PHOEBE SUMTER MEDICAL CENTER, INC.

FINANCIAL STATEMENTS

for the years ended July 31, 2017 and 2016

C O N T E N T S

Draffin & Tucker, LLP
CERTIFIED PUBLIC ACCOUNTANTS

Member:
THE AMERICAN INSTITUTE OF
CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT

Board of Directors
Phoebe Sumter Medical Center, Inc.
Americus, Georgia

We have audited the accompanying financial statements of Phoebe Sumter Medical Center, Inc. (Hospital), which comprise the balance sheets as of July 31, 2017 and 2016, and the related statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

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P.O. Box 71309
2617 Gillionville Road
Albany, GA 31708-1309
Tel. (229) 883-7878
Fax (229) 435-3152

Five Concourse Parkway
Suite 1250
Atlanta, GA 30328
Tel. (404) 220-8494
Fax (229) 435-3152

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Hospital's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Hospital's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Phoebe Sumter Medical Center, Inc. as of July 31, 2017 and 2016, and the results of its operations and changes in net assets, and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Draffin & Tucker, LLP
Albany, Georgia
February 2, 2018

PHOEBE SUMTER MEDICAL CENTER, INC.

BALANCE SHEETS, July 31, 2017 and 2016

	2017	2016
ASSETS		
Current assets:		
Cash	$ 29,789,000	$ 24,892,000
Patient accounts receivable, net of allowance for doubtful accounts of $4,957,000 in 2017 and $12,368,000 in 2016	9,360,000	9,641,000
Supplies, at lower of cost (first-in, first-out) or market	1,336,000	1,372,000
Other current assets	1,129,000	1,704,000
Total current assets	41,614,000	37,609,000
Assets limited as to use:		
Internally designated for capital improvements	18,889,000	4,175,000
Externally designated by donors	4,000,000	-
Total assets limited as to use	22,889,000	4,175,000
Property and equipment, net	43,521,000	43,782,000
Other assets:		
Notes receivable	133,000	210,000
Interest in net assets of Sumter Regional Hospital Foundation, Inc.	3,355,000	3,238,000
Total other assets	3,488,000	3,448,000
Total assets	$ 111,512,000	$ 89,014,000

	2017	2016
LIABILITIES AND NET ASSETS		
Current liabilities:		
Accounts payable	$ 2,172,000	$ 1,826,000
Accrued expenses	3,931,000	3,111,000
Estimated third-party payor settlement	1,408,000	749,000
Total current liabilities	7,511,000	5,686,000
Related party payables	3,422,000	2,216,000
Total liabilities	10,933,000	7,902,000
Net assets:		
Unrestricted	96,579,000	81,112,000
Temporarily restricted	4,000,000	-
Total net assets	100,579,000	81,112,000
Total liabilities and net assets	$ 111,512,000	$ 89,014,000

See accompanying notes to financial statements.

PHOEBE SUMTER MEDICAL CENTER, INC.

STATEMENTS OF OPERATIONS AND
CHANGES IN NET ASSETS
for the years ended July 31, 2017 and 2016

	2017	2016
Unrestricted revenues, gains, and other support:		
Patient service revenue (net of contractual allowances and discounts)	$ 83,544,000	$ 90,067,000
Provision for bad debts	(11,394,000)	(19,976,000)
Net patient service revenue	72,150,000	70,091,000
Other revenue	2,282,000	2,118,000
Total revenues, gains, and other support	74,432,000	72,209,000
Expenses:		
Salaries and wages	18,742,000	18,812,000
Employee health and welfare	5,218,000	6,188,000
Medical supplies and other	26,641,000	22,188,000
Purchased services	13,915,000	13,824,000
Depreciation and amortization	2,917,000	4,312,000
Total expenses	67,433,000	65,324,000
Operating profit	6,999,000	6,885,000
Nonoperating gains:		
Investment income	635,000	97,000
Contributions	36,000	-
Other income	7,745,000	-
Gain on disposal of assets	-	29,000
Total nonoperating gains	8,416,000	126,000

Continued

PHOEBE SUMTER MEDICAL CENTER, INC.

STATEMENTS OF OPERATIONS AND
CHANGES IN NET ASSETS, Continued
for the years ended July 31, 2017 and 2016

	2017	2016
Excess revenues	$ 15,415,000	$ 7,011,000
Change in unrealized gains (losses) on investments other than trading	(65,000)	37,000
Change in interest in net assets of Sumter Regional Hospital Foundation, Inc.	117,000	78,000
Increase in unrestricted net assets	15,467,000	7,126,000
Temporarily restricted net assets: Restricted contributions	4,000,000	-
Increase in net assets	19,467,000	7,126,000
Net assets, beginning of year	81,112,000	73,986,000
Net assets, end of year	$ 100,579,000	$ 81,112,000

See accompanying notes to financial statements.

PHOEBE SUMTER MEDICAL CENTER, INC.

STATEMENTS OF CASH FLOWS
for the years ended July 31, 2017 and 2016

	2017	2016
Cash flows from operating activities:		
Increase in net assets	$ 19,467,000	$ 7,126,000
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Realized (gain) loss and changes in unrealized (gain) loss on investments	(372,000)	(37,000)
Gain on disposal of assets	-	(29,000)
Depreciation and amortization	2,917,000	4,312,000
Change in interest in net assets of Sumter Regional Hospital Foundation, Inc.	(117,000)	(78,000)
Forgiveness of notes receivable	92,000	55,000
Changes in:		
Patient accounts receivable	281,000	(97,000)
Supplies	36,000	(458,000)
Other current assets	575,000	(305,000)
Notes receivable	(15,000)	(13,000)
Accounts payable	346,000	635,000
Accrued expenses	820,000	132,000
Estimated third-party payor settlements	659,000	489,000
Net cash provided by operating activities	24,689,000	11,732,000
Cash flows from investing activities:		
Purchase of property and equipment	(2,656,000)	(4,273,000)
Proceeds from sale of fixed assets	-	139,000
Proceeds from sale of investments	9,066,000	1,241,000
Purchase of investments	(27,408,000)	(1,287,000)
Net cash used by investing activities	(20,998,000)	(4,180,000)

Continued

PHOEBE SUMTER MEDICAL CENTER, INC.

STATEMENTS OF CASH FLOWS, Continued
for the years ended July 31, 2017 and 2016

	2017	2016
Cash flows from financing activities:		
Advances from related parties	$ 21,096,000	$ 22,209,000
Payments to related parties	(19,890,000)	(21,691,000)
Net cash provided by financing activities	1,206,000	518,000
Net increase in cash	4,897,000	8,070,000
Cash at beginning of year	24,892,000	16,822,000
Cash at end of year	$ 29,789,000	$ 24,892,000

See accompanying notes to financial statements.

1. Summary of Significant Accounting Policies

Organization

Phoebe Sumter Medical Center, Inc. (Hospital) was organized on January 5, 2009 as a nonprofit corporation and is a wholly-owned subsidiary of Phoebe Putney Health System, Inc. (System).

Effective June 30, 2009, the Americus-Sumter County Hospital Authority (Authority) implemented a reorganization plan for Sumter Regional Hospital (SRH) whereby all the assets, management, and governance of SRH was transferred to the Hospital, pursuant to a lease and transfer agreement. The lease term is forty years with an annual contribution of $25,000 to the Authority. Under the lease and transfer agreement, the Authority was required to construct a new hospital facility. The new hospital facility was placed in service and leased to the Hospital for the remainder of the lease term. As part of the lease and transfer agreement, System agreed to contribute up to $25,000,000 to the construction cost of the new facility or the physician recruiting efforts of the Hospital, as needed. The lease and transfer agreement was amended effective September 27, 2016. See Note 4 for further detail regarding the amendment.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Allowance for Doubtful Accounts

Accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, the Hospital analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, the Hospital analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party

Continued

1. Summary of Significant Accounting Policies, Continued

Allowance For Doubtful Accounts, Continued

payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the Hospital records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts. The Hospital has implemented an early out strategy for self-pay accounts which provides patients 30 days to pay on their bill. If no payment is received within this time period, the client contracts a third-party to pursue collection efforts and records an allowance for doubtful accounts of approximately 97%.

The Hospital's allowance for doubtful accounts for self-pay patients decreased from 91% of self-pay accounts receivable at July 31, 2016 to 81% of self-pay accounts receivable at July 31, 2017. The decrease was a result of the Hospital implementing strategies to better identify accounts receivable associated with patient balances after insurance or another third-party has paid. These accounts are more likely to be collectible than true self-pay accounts. The Hospital updated its financial assistance policy during 2017 as discussed in Note 2.

Supplies

Supplies, which consist primarily of drugs and medical supplies, are valued at first-in, first-out cost, but not in excess of market.

Investments

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the balance sheet. Investment income or loss (including realized gains and losses on investments, interest and dividends) is included in excess revenues unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are excluded from excess revenues unless the investments are trading securities.

Continued

1. Summary of Significant Accounting Policies, Continued

Assets Limited as to Use

Assets limited as to use include assets restricted by donors and designated assets set aside by the Board of Directors for future capital improvements, over which the Board retains control and may at its discretion, subsequently use for other purposes.

Property and Equipment

Property and equipment acquisitions are recorded at cost. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed on the straight-line method.

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted support, and are excluded from excess revenues, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained; expirations of donor restrictions are reported when the donated or acquired long-lived assets are placed in service.

Beneficial Interest in Net Assets of Foundation

The Hospital accounts for the activities of its related Foundation in accordance with FASB ASC 958-20, *Not-For-Profit Entities, Financially Interrelated Entities*. FASB ASC 958-20 establishes reporting standards for transactions in which a donor makes a contribution to a not-for-profit organization which accepts the assets on behalf of or transfers these assets to a beneficiary which is specified by the donor. Sumter Regional Hospital Foundation, Inc. (Foundation) accepts assets on behalf of the Hospital.

Temporarily Restricted Net Assets

Temporarily restricted net assets are those whose use by the Hospital has been limited by donors to a specific time period or purpose.

Continued

1. Summary of Significant Accounting Policies, Continued

Excess Revenues

The statement of operations and changes in net assets includes excess revenues. Changes in net assets which are excluded from excess revenues, consistent with industry practice, include unrealized gains and losses on investments other than trading securities, permanent transfers of assets to and from affiliates for other than goods and services, and contributions of long-lived assets (including assets acquired using contributions which by donor restriction were to be used for the purposes of acquiring such assets).

Net Patient Service Revenue

The Hospital has agreements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments.

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Charity Care

The Hospital provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

Donor-Restricted Gifts

Unconditional promises to give cash and other assets to the Hospital are reported at fair value at the date the promise is received. Conditional promises to give and indications of intentions to give are reported at fair value at the date the gift is received. The gifts are reported as either temporarily or permanently restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily

Continued

1. Summary of Significant Accounting Policies, Continued

Donor-Restricted Gifts, Continued

restricted net assets are reclassified as unrestricted net assets and reported in the statement of operations and changes in net assets as net assets released from restrictions. Donor-restricted contributions whose restrictions are met within the same year as received are reported as unrestricted contributions in the accompanying financial statements.

Estimated Malpractice and Other Self-Insurance Costs

The provisions for estimated medical malpractice claims and other claims under self-insurance plans include estimates of the ultimate costs for both reported claims and claims incurred but not reported.

Income Taxes

The Hospital is a not-for-profit corporation that has been recognized as tax-exempt pursuant to Section 501(c)(3) of the Internal Revenue Code.

The Hospital applies accounting policies that prescribe when to recognize and how to measure the financial statement effects of income tax positions taken or expected to be taken on its income tax returns. These rules require management to evaluate the likelihood that, upon examination by the relevant taxing jurisdictions, those income tax positions would be sustained. Based on that evaluation, the Hospital only recognizes the maximum benefit of each income tax position that is more than 50% likely of being sustained. To the extent that all or a portion of the benefits of an income tax position are not recognized, a liability would be recognized for the unrecognized benefits, along with any interest and penalties that would result from disallowance of the position. Should any such penalties and interest be incurred, they would be recognized as operating expenses.

Based on the results of management's evaluation, no liability is recognized in the accompanying balance sheet for unrecognized income tax positions. Further, no interest or penalties have been accrued or charged to expense as of July 31, 2017 and 2016 or for the years then ended. The Hospital's tax returns are subject to possible examination by the taxing authorities. For federal income tax purposes, the tax returns essentially remain open for possible examination for a period of three years after the respective filing deadlines of those returns.

Continued

1. Summary of Significant Accounting Policies, Continued

Impairment of Long-Lived Assets

The Hospital evaluates on an ongoing basis the recoverability of its assets for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is required to be recognized if the carrying value of the asset exceeds the undiscounted future net cash flows associated with that asset. The impairment loss to be recognized is the amount by which the carrying value of the long-lived asset exceeds the asset's fair value. In most instances, the fair value is determined by discounted estimated future cash flows using an appropriate interest rate. The Hospital has not recorded any impairment charges in the accompanying statements of operations and changes in net assets for the years ended July 31, 2017 and 2016.

Fair Value Measurements

FASB ASC 820, *Fair Value Measurement and Disclosures* defines fair value as the amount that would be received for an asset or paid to transfer a liability (i.e., an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. FASB ASC 820 also establishes a fair value hierarchy that requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value. FASB ASC 820 describes the following three levels of inputs that may be used:

- *Level 1*: Quoted prices (unadjusted) in active markets that are accessible at the measurement date for identical assets and liabilities. The fair value hierarchy gives the highest priority to Level 1 inputs.

- *Level 2*: Observable prices that are based on inputs not quoted on active markets but corroborated by market data.

- *Level 3*: Unobservable inputs when there is little or no market data available, thereby requiring an entity to develop its own assumptions. The fair value hierarchy gives the lowest priority to Level 3 inputs.

Subsequent Event

In preparing these financial statements, the Hospital has evaluated events and transactions for potential recognition or disclosure through February 2, 2018, the date the financial statements were available to be issued.

Continued

1. Summary of Significant Accounting Policies, Continued

Prior Year Reclassifications

Certain reclassifications have been made to the fiscal year 2016 financial statements to conform to the fiscal year 2017 presentation. These reclassifications had no impact on the change in net assets in the accompanying financial statements.

2. Net Patient Service Revenue

The Hospital has arrangements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. The Hospital does not believe that there are any significant credit risks associated with receivables due from third-party payors.

The Hospital recognizes patient service revenue associated with services provided to patients who have third-party coverage on the basis of contractual rates for the services rendered. For uninsured patients that do not qualify for charity care, the Hospital recognizes revenue on the basis of its standard rates for services provided (or on the basis of discounted rates, if negotiated or provided by policy). On the basis of historical experience, a significant portion of the Hospital's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Hospital records a significant provision for bad debts related to uninsured patients in the period the services are provided.

Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period from these major payor sources, is as follows:

July 31, 2017
Patient Service Revenue
(Net of Contractual Allowances and Discounts)

Medicare	Medicaid	Self-Pay	Other	Total All Payors
$ 26,242,000	$ 12,443,000	$ 4,602,000	$ 40,257,000	$ 83,544,000

Continued

2. Net Patient Service Revenue, Continued

July 31, 2016
Patient Service Revenue
(Net of Contractual Allowances and Discounts)

Medicare	Medicaid	Self-Pay	Other	Total All Payors
$ 19,851,000	$ 14,457,000	$ 17,304,000	$ 38,455,000	$ 90,067,000

Revenue from the Medicare and Medicaid programs accounted for approximately 36% and 17%, respectively, of the Hospital's net patient revenue for the year ended July 31, 2017 and 28% and 21%, respectively, of the Hospital's net patient revenue for the year ended July 31, 2016. Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Cost report estimated reimbursement amounts are adjusted in subsequent periods as final settlements are determined.

The Hospital believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. However, there has been an increase in regulatory initiatives at the state and federal levels including the initiation of the Recovery Audit Contractor (RAC) program and the Medicaid Integrity Contractor (MIC) program. These programs were created to review Medicare and Medicaid claims for medical necessity and coding appropriateness. The RAC's have authority to pursue improper payments with a three year look back from the date the claim was paid. Compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs.

A summary of the payment arrangements with major third-party payors follows:

- Medicare

  Inpatient acute care services and outpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors.

Continued

2. Net Patient Service Revenue, Continued

- Medicare, Continued

The Hospital is reimbursed for certain reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicare Administrative Contractor (MAC). The Hospital's classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review by a peer review organization under contract with the Hospital. The Hospital's Medicare cost reports have been audited by the MAC through July 31, 2013, with the exception of July 31, 2012.

- Medicaid

Inpatient acute care services rendered to Medicaid program beneficiaries are paid at a prospectively determined rate per admission. These rates vary according to a patient classification system that is based on clinical, diagnostic and other factors.

Outpatient services rendered to the Medicaid program beneficiaries are reimbursed under a cost reimbursement methodology. The Hospital is reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by the Hospital and audits thereof by the Medicaid fiscal intermediary. The Hospital's Medicaid cost reports have been audited by the Medicaid fiscal intermediary through July 31, 2014.

The Hospital has also entered into contracts with certain managed care organizations to receive reimbursement for providing services to selected enrolled Medicaid beneficiaries. Payment arrangements with these managed care organizations consist primarily of prospectively determined rates per discharge, discounts from established charges, or prospectively determined per diems.

The Hospital participates in the Georgia Indigent Care Trust Fund (ICTF) Program. The Hospital receives ICTF payments for treating a disproportionate number of Medicaid and other indigent patients. ICTF payments are based on the Hospital's estimated uncompensated cost of services to Medicaid and uninsured patients. The amount of ICTF payments recognized in net patient service revenue was approximately $2,074,000 and $2,932,000 for the years ended July 31, 2017 and 2016, respectively.

Continued

2. Net Patient Service Revenue, Continued

- Medicaid, Continued

  The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) provides for payment adjustments to certain facilities based on the Medicaid Upper Payment Limit (UPL). The UPL payment adjustments are based on a measure of the difference between Medicaid payments and the amount that could be paid based on Medicare payment principles. The net amount of UPL payment adjustments recognized in net patient service revenue was approximately $180,000 and $349,000 for the years ended July 31, 2017 and 2016, respectively.

  During 2010, the state of Georgia enacted legislation known as the Provider Payment Agreement Act (Act) whereby hospitals in the state of Georgia are assessed a "provider payment" in the amount of 1.45% of their net patient revenue. The Act became effective July 1, 2010, the beginning of state fiscal year 2011. The provider payments are due on a quarterly basis to the Department of Community Health. The payments are to be used for the sole purpose of obtaining federal financial participation for medical assistance payments to providers on behalf of Medicaid recipients. The provider payment will result in an increase in hospital payments on Medicaid services of approximately 11.88%. Approximately $717,000 and $691,000 relating to the Act is included in medical supplies and other in the accompanying statement of operations and changes in net assets for the years ended July 31, 2017 and 2016, respectively.

- Other Arrangements

  The Hospital has also entered into payment arrangements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the Hospital under these arrangements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

- Uninsured Patients

  In 2017, the Hospital updated its Financial Assistance Policy (FAP) in accordance with Internal Revenue Code 501(r). Based on the FAP, following a determination of financial assistance eligibility, patients who are eligible individuals will not be charged more for emergency or other medically necessary care than the Amounts Generally Billed (AGB) for individuals who have insurance coverage. The minimum percentage

Continued

2. Net Patient Service Revenue, Continued

- Uninsured Patients, Continued

discount to be applied to FAP eligible individuals shall be calculated on an annual basis. AGB is determined by dividing the sum of claims paid the previous fiscal year by Medicare fee-for-service and all private health insurance, including payments received from beneficiaries and insured patients, by the sum of the associated gross charges for those claims.

3. Uncompensated Services

The Hospital was compensated for services at amounts less than its established rates.

Charges for uncompensated services for 2017 and 2016 were approximately $177,868,000 and $158,154,000, respectively.

Uncompensated care includes charity and indigent care services of approximately $16,964,000 and $5,875,000 for the years ended July 31, 2017 and 2016, respectively. The cost of charity and indigent care services provided during the years ended July 31, 2017 and 2016 was approximately $4,575,000 and $1,681,000, respectively computed by applying a total cost factor to the charges foregone.

The following is a summary of uncompensated services and a reconciliation of gross patient charges to net patient service revenue for the years ended July 31, 2017 and 2016.

	2017	2016
Gross patient charges	$ 250,018,000	$ 228,245,000
Uncompensated services:		
Charity and indigent care	16,964,000	5,875,000
Medicare	86,122,000	81,068,000
Medicaid	38,485,000	29,386,000
Other allowances	24,903,000	21,849,000
Bad debts	11,394,000	19,976,000
Total uncompensated care	177,868,000	158,154,000
Net patient service revenue	$ 72,150,000	$ 70,091,000

Continued

4. Assets Limited as to Use

The composition of assets limited as to use as of July 31, 2017 and 2016 is set forth in the following table. Effective February 2017, the Hospital changed its investment policy resulting in assets limited as to use being classified as trading. Prior to February 2017, assets limited as to use are classified as other than trading. All assets limited as to use are stated at fair value.

	2017	2016
By board for capital improvements:		
Money market funds	$ 7,803,000	$ 1,007,000
Government debt securities	1,839,000	2,110,000
Corporate debt securities	2,378,000	1,058,000
Equity securities	6,869,000	-
Total board designated for capital improvements	18,889,000	4,175,000
Externally designated by donors:		
Money market funds	2,601,000	-
Corporate debt securities	1,040,000	-
Equity securities	359,000	-
Total externally designated by donors	4,000,000	-
Total assets limited as to use	$ 22,889,000	$ 4,175,000

During fiscal year 2007, Sumter Regional Hospital, as operated by the Authority, was destroyed in a tornado. As described in Note 1, the Authority entered into a lease and transfer agreement which included the construction of a new hospital facility. The Authority has received proceeds from the Federal Emergency Management Agency (FEMA) and the Georgia Emergency Management Agency (GEMA) for a portion of the construction costs of the new Hospital and intends to pursue further reimbursement from FEMA and GEMA to the fullest extent possible. It is anticipated, based on guidance received from an independent consultant, that the project audits are likely to be conducted by FEMA and GEMA once all outstanding claims are closed, which could result in demand(s) to recover a portion of the funds paid to the Authority.

Continued

4. Assets Limited as to Use, Continued

Effective with an amendment to the lease and transfer agreement (Amendment) dated September 27, 2016, the Authority transferred approximately $11,745,000 of receipts from FEMA and GEMA to the Hospital. The Amendment specifies that the FEMA and GEMA funds may be used for the following purposes:

- First, to pay FEMA and GEMA all sums determined to be owed as a result of any audits.
- Second, and only after adequate provision for the funding of the first bullet point, the funds can be used to fund physician development in the Hospital's service area.
- Third, and only after adequate provision for the first two bullet points above, the funds can be used by the Hospital for any purposes permitted under the lease and transfer agreement.

Also in accordance with the Amendment, the Hospital agreed to establish a separate account to hold the sum of $4,000,000 of the above funds until the conclusion of the expected FEMA and GEMA audits to ensure the immediate availability of funds to repay any amounts finally determined to be owed to FEMA and GEMA as a result of the audits. Should the $4,000,000 not be sufficient to repay any amounts due to FEMA and GEMA, the Hospital agrees that it will pay in full and fully indemnify the Authority for all related sums finally determined to be owed to FEMA and GEMA. This amount is included in donor restricted investments above.

The Amendment states that the adequate provision of both the FEMA and GEMA fund repayment and the adequate provision to fund physician development are to be determined at the sole discretion of the Hospital. Per a Hospital Board of Directors resolution dated November 1, 2016, the Hospital believes the $4,000,000 is adequate provision for the repayment of the FEMA and GEMA funds. Also, based on the current and long-term physician development plan, coupled with the requirement that the Hospital chief executive officer report on the efforts and results of physician development at each Board of Directors meeting, and the requirement that the Hospital's Board of Directors approve the budget and strategic plan each year, the Hospital believes this constitutes adequate provision for the funding of physician development.

In 2017, $7,745,000 of the above described receipts are recorded in nonoperating gains.

Continued

4. Assets Limited as to Use, Continued

The following table provides a summary of the Hospital's investments as of July 31, 2017 and 2016, for which the cost basis of securities exceeds fair value, aggregated by investment category and length of time that individual securities have been in continuous unrealized loss positions:

	(Dollars in Thousands)					
	July 31, 2017					
	Less Than 12 Months		12 Months or More		Total	
Description of Securities	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
Corporate debt securities	$ 21	$(1)	$ -	$ -	$ 21	$(1)
Governmental debt securities	928	(32)	195	(7)	1,123	(39)
Total	$ 949	$(33)	$ 195	$(7)	$ 1,144	$(40)

	(Dollars in Thousands)					
	July 31, 2016					
	Less Than 12 Months		12 Months or More		Total	
Description of Securities	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses
Corporate debt securities	$ -	$ -	$ -	$ -	$ -	$ -
Governmental debt securities	693	(20)	-	-	693	(20)
Total	$ 693	$(20)	$ -	$ -	$ 693	$(20)

Management evaluates securities for other-than-temporary impairment at least on an annual basis, and more frequently when economic or market concerns warrant such evaluation. In analyzing an issuer's financial condition, management considers whether the investments are issued by the federal government or its agencies, whether downgrades by bond rating agencies have occurred, and the results of reviews of the issuer's financial condition.

Continued

4. Assets Limited as to Use, Continued

Management has considered the nature of investments in an unrealized loss position, the cause of their impairment, the severity and duration of their impairment, the current global economic conditions, the Hospital's intentions to sell or ability to hold the investments, and other relevant information available to management in determining if investments are other than temporarily impaired. Based on an evaluation of these factors, management has concluded that the declines in fair values of the Hospital's investments reported in the above table are temporary.

Investment income, including realized gains and losses and unrealized gains and losses for the above securities are comprised of the following for the years ended July 31, 2017 and 2016:

	2017	2016
Income (loss):		
Interest income	$ 166,000	$ 80,000
Realized gains (losses)	9,000	(5,000)
Change in unrealized gains	428,000	-
Investment expenses	(68,000)	(29,000)
Total income	$ 535,000	$ 46,000
Other changes in unrestricted net assets:		
Change in unrealized gains (losses)	$(65,000)	$ 37,000
Total changes in unrestricted net assets	$(65,000)	$ 37,000

The Hospital's investments are exposed to various risks such as interest rate, market and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the accompanying financial statements.

Continued

5. Property and Equipment

A summary of property and equipment at July 31, 2017 and 2016 follows:

	2017	2016
Land	$ 1,746,000	$ 1,746,000
Land improvements	2,408,000	2,337,000
Buildings and improvements	42,739,000	42,739,000
Equipment	23,304,000	22,131,000
	70,197,000	68,953,000
Less accumulated depreciation and amortization	(27,643,000)	(25,181,000)
	42,554,000	43,772,000
Construction-in-progress	967,000	10,000
Property and equipment, net	$ 43,521,000	$ 43,782,000

Depreciation expense for the years ended July 31, 2017 and 2016 amounted to approximately $2,917,000 and $4,312,000, respectively.

6. Notes Receivable

Notes receivable consist of educational loans to employees as well as loans secured by promissory notes to physicians under recruitment arrangements. Loans are service cancellable with forgiveness over a period of time in which the employee or physician works in the System or in the System's service area. The amounts forgiven and charged to expense during 2017 and 2016 were approximately $92,000 and $55,000, respectively.

Continued

7. Defined Contribution Plan

The Hospital participates in the System's defined contribution pension plan covering substantially all eligible employees. Employees may deposit a portion of their earnings for each pay period on a pre-tax basis and the System matches 50% of each participant's voluntary contributions up to a maximum of 4% of the employee's annual salary. Effective January 1, 2017, the System increased its match to 50% of each participant's voluntary contributions up to a maximum of 6% of the employee's annual salary. At its discretion, the System may make additional contributions to the plan. Matching and discretionary contribution expense was approximately $90,000 and $378,000, for the years ended July 31, 2017 and 2016, respectively.

8. Employee Health Insurance

The Hospital participates in the System's self-insurance program under which a third-party administrator processes and pays claims. The Hospital reimburses the third-party administrator for claims incurred and paid. In addition, the Hospital participates in a shared group financing layer agreement with other Georgia hospitals through a program offered by Georgia ADS, LLC. The program is designed to provide for the financing and payment of covered claims. For fiscal year 2016 through December 31, 2015, the claims included in the financing program were covered claims between $150,000 and $500,000. Effective January 1, 2016, the parameters of the program changed to include covered claims between $225,000 and $650,000. Each participant in the program is responsible for a portion of the shared claims based on their percentage of the total claims for the group. Additional insurance has been obtained to provide coverage for claims exceeding $650,000. Total expenses related to this plan were approximately $3,067,000 and $4,204,000 for 2017 and 2016, respectively.

9. Malpractice Insurance

The Hospital is covered by the System's claims-made general and professional liability insurance policy with a specified deductible per incident and excess coverage on a claims-made basis through the System's wholly-owned subsidiary, Phoebe Putney Indemnity, LLC (PPI), located in South Carolina. The System's policy with PPI includes limit of liability of $5,000,000 per occurrence, with an annual aggregate of $27,000,000 at July 31, 2017 and 2016.

Continued

9. Malpractice Insurance, Continued

Effective August 1, 2015, PPI purchased excess of loss reinsurance coverage in order to limit its financial exposure to large claims relating to employed physicians and surgeons. Under the per risk coverage, the reinsurer shall pay up to $750,000 per loss, per insured, in excess of $250,000 per loss, per insured. Under the clash coverage, the reinsurer shall pay up to $750,000 per loss occurrence, in excess of $250,000 per loss occurrence. The maximum amount recoverable for both of these coverages combined shall not exceed 40% of the subject premium or $6,000,000, whichever is greater. Under the excess of limits coverage, the reinsurer shall pay up to $4,000,000 per loss, per insured, in excess of $1,000,000, per loss, per insured. The maximum amount recoverable for this coverage shall not exceed $8,000,000. The reinsurance treaty provides for adjustable premiums based on ceded losses up to a stated maximum.

The System has also purchased excess liability coverage which covers $50,000,000 per occurrence and in aggregate in excess of the PPI coverage of $5,000,000. All of the risk related to this coverage has been ceded to unrelated reinsurers via a contract of reinsurance.

Various claims and assertions have been made against the Hospital in its normal course of providing services. In addition, other claims may be asserted arising from services provided to patients in the past. In the opinion of management, adequate provision has been made for losses which may occur from such asserted and unasserted claims that are not covered by liability insurance.

10. Concentrations of Credit Risk

The Hospital grants credit without collateral to patients, most of whom are local residents and are insured under third-party payor arrangements. The mix of receivables from patients and third-party payors at July 31, 2017 and 2016 was as follows:

	2017	2016
Medicare	27%	31%
Medicaid	11%	15%
Other third-party payors	42%	47%
Patients	20%	7%
Total	100%	100%

Continued

10. Concentrations of Credit Risk, Continued

At July 31, 2017, the Hospital had deposits at major financial institutions which exceeded the Federal Deposit Insurance Corporation limits. Management believes the credit risks related to these deposits are minimal.

11. Related Party Transactions

Related party transactions as of July 31, 2017 and 2016 consist of the following:

	2017	2016
Due to Phoebe Putney Health System, Inc.	$ 3,422,000	$ 2,216,000

The related party transactions that affect the above payables arise from normal management related services, physician practice operations, and other shared cost.

12. Related Organization

The Foundation was established to raise funds to support the operation of the Hospital. The Foundation's bylaws provide that the majority of all funds raised, except for funds acquired for the operation of the Foundation, be distributed to or be held for the benefit of the Hospital. The Foundation's general funds, which represent the Foundation's unrestricted resources, are distributed to the Hospital in amounts and in periods determined by the Foundation's Board of Trustees, who may also restrict the use of general funds for Hospital plant replacement or other specific purposes. Plant replacement and expansion funds, and specific-purpose funds are distributed to the Hospital as required to comply with the purpose specified by donors. A summary of the Foundation's assets, liabilities, net assets, results of operations, and changes in net assets follows. The Hospital's interest in the net assets of the Foundation is reported in other assets in the balance sheets.

	2017	2016
Assets:		
Cash and cash equivalents	$ 1,057,000	$ 972,000
Investments	2,291,000	2,256,000
Other assets	24,000	24,000
Total assets	$ 3,372,000	$ 3,252,000

Continued

12. Related Organization, Continued

	2017	2016
Liabilities and net assets:		
Accounts payable	$ 17,000	$ 14,000
Net assets	3,355,000	3,238,000
Total liabilities and net assets	$ 3,372,000	$ 3,252,000
Revenue and support	$ 140,000	$ 108,000
Expenses	(23,000)	(30,000)
Excess of revenue and support	117,000	78,000
Net assets, beginning of year	3,238,000	3,160,000
Net assets, end of year	$ 3,355,000	$ 3,238,000

13. Functional Expenses

The Hospital provides general health care services to residents within its geographic location. Expenses related to providing these services are as follows:

	2017	2016
Patient care services	$ 53,604,000	$ 53,272,000
General and administrative	13,829,000	12,052,000
Total	$ 67,433,000	$ 65,324,000

Continued

14. Fair Values of Financial Instruments

The following methods and assumptions were used by the Hospital in estimating the fair value of its financial instruments:

- *Cash:* The carrying amount reported in the balance sheet for cash approximates its fair value.

- *Assets limited as to use:* Amounts reported in the balance sheet are at fair value. See Note 15 for fair value measurement disclosures.

- *Accounts payable and accrued expenses:* The carrying amount reported in the balance sheet for accounts payable and accrued expenses approximates its fair value.

- *Estimated third-party payor settlements:* The carrying amount reported in the balance sheet for estimated third-party payor settlements approximates its fair value.

15. Fair Value Measurement

Following is a description of the valuation methodologies used for assets at fair value. There have been no changes in the methodologies used at July 31, 2017 and 2016.

- *Money market funds:* Valued at amortized cost, which approximates fair value.

- *Corporate debt securities:* Certain corporate bonds are valued at the closing price reported in the active market in which the bond is traded. Other corporate bonds are valued based on yields currently available on comparable securities of issuers with similar credit ratings. When quoted prices are not available for identical and similar bonds, the bond is valued under a discounted cash flows approach that maximizes observable inputs, such as current yields of similar instruments, but includes adjustments for certain risks that may not be observable, such as credit and liquidity risks.

- *Government debt securities:* Certain government debt securities are valued at the closing price reported in the active market in which the individual security is traded. Other government debt securities are valued based on yields currently available on comparable securities of issuers with similar credit ratings.

Continued

15. Fair Value Measurement, Continued

- *Equity securities:* Certain equity securities are valued at the closing price reported on the active market on which the individual securities are traded. Other equity securities are valued based on quoted prices for similar investments in active or inactive markets or valued using observable market data.

The preceding methods described may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Hospital believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

Fair values of assets measured on a recurring basis at July 31, 2017 and 2016 are as follows:

		Fair Value Measurements At Reporting Date Using		
	Fair Value	Quoted Prices In Active Markets For Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
July 31, 2017				
Assets:				
Money market funds	$ 10,404,000	$ -	$ 10,404,000	$ -
Government debt securities	1,839,000	-	1,839,000	-
Corporate debt securities	3,418,000	1,479,000	1,939,000	-
Equity securities	7,228,000	7,228,000	-	-
Total assets	$ 22,889,000	$ 8,707,000	$ 14,182,000	$ -
July 31, 2016				
Assets:				
Money market funds	$ 1,007,000	$ -	$ 1,007,000	$ -
Government debt securities	2,110,000	-	2,110,000	-
Corporate debt securities	1,058,000	-	1,058,000	-
Total assets	$ 4,175,000	$ -	$ 4,175,000	$ -

Continued

15. Fair Value Measurement, Continued

Financial assets valued using Level 1 inputs are based on unadjusted quoted market prices within active markets. Financial assets valued using Level 2 inputs are based primarily on quoted prices for similar investments in active or inactive markets. Valuation techniques utilized to determine fair value are consistently applied. All assets have been valued using a market approach.

16. Commitments and Contingencies

Health Care Reform

There has been increasing pressure on Congress and state legislatures to control and reduce the cost of healthcare on the national or at the state level. Legislation has been passed that includes cost controls on healthcare providers, insurance market reforms, delivery system reforms, and various individual and business mandates among other provisions. The costs of these provisions are and will be funded in part by reductions in payments by government programs, including Medicare and Medicaid. There can be no assurance that these changes will not adversely affect the Hospital.

Compliance Plan

The healthcare industry has been subjected to increased scrutiny from governmental agencies at both the federal and state level with respect to compliance with regulations. Areas of noncompliance identified at the national level include Medicare and Medicaid, Internal Revenue Service, and other regulations governing the healthcare industry. In addition, the Reform Legislation includes provisions aimed at reducing fraud, waste, and abuse in the healthcare industry. These provisions allocate significant additional resources to federal enforcement agencies and expand the use of private contractors to recover potentially inappropriate Medicare and Medicaid payments. The Hospital has implemented a compliance plan focusing on such issues. There can be no assurance that the Hospital will not be subjected to future investigations with accompanying monetary damages.

Litigation

The Hospital is involved in litigation and regulatory investigations arising in the course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the Hospital's future financial position or results from operations. See malpractice insurance disclosures in Note 9.

Continued

17. Electronic Health Record Incentive Payments

The Health Information Technology for Economic and Clinical Health Act (HITECH Act) was enacted into law on February 17, 2009, as part of the American Recovery and Reinvestment Act of 2009 (ARRA). The HITECH Act includes provisions designed to increase the use of Electronic Health Records (EHR) by both physicians and hospitals.

Beginning with federal fiscal year 2011 and extending through federal fiscal year 2016, eligible hospitals participating in the Medicare and Medicaid programs are eligible for reimbursement incentives based on successfully demonstrating meaningful use of its certified EHR technology. Conversely, those hospitals that do not successfully demonstrate meaningful use of EHR technology are subject to reductions in Medicare reimbursements beginning in FY 2015. On July 13, 2010, the Department of Health and Human Services (DHHS) released final meaningful use regulations. Meaningful use criteria are divided into three distinct stages: I, II and III. The final rules specify the initial criteria for physicians and eligible hospitals necessary to qualify for incentive payments; calculation of incentive payment amounts; payment adjustments under Medicare for covered professional services and inpatient hospital services; eligible hospitals failing to demonstrate meaningful use of certified EHR technology; and other program participation requirements.

The final rule set the earliest interim payment date for the incentive payment at May 2011. The first year of the Medicare portion of the program is defined as the federal government fiscal year October 1, 2010 to September 30, 2011.

The Hospital recognizes income related to Medicare and Medicaid incentive payments using a grant model based upon when it has determined that it is reasonably assured that the Hospital will be meaningfully using EHR technology for the applicable period and the cost report information is reasonably estimable.

The Hospital successfully demonstrated meeting meaningful use of its certified EHR technology for fiscal years 2017 and 2016. The Hospital applied for and received approval from Medicare and Medicaid. As of July 31, 2017 and 2016, the Hospital has recognized revenue of approximately $33,000 and $248,000, respectively, which has been recorded in other revenue. Approximately $-0- and $248,000 of the payments are accrued in other current assets at July 31, 2017 and 2016, respectively.

Draffin & Tucker, LLP
CERTIFIED PUBLIC ACCOUNTANTS

Member:
THE AMERICAN INSTITUTE OF
CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT ON SUPPLEMENTAL INFORMATION

Board of Directors
Phoebe Sumter Medical Center, Inc.
Americus, Georgia

We have audited the financial statements of Phoebe Sumter Medical Center, Inc. as of and for the years ended July 31, 2017 and 2016 and our report thereon dated February 2, 2018, which expressed an unmodified opinion on those financial statements, appears on pages 1 and 2. Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The information included in this report on pages 34 to 37, inclusive, which is the responsibility of management, is presented for purposes of additional analysis and is not a required part of the financial statements. Such information has not been subjected to the auditing procedures applied in the audits of the financial statements, and, accordingly, we do not express an opinion or provide any assurance on it.

Draffin & Tucker, LLP
Albany, Georgia
February 2, 2018

P.O. Box 71309
2617 Gillionville Road
Albany, GA 31708-1309
Tel. (229) 883-7878
Fax (229) 435-3152

Five Concourse Parkway
Suite 1250
Atlanta, GA 30328
Tel. (404) 220-8494
Fax (229) 435-3152

PHOEBE SUMTER MEDICAL CENTER, INC.

SERVICE TO THE COMMUNITY
July 31, 2017

Phoebe Sumter Medical Center, Inc. (PSMC), formerly Sumter Regional Hospital, is a not-for-profit health care organization that exists to serve the community. PSMC opened in 1953 to serve the community by caring for the sick regardless of their ability to pay. As a not-for-profit hospital, PSMC has no stockholders or owners. All revenue after expenses is reinvested in the mission to care for the citizens of the community – into clinical care, health programs, state-of-the-art technology and facilities, research, and teaching and training of medical professionals now and for the future.

PSMC operates as a charitable organization consistent with the requirements of Internal Revenue Code Section 501(c)(3) and the "community benefit standard" of IRS Revenue Ruling 69-545. PSMC takes seriously its responsibility as the community's safety net hospital and has a strong record of meeting and exceeding the charitable care and the organizational and operational standards required for federal tax-exempt status. PSMC demonstrates a continued and expanding commitment to meeting its mission and serving the citizens by providing community benefits. A community benefit is a planned, managed, organized, and measured approach to meeting identified community health needs, requiring a partnership between the healthcare organization and the community to benefit residents through programs and services that improve health status and quality of life.

PSMC improves the health and well being of Southwest Georgia through clinical services, education, research, and partnerships that build health capacity in the community. PSMC provides community benefits for all citizens, as well as for the medically underserved. PSMC conducts community needs assessments and pays close attention to the needs of low income and other vulnerable persons and the community at large. PSMC often works with community groups to identify needs, strengthen existing community programs, and plan newly needed services. It provides a wide-ranging array of community benefit services designed to improve community health and the health of individuals and to increase access to health care, in addition to providing free and discounted services to people who are uninsured and underinsured. Drawing on a dynamic and flexible structure, the community benefit programs are designed to respond to assessed needs and are focused on upstream prevention.

PSMC participates in the Medicare and Medicaid programs and is one of the leading providers of Medicaid services in Georgia.

Continued

The following table summarizes the amounts of charges foregone (i.e., contractual adjustments) and estimates the losses incurred by PSMC due to inadequate payments by these programs and for indigent/charity services. This table does not include discounts offered by PSMC under managed care and other agreements:

	Charges Foregone	Estimated Unreimbursed Cost
Medicare	$ 86,000,000	$ 23,000,000
Medicaid	38,000,000	10,000,000
Indigent/charity	17,000,000	5,000,000
	$ 141,000,000	$ 38,000,000

The following is a summary of the community benefit activities and health improvement services offered by PSMC and illustrates the activities and donations during fiscal year 2017.

I. Community Health Improvement Services

A. Community Health Education

Men's Health Conferences

PSMC held the 8th Annual Men's Health Conference on September 24, 2016 and the 9th Annual Men's Health Conference on June 3, 2017 that provided health screenings for PSA, cholesterol, blood pressure, hearing and vision, health information, speakers, and fellowship to more than 250 attendees in September and 125 attendees in June. The health conference programs provide outreach, health screenings, educational programs, and health conferences and events. These programs target men at risk of poor health status. The programs target uninsured or underinsured men without a primary care physician or knowledge of recommended preventive health care services. PSMC incurred expenses of $7,792 for both events.

Continued

I. Community Health Improvement Services, Continued

A. Community Health Education, Continued

Children's Health Fair

PSMC held a Children's Health Fair on July 22, 2017 that provided health screenings for weight, BMI, blood pressure and blood sugar, health information, speakers and fellowship to more than 500 attendees. Soil screening for lead were also available from Rural Georgia Healthy Housing. The health conference programs provide outreach, health screenings and educational programs about nutrition and physical activity. These programs target children at risk of poor health status. The programs target uninsured or underinsured children without a primary care physician or knowledge of recommended preventive health care services. PSMC incurred expenses of $9,616 for this event.

B. Community Based Clinical Services

Flu Shots and Health Screenings

PSMC provides free flu shots to volunteers and students. In FY 2017, PSMC administered 63 flu shots at an unreimbursed cost of $1,046.

School Nurse Program

PSMC places a nurse and two techs in the Sumter County School System. During the 2016/2017 school year, the school nurse program had 18,462 clinic visits and administered 29,686 doses of medication at a cost of $19,766.

Nurses/Nursing Students

In FY 2017, PSMC provided an estimated $11,000 representing 1,528 hours in clinical supervision and training of 14 nursing students.

Continued

I. Community Health Improvement Services, Continued

C. Health Care Support Services

Indigent Financial Assistance

Patients whose household income is below 125% of the Federal Poverty Guidelines are classified as indigent and receive care at no cost.

Charity Financial Assistance

Patients whose household income is between 126% - 200% of the Federal Poverty Guidelines will be classified as charity. These patients will be responsible for a percentage of the Hospital charges. This percentage will be based on calculations using the Federal Poverty Guidelines that are published in the "Federal Register" each year. If it is determined the patient responsibility will be an undue hardship on the patient/guarantor, these cases will be reviewed on an individual basis with the Phoebe Cares Supervisor for possible catastrophic charity based on sliding scale guidelines.

Catastrophic Financial Assistance

Patients whose income exceeds 200% of the Federal Poverty Guidelines, and whose Hospital charges exceed 25% of their annual income, resulting in excessive hardship, are eligible for a discount up to 75% of the patient balance. The patient may pay the remaining balance over 24 months.

During FY 2017, 459 patients were approved for financial assistance.

II. Community Benefit Operations

PSMC incurred $77,980 in support staff costs to support its community benefit efforts.