
<b>m</b> Performance of services or membership or fundraising solicitations by related organization(s) . . . . .	<b>1m</b>	No
<b>n</b> Sharing of facilities, equipment, mailing lists, or other assets with related organization(s) . . . . .	<b>1n</b>	No
<b>o</b> Sharing of paid employees with related organization(s) . . . . .	<b>1o</b>	No
<b>p</b> Reimbursement paid to related organization(s) for expenses . . . . .	<b>1p</b>	Yes
<b>q</b> Reimbursement paid by related organization(s) for expenses . . . . .	<b>1q</b>	Yes
<b>r</b> Other transfer of cash or property to related organization(s) . . . . .	<b>1r</b>	No
<b>s</b> Other transfer of cash or property from related organization(s) . . . . .	<b>1s</b>	No

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

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



**Part VII**    **Supplemental Information**

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

<b>Return Reference</b>	<b>Explanation</b>

**Additional Data**

**Software ID:**  
**Software Version:**  
**EIN:** 58-1685139  
**Name:** The Medical Center Inc

**Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
1800 HOWELL MILL RD STE 850 ATLANTA, GA 30318 58-1503902	MANAGEMENT	GA	501(c)(3)	12C, III-FI	NA		No
1968 PEACHTREE ROAD NW ATLANTA, GA 30309 58-0566213	HOSPITAL	GA	501(c)(3)	3	PHC		No
1255 HIGHWAY 54 WEST FAYETTEVILLE, GA 30214 58-2232328	HOSPITAL	GA	501(c)(3)	3	phc		No
1266 HIGHWAY 515 SOUTH JASPER, GA 30143 35-2228583	HOSPITAL	GA	501(c)(3)	3	phc		No
745 POPLAR ROAD NEWMAN, GA 30265 20-5077249	HOSPITAL	GA	501(c)(3)	3	phc		No
2001 PEACHTREE ROAD NE SUITE 400 ATLANTA, GA 30309 58-1272768	FUNDRAISING	GA	501(c)(3)	12B, II	phc		No
1133 EAGLES LANDING PKWY STOCKBRIDGE, GA 30281 58-2200195	HOSPITAL	GA	501(c)(3)	3	PHC		No
5126 HOSPITAL DRIVE NE COVINGTON, GA 30014 58-2155150	HOSPITAL	GA	501(C)(3)	3	PHC		No
1199 PRINCE AVENUE ATHENS, GA 30606 58-1978389	fundraising	GA	501(c)(3)	12B, II	PARMC		No
1199 PRINCE AVENUE athens, GA 30606 58-1930580	development	GA	501(c)(3)	12B, II	PARMC		No
1199 PRINCE AVENUE ATHENS, GA 30606 58-2179986	Hospital	GA	501(c)(3)	3	PHC		No
1199 PRINCE AVENUE ATHENS, GA 30606 58-2332921	Healthcare	GA	501(c)(3)	12B, II	PARMC		No
1199 PRINCE AVENUE Athens, GA 30606 27-1975001	Healthcare	GA	501(c)(3)	3	PARMC		No
1199 PRINCE AVENUE Athens, GA 30606 58-2362733	Urgent Care	GA	501(c)(3)	12B, II	PARMC		No
707 CENTER STREET COLUMBUS, GA 31901 58-2628502	HEALTHCARE	GA	501(C)(3)	12C, III-FI	PHC		No
707 CENTER STREET COLUMBUS, GA 31901 58-1719994	MANAGEMENT	GA	501(C)(3)	12B, II	PHC		No
707 CENTER STREET COLUMBUS, GA 31901 58-1501642	FUNDRAISING	GA	501(C)(3)	7	CRHS		No
707 CENTER STREET COLUMBUS, GA 31901 33-1216751	HOSPITAL	GA	501(C)(3)	3	CRHS		No
1412 MILSTEAD AVE CONYERS, GA 30012 30-0999841	HOSPITAL	GA	501(C)(3)	3	PHC		No
2151 WEST SPRING ST MONROE, GA 30655 82-4194264	HOSPITAL	GA	501(C)(3)	3	PHC		No

**Form 990, Schedule R, Part II - Identification of Related Tax-Exempt Organizations**

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c) (3))	(f) Direct controlling entity	(g) Section 512 (b)(13) controlled entity?	
						Yes	No
95 COLLIER ROAD NW STE 2045 ATLANTA, GA 30309 26-3553500	healthcare	GA	501(C)(3)	10	PHC		No
707 CENTER STREET COLUMBUS, GA 31901 58-1719867	AMBULATORY	GA	501(C)(3)	3	CRHS		No
960 JOE FRANK HARRIS PKWY SE CARTERSVILLE, GA 30120 87-0963633	HOSPITAL	GA	501(C)(3)	3	PHC		No
1700 MEDICAL WAY snellville, GA 30078 87-0982886	HOSPITAL	GA	501(C)(3)	3	PHC		No
350 HOSPITAL DR MACON, GA 31217 87-1006981	HOSPITAL	GA	501(C)(3)	3	PHC		No
400 CHARTER BLVD MACON, GA 31210 87-1031034	HOSPITAL	GA	501(C)(3)	3	PHC		No
1350 WALTON WAY AUGUSTA, GA 30901 58-1581103	HOSPITAL	GA	501(C)(3)	3	PHC		No
1350 WALTON WAY AUGUSTA, GA 30901 45-4166209	HOSPITAL	GA	501(C)(3)	3	PHC		No
2260 WRIGHTSBORO ROAD AUGUSTA, GA 30904 58-1343550	FUNDRAISING	GA	501(C)(3)	7	UHS		No
1350 WALTON WAY AUGUSTA, GA 30901 58-1581105	HEALTHCARE	GA	501(C)(3)	3	UHS		No

Form 990, Schedule R, Part III - Identification of Related Organizations Taxable as a Partnership												
(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	
GA SURGICAL CTR ON PEACHTREE  2061 PEACHTREE RD STE 100 ATLANTA, GA 30309 58-2394271	SURGERY	GA	NA	NONE	0	0		No	0		No	
ORTHOATLANTA SURGERY CENTER FAYETTEVILLE  900 CIRCLE 75 PKWY SE STE 1700 ATLANTA, GA 30339 20-2961633	SURGERY	GA	NA	NONE	0	0		No	0		No	
ATHENS ASC HOLDINGS LLC  2142 W BROAD ST BLDG 100 STE 100 ATHENS, GA 30606 45-4014891	SURGERY	GA	NA	NONE	0	0		No	0		No	
COLUMBUS DIAGNOSTIC IMAGING CTR  116 INTRACOASTAL POINTE DR 300 JUPITER, FL 33477 26-2291768	IMAGING	GA	NA	NONE	0	0		No	0		No	
THE SURGERY CTR LLC  100 FIRST COURT COLUMBUS, GA 31909 58-2520623	SURGERY	GA	NA	NONE	0	0		No	0		No	
PIEDMONT ENCOMPASS REHAB HOSPITALS LLC  9001 LIBERTY PKWY BIRMINGHAM, AL 35242 85-3544795	HEALTHCARE	DE	NA	NONE	0	0		No	0		No	
COLISEUM SAME DAY SURGERY CTR LP  340 HOSPITAL DR MACON, GA 31217 62-1805346	SURGERY	GA	NA	NONE	0	0		No	0		No	

**Form 990, Schedule R, Part IV - Identification of Related Organizations Taxable as a Corporation or Trust**

(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
PIEDMONT MEDICAL CARE CORPORATION 2727 PACES FERRY ROAD SUITE 1-1100 ATLANTA, GA 30339 58-2092768	HEALTHCARE	GA	NA	C-CORP	0	0			No
THE PIEDMONT CLINIC INC 2727 PACES FERRY ROAD SUITE 1-1100 ATLANTA, GA 30339 58-2005358	HEALTHCARE	GA	NA	C-CORP	0	0			No
PIEDMONT HEART INSTITUTE PHYSICIANS INC 95 COLLIER ROAD NW STE 2045 ATLANTA, GA 30309 26-0593850	HEALTHCARE	GA	NA	C-CORP	0	0			No
AMSTER MCRAE INSURANCE COMPANY PO BOX 1159 GRAND CAYMAN KY1-1102 CJ 98-0427603	Related Insurance	CJ	NA	C-CORP	0	0			No
COLUMBUS HEALTHCARE RESOURCES PO BOX 790 COLUMBUS, GA 31902 58-1717754	HEALTHCARE	GA	NA	C-CORP	0	0			No
COLUMBUS HEALTH SERVICES INC PO BOX 790 COLUMBUS, GA 31902 58-1640939	HEALTHCARE	GA	NA	C-CORP	0	0			No
UNIVERSITY HEALTH RESOURCES INC 1350 WALTON WAY AUGUSTA, GA 30901 58-1601372	HEALTHCARE	GA	NA	C-CORP	0	0			No
UNIVERSITY HOSPITAL AIKEN INC 1350 WALTON WAY AUGUSTA, GA 30901 47-2713774	HOSPITAL	SC	NA	C-CORP	0	0			No