PHOEBE SUMTER MEDICAL CENTER, INC.

FINANCIAL STATEMENTS

for the years ended July 31, 2019 and 2018

C O N T E N T S

Draffin Tucker

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, 2019 and 2018, 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.

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.

Continued

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, 2019 and 2018, 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.

Changes in Accounting Principle

As discussed in Note 1 to the financial statements, the Hospital adopted new accounting guidance, Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Accounting Standards Update (ASU) No. 2014-09, *Revenue from Contracts with Customers (Topic 606)*. Our opinion is not modified with respect to that matter.

As discussed in Note 1 to the financial statements, the Hospital adopted new accounting guidance, FASB ASC ASU No. 2016-14, *Not-for-Profit Entities (Topic 958): Presentation of Financial Statements of Not-for-Profit Entities*. Our opinion is not modified with respect to that matter.

Draffin & Tucker, LLP

Albany, Georgia
January 30, 2020

PHOEBE SUMTER MEDICAL CENTER, INC.

BALANCE SHEETS, July 31, 2019 and 2018

	2019	2018
ASSETS		
Current assets:		
Cash and cash equivalents	$ 37,463,000	$ 32,964,000
Patient accounts receivable, net	10,430,000	8,800,000
Supplies	1,270,000	1,370,000
Other current assets	2,929,000	1,309,000
Total current assets	52,092,000	44,443,000
Assets limited as to use:		
Internally designated for capital improvements	26,028,000	24,434,000
Restricted by donors	4,000,000	4,000,000
Total assets limited as to use	30,028,000	28,434,000
Property and equipment, net	45,098,000	41,699,000
Other assets:		
Notes receivable	-	65,000
Interest in net assets of Sumter Regional Hospital Foundation, Inc.	3,127,000	3,262,000
Total other assets	3,127,000	3,327,000
Total assets	$ 130,345,000	$ 117,903,000

	2019	2018
LIABILITIES AND NET ASSETS		
Current liabilities:		
Accounts payable	$ 1,856,000	$ 1,984,000
Accrued expenses	5,028,000	4,562,000
Estimated third-party payor settlement	1,160,000	1,175,000
Total current liabilities	8,044,000	7,721,000
Related party payables	4,727,000	2,216,000
Total liabilities	12,771,000	9,937,000
Net assets:		
Without donor restrictions	113,574,000	103,966,000
With donor restrictions:		
Purpose restrictions	4,000,000	4,000,000
Total net assets	117,574,000	107,966,000
Total liabilities and net assets	$ 130,345,000	$ 117,903,000

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, 2019 and 2018

	2019	2018
Revenues, gains, and other support:		
Net patient service revenue	$ 78,070,000	$ 75,295,000
Other revenue	3,106,000	2,254,000
Total revenues, gains, and other support	81,176,000	77,549,000
Expenses:		
Salaries and wages	20,350,000	18,911,000
Employee health and welfare	7,168,000	5,657,000
Medical supplies and other	26,760,000	27,440,000
Purchased services	18,790,000	17,438,000
Depreciation and amortization	3,208,000	3,260,000
Total expenses	76,276,000	72,706,000
Operating income	4,900,000	4,843,000
Nonoperating income:		
Investment income	2,109,000	1,762,000
Contributions	846,000	632,000
Other nonoperating gains (losses)	1,677,000	(71,000)
Total nonoperating income	4,632,000	2,323,000
Excess revenues	9,532,000	7,166,000
Capital contribution	211,000	314,000
Change in interest in net assets of Sumter Regional Hospital Foundation, Inc.	(135,000)	(93,000)
Increase in net assets	9,608,000	7,387,000
Net assets, beginning of year	107,966,000	100,579,000
Net assets, end of year	$ 117,574,000	$ 107,966,000

See accompanying notes to financial statements.

PHOEBE SUMTER MEDICAL CENTER, INC.

STATEMENTS OF CASH FLOWS
for the years ended July 31, 2019 and 2018

	2019	2018
Cash flows from operating activities:		
Increase in net assets	$ 9,608,000	$ 7,387,000
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	(1,071,000)	(1,139,000)
Loss on disposal of assets	-	71,000
Depreciation and amortization	3,208,000	3,260,000
Change in interest in net assets of Sumter Regional Hospital Foundation, Inc.	135,000	93,000
Forgiveness of notes receivable	73,000	104,000
Changes in:		
Patient accounts receivable	(1,630,000)	560,000
Supplies	100,000	(34,000)
Other current assets	(1,620,000)	(180,000)
Notes receivable	(8,000)	(36,000)
Accounts payable	(128,000)	(188,000)
Accrued expenses	466,000	631,000
Estimated third-party payor settlements	(15,000)	(233,000)
Net cash provided by operating activities	9,118,000	10,296,000
Cash flows from investing activities:		
Purchase of property and equipment	(6,607,000)	(1,509,000)
Proceeds from sale of investments	4,793,000	14,168,000
Purchase of investments	(5,316,000)	(18,574,000)
Net cash used by investing activities	(7,130,000)	(5,915,000)
Cash flows from financing activities:		
Advances from related parties	25,509,000	22,929,000
Payments to related parties	(22,998,000)	(24,135,000)
Net cash provided (used) by financing activities	2,511,000	(1,206,000)
Net increase in cash and cash equivalents	4,499,000	3,175,000
Cash and cash equivalents at beginning of year	32,964,000	29,789,000
Cash and cash equivalents at end of year	$ 37,463,000	$ 32,964,000

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.

Cash and Cash Equivalents

Cash and cash equivalents include certain investments in money market mutual funds.

Supplies

Supplies, which consist primarily of drugs, and medical supplies are valued at the lower of cost and net realizable value, as determined on a first-in, first-out basis.

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 increases in net assets without donor restrictions, 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 increases in net assets with donor restrictions. 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.

Net assets

Net assets, revenues, gains, and losses are classified based on the existence or absence of donor-imposed restrictions. Accordingly, net assets and changes therein are classified and reported as follows:

> *Net assets without donor restrictions* – net assets available for use in the general operations and not subject to donor-imposed restrictions. The Board of Directors has discretionary control over these resources. Designated amounts represent those net assets that the Board has set aside for a particular purpose. All revenue not restricted by donors and donor restricted contributions whose restrictions are met in the same period in which they are received are accounted for in net assets without donor restrictions.

Continued

1. Summary of Significant Accounting Policies, Continued

Net Assets, Continued

Net assets with donor restrictions – net assets subject to donor-imposed restrictions. Some donor-imposed restrictions are temporary in nature, such as those that will be met by the passage of time or other events specified by the donor. Other donor-imposed restrictions are perpetual in nature, where the donor stipulates that resources be maintained in perpetuity. All revenues restricted by donors as to either timing or purpose of the related expenditures or required to be maintained in perpetuity as a source of investment income are accounted for in net assets with donor restrictions. When a donor restriction expires, that is when a stipulated time restriction ends or purpose restriction is accomplished, net assets with donor restrictions are reclassified to net assets without donor restrictions.

Excess Revenues

The statement of operations and changes in net assets includes excess revenues. Changes in net assets without donor restrictions 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 amount that reflects the consideration to which the Hospital expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors, and others and includes variable consideration for retroactive revenue adjustments under reimbursement arrangements with third-party payors. Retroactive adjustments are included in the determination of the estimated transaction price and adjusted in future periods as 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.

Continued

1. Summary of Significant Accounting Policies, Continued

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 increases in the appropriate categories of net assets in accordance with donor restrictions.

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, 2019 and 2018 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, 2019 and 2018.

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 January 30, 2020, the date the financial statements were available to be issued.

Continued

1. Summary of Significant Accounting Policies, Continued

Recently Adopted Accounting Pronouncements

In May 2014, the FASB issued ASU No. 2014-09, *Revenue from Contracts with Customers (Topic 606)*, which is a new comprehensive revenue recognition standard. The core principle of the revenue model is that an entity recognizes revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration in which the entity expects to be entitled in exchange for those goods or services. The Hospital early adopted ASU No. 2014-09 on August 1, 2018, using the full retrospective method of transition with practical expedients in FASB ASC 606-10-65-1(f) with no significant impact. The Hospital performed an analysis of revenue streams and transactions under ASU No. 2014-09. In particular, for net patient service revenue, the Hospital performed an analysis into the application of the portfolio approach as a practical expedient to group patient contracts with similar characteristics, such that revenue for a given portfolio would not be materially different than if it were evaluated on a contract-by-contract basis. Upon adoption, the majority of what was previously classified as provision for bad debts (representing approximately $17,303,000 for the year ended July 31, 2018) and presented as a reduction to net patient service revenue on the statements of operations and changes in net assets is now treated as a price concession that reduces the transaction price, which is reported as net patient service revenue. Changes in credit issues not assessed at the date of service, are recognized as bad debt expense and included as a component of operating expenses on the statement of operations. The new standard also requires enhanced disclosures related to the disaggregation of revenue and significant judgments made in measurement and recognition. The adoption of this guidance did not materially impact total operating revenues, excess revenues, or net assets.

In August 2016, the FASB issued ASU No. 2016-14, *Not-for-Profit Entities (Topic 958): Presentation of Financial Statements of Not-for-Profit Entities*. This comprehensive standard provides guidance on net asset classification and required disclosures on liquidity and availability of resources, requires expanded disclosure about expense and investment returns, and eliminates the requirement to present or disclose the indirect method reconciliation if using the direct method when presenting cash flows. The standard is effective for annual periods beginning after December 15, 2017. The Hospital has adjusted the presentation of these financial statements for all periods presented, except for the disclosures around liquidity and availability of resources and analysis of expenses by nature and function. Those disclosures have been presented for 2019 only, as allowed by ASU 2016-14.

Accounting Pronouncements Not Yet Adopted

In February 2016, the FASB issued ASU No. 2016-02, *Leases (Topic 842)*, which is a new comprehensive lease accounting model. The new standard clarifies the definition of a lease and requires lessees to recognize right-of-use assets and related lease liabilities for all leases with terms greater than twelve months. The new guidance, including subsequent amendments, is effective for the Hospital as of August 1, 2021. The Hospital is continuing to evaluate the impact the guidance will have on the financial statements. As of August 1, 2019, management has estimated that the recognized right-of-use assets and related lease liabilities will approximate $1,400,000.

Continued

1. Summary of Significant Accounting Policies, Continued

Accounting Pronouncements Not Yet Adopted, Continued

In January 2016, the FASB issued ASU No. 2016-01, *Financial Instruments-Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities*. The new guidance requires equity investments (except those accounted for under the equity method or those that result in consolidation) to be measured at fair value, with changes in fair value recognized in net income; simplifies the impairment assessment of equity investments without readily determinable fair values; and amends certain disclosure requirements associated with the fair value of financial instruments. The standard is effective for annual periods beginning after December 15, 2018. The Hospital expects to adopt the new guidance for the year ending July 31, 2020 and is continuing to evaluate the impact the guidance will have on the financial statements.

In June 2018, the FASB issued ASU No. 2018-08, *Not-for-Profit Entities (Topic 958) Clarifying the Scope and Accounting Guidance for Contributions Received and Contributions Made*. The update assists entities in determining when a transaction should be accounted for as a contribution or as an exchange transaction and provides additional guidance about how to determine whether a contribution is conditional. The Hospital expects to adopt the new guidance for the year ending July 31, 2020 and is continuing to evaluate the impact the guidance will have on the financial statements.

Prior Year Reclassifications

Certain reclassifications have been made to the fiscal year 2018 financial statements to conform to the fiscal year 2019 presentation. These reclassifications had no impact on the change in net assets in the accompanying financial statements.

2. Net Patient Service Revenue

Net patient service revenue is reported at the amount that reflects the consideration to which the Hospital expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors (including health insurers and government programs), and others and includes variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Generally, the Hospital bills the patients and third-party payors several days after the services are performed and/or the patient is discharged from the facility. Revenue is recognized as performance obligations are satisfied.

Performance obligations are determined based on the nature of the services provided by the Hospital. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected (or actual) charges. The Hospital believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients receiving inpatient and outpatient services.

Continued

2. Net Patient Service Revenue, Continued

The Hospital measures the performance obligation from admission into the hospital to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge. These services are considered to be a single performance obligation and have a duration of less than one year. Revenue for performance obligations satisfied at a point in time is recognized when services are provided and the Hospital does not believe it is required to provide additional services to the patient.

Because all of its performance obligations relate to contracts with a duration of less than one year, the Hospital has elected to apply the optional exemption provided in FASB ASC 606-10-50-14(a) and, therefore, is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied at the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations referred to above are primarily related to inpatient acute care services at the end of the reporting period. The performance obligations for these contracts are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

The Hospital is utilizing the portfolio approach practical expedient in ASC 606 for contracts related to net patient service revenue. The Hospital accounts for the contracts within each portfolio as a collective group, rather than individual contracts, based on the payment pattern expected in each portfolio category and the similar nature and characteristics of the patients within each portfolio. As a result, the Hospital has concluded that revenue for a given portfolio would not be materially different than if accounting for revenue on a contract by contract basis.

The Hospital has arrangements with third-party payors that provide for payments to the Hospital at amounts different from its established rates. For uninsured patients that do not qualify for charity care, the Hospital recognizes revenue on the basis of its standard rates, subject to certain discounts and implicit price concessions as determined by the Hospital. The Hospital determines the transaction price based on standard charges for services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the Hospital's policy, and implicit price concessions provided to uninsured patients. Implicit price concessions represent the difference between amounts billed and the estimated consideration the Hospital expects to receive from patients, which are determined based on historical collection experience, current market conditions, and other factors. The Hospital determines its estimates of contractual adjustments and discounts based on contractual agreements, discount policies, and historical experience.

Continued

2. Net Patient Service Revenue, Continued

Agreements with third-party payors typically provide for payments at amounts less than established charges. 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.

  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, 2015, 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 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, 2015.

  The Hospital 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 $1,247,000 and $2,172,000 for the years ended July 31, 2019 and 2018, 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 $568,000 and $1,074,000 for the years ended July 31, 2019 and 2018, 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 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 results in an increase in hospital payments on Medicaid services of approximately 11.88%. Approximately $799,000 and $786,000 relating to the Act is included in medical supplies and other in the accompanying consolidated statements of operations and changes in net assets for the years ended July 31, 2019 and 2018, 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

  The Hospital maintains its Financial Assistance Policy (FAP) in accordance with Internal Revenue Code Section 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 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.

Continued

2. Net Patient Service Revenue, Continued

Laws and regulations concerning government programs, including Medicare and Medicaid, are complex and subject to varying interpretation. As a result of investigations by governmental agencies, various health care organizations have received requests for information and notices regarding alleged noncompliance with those laws and regulations, which in some instances, have resulted in organizations entering into significant settlement agreements. Compliance with such laws and regulations may also be subject to future government review and interpretation as well as significant regulatory action, including fines, penalties, and potential exclusion from related programs. There can be no assurance that regulatory authorities will not challenge the Hospital's compliance with these laws and regulations, and it is not possible to determine the impact (if any) such claims or penalties would have upon the Hospital. In addition, the contracts the Hospital has with commercial payors also provide for retroactive audit and review of claims.

Settlements with third-party payors for retroactive adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and the Hospital's historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews, and investigations. Adjustments arising from a change in the transaction price were not significant in 2019 or 2018.

Generally patients who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. The Hospital also provides services to uninsured patients, and offers those uninsured patients a discount, either by policy or law, from standard charges. The Hospital estimates the transaction price for patients with deductibles and coinsurance and from those who are uninsured based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments, discounts, and implicit price concessions. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. Adjustments arising from a change in the transaction price were not significant for the years ending July 31, 2019 and 2018. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay are recorded as bad debt expense. Bad debt expense for the years ended July 31, 2019 and 2018 was not significant.

Consistent with the Hospital's mission, care is provided to patients regardless of their ability to pay. Therefore, the Hospital has determined it has provided implicit price concessions to uninsured patients and patients with other uninsured balances (for example, copays and deductibles).

Continued

2. Net Patient Service Revenue, Continued

Patients who meet the Hospital's criteria for charity care are provided care without charge or at amounts less than established rates. Such amounts determined to qualify as charity care are not reported as revenue.

Net patient service revenue by major payor source for the years ended July 31, 2019 and 2018 is as follows:

	Net Patient Service Revenue				
	Medicare	Medicaid	Other	Self-Pay	Total
2019	$ 26,581,000	$ 9,739,000	$ 40,957,000	$ 793,000	$ 78,070,000
2018	$ 23,672,000	$ 12,158,000	$ 38,629,000	$ 836,000	$ 75,295,000

Net patient service revenue by facility, line of business, and timing of revenue recognition for the years ended July 31, 2019 and 2018 is as follows:

	2019	2018
Service lines:		
Hospital	$ 76,658,000	$ 73,671,000
Hospice	1,230,000	1,365,000
Clinic	182,000	259,000
Timing of revenue recognition:		
Services transferred over time	$ 78,070,000	$ 75,295,000

Hospital net patient service revenue includes a variety of services mainly covering inpatient acute care services requiring overnight stays, outpatient procedures that require anesthesia or use of the Hospital's diagnostic and surgical equipment, and emergency care services. Performance obligations for the hospital, hospice, and clinic are satisfied over time as the patient simultaneously receives and consumes the benefits the Hospital performs. Requirements to recognize revenue for inpatient services are generally satisfied over periods that average approximately five days and for outpatient services are generally satisfied over a period of less than one day. Retail and employee pharmacy, cafeteria, gift shop, and other point-of-sale performance obligations are satisfied at a point in time when the goods are provided. These revenues are recorded in other revenue on the statements of operations and changes in net assets.

Continued

3. Uncompensated Services

The Hospital was compensated for services at amounts less than its established rates. Charges for uncompensated services for 2019 and 2018 were approximately $210,554,000 and $181,557,000, respectively.

Uncompensated care includes charity and indigent care services of approximately $16,302,000 and $12,762,000 in 2019 and 2018, respectively. The cost of charity and indigent care services provided during 2019 and 2018 was approximately $4,308,000 and $3,612,000, 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 2019 and 2018.

	2019	2018
Gross patient charges	$ 288,624,000	$ 256,852,000
Uncompensated services:		
Charity and indigent care	16,302,000	12,762,000
Medicare	104,078,000	88,498,000
Medicaid	39,798,000	34,443,000
Other third-party payors	31,824,000	28,551,000
Price concessions	18,552,000	17,303,000
Total uncompensated care	210,554,000	181,557,000
Net patient service revenue	$ 78,070,000	$ 75,295,000

4. Assets Limited as to Use

The composition of assets limited as to use as of July 31, 2019 and 2018 is set forth in the following table. All assets limited as to use are classified as trading and are stated at fair value.

	2019	2018
By board for capital improvements:		
Money market funds	$ 1,467,000	$ 1,183,000
Government debt securities	922,000	1,611,000
Corporate debt securities	6,914,000	5,898,000
Equity securities	16,725,000	15,742,000
Total board designated for capital improvements	26,028,000	24,434,000

Continued

4. Assets Limited as to Use, Continued

	2019	2018
Restricted by donors:		
Money market funds	$ 274,000	$ 138,000
Corporate debt securities	2,917,000	2,991,000
Equity securities	809,000	871,000
Total restricted by donors	4,000,000	4,000,000
Total assets limited as to use	$ 30,028,000	$ 28,434,000

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.

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.

Continued

4. Assets Limited as to Use, Continued

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 addition to the amounts described above, additional FEMA and GEMA funds were received by the Authority and transferred to the Hospital totaling approximately $1,677,000 and $-0- during fiscal years 2019 and 2018, respectively. These funds are included in other nonoperating gains (losses) on the statements of operations and changes in net assets.

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.

5. Property and Equipment

A summary of property and equipment at July 31, 2019 and 2018 follows:

	2019	2018
Land	$ 2,023,000	$ 2,023,000
Land improvements	2,461,000	2,461,000
Buildings and improvements	44,428,000	43,711,000
Equipment	24,659,000	23,314,000
	73,571,000	71,509,000
Less accumulated depreciation and amortization	(33,277,000)	(30,083,000)
	40,294,000	41,426,000
Construction-in-progress	4,804,000	273,000
Property and equipment, net	$ 45,098,000	$ 41,699,000

Continued

5. Property and Equipment, Continued

Depreciation expense for the years ended July 31, 2019 and 2018 amounted to approximately $3,208,000 and $3,260,000, respectively. Construction contracts exist for various projects at year end with a total commitment of approximately $641,000. At July 31, 2019, the remaining commitment on these contracts approximated $322,000.

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 2019 and 2018 were approximately $73,000 and $104,000, respectively.

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 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 $408,000 and $107,000, for the years ended July 31, 2019 and 2018, 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. 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 $4,353,000 and $3,519,000 for 2019 and 2018, respectively.

Continued

9. Malpractice Insurance

Phoebe Putney Indemnity, LLC, located in South Carolina, is a wholly-owned subsidiary of the System organized on August 1, 2006 as a single parent captive under the captive insurance laws of the state of South Carolina to insure the risks of the System, including the Hospital. Phoebe Putney Indemnity, Ltd. (PPI), located in the Cayman Islands, is a wholly-owned subsidiary of the System, that was incorporated on November 14, 2018 as an exempted company under the Companies Law of the Cayman Islands. Effective January 31, 2019, Phoebe Putney Indemnity, Ltd. merged with Phoebe Putney Indemnity, LLC, with Phoebe Putney Indemnity, Ltd. remaining as the surviving entity. Upon merger, the rights, property, benefits, immunities, and powers and privileges of Phoebe Putney Indemnity, LLC immediately vested to PPI. PPI continued the business of Phoebe Putney Indemnity, LLC to provide insurance coverage to the System, including the Hospital.

PPI issues a claims-made policy covering professional and general liabilities, personal injury, advertising injury liability, and contractual liability of the Hospital. Under the policy, the limit of liability is $5,000,000 per occurrence, with an annual aggregate of $27,000,000 at July 31, 2019 and 2018.

PPI purchases annual 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 coverage's 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. Such adjustments are recorded in the period when they become known.

The System has also purchased excess liability coverage which includes coverage of the Hospital. The limits of the policy are $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.

Continued

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, 2019 and 2018 was as follows:

	2019	2018
Medicare	26%	23%
Medicaid	9%	10%
Other third-party payors	50%	47%
Patients	15%	20%
Total	100%	100%

At July 31, 2019, 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, 2019 and 2018 consist of the following:

	2019	2018
Due to Phoebe Putney Health System, Inc.	$ 4,727,000	$ 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 incurred in the ordinary course of business.

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 undesignated 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.

Continued

12. Related Organization, Continued

	2019	2018
Assets:		
Cash and cash equivalents	$ 98,000	$ 326,000
Investments	3,030,000	2,933,000
Other assets	24,000	24,000
Total assets	$ 3,152,000	$ 3,283,000
Liabilities and net assets:		
Accounts payable	$ 25,000	$ 21,000
Net assets	3,127,000	3,262,000
Total liabilities and net assets	$ 3,152,000	$ 3,283,000
Revenue and support	$ 155,000	$ 231,000
Expenses	(290,000)	(324,000)
Changes in net assets	(135,000)	(93,000)
Net assets, beginning of year	3,262,000	3,355,000
Net assets, end of year	$ 3,127,000	$ 3,262,000

13. Functional Expenses

The Hospital provides general health care services to residents within its geographic location. Expenses related to providing these services in 2019 are as follows:

	Patient Care Services	General and Administrative	Total
Salaries and wages	$ 16,933,000	$ 3,417,000	$ 20,350,000
Employee health and welfare	5,860,000	1,308,000	7,168,000
Medical supplies and other	21,037,000	5,723,000	26,760,000
Purchased services	11,227,000	7,563,000	18,790,000
Depreciation and amortization	1,511,000	1,697,000	3,208,000
	$ 56,568,000	$ 19,708,000	$ 76,276,000

For 2018, the Hospital incurred expenses of approximately $55,669,000 and $17,037,000 for patient care services and general and administrative, respectively.

Continued

13. Functional Expenses, Continued

The financial statements report certain expense categories that are attributable to more than one health care service or support function. Therefore, these expenses require an allocation on a reasonable basis that is consistently applied. Costs not directly attributable to a function, including depreciation and amortization, and other occupancy related costs, are allocated to a function based on a square footage basis. Benefit related expenses are allocated consistent with salaries.

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 and cash equivalents:* The carrying amount reported in the balance sheet for cash and cash equivalents 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 settlement:* The carrying amount reported in the balance sheet for estimated third-party payor settlement 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, 2019 and 2018.

- *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.

Continued

15. Fair Value Measurement, Continued

- *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.

- *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, 2019 and 2018 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, 2019				
Assets:				
Money market funds	$ 1,741,000	$ -	$ 1,741,000	$ -
Government debt securities	922,000	-	922,000	-
Corporate debt securities	9,831,000	5,753,000	4,078,000	-
Equity securities	17,534,000	17,534,000	-	-
Total assets	$ 30,028,000	$ 23,287,000	$ 6,741,000	$ -
July 31, 2018				
Assets:				
Money market funds	$ 1,321,000	$ -	$ 1,321,000	$ -
Government debt securities	1,611,000	-	1,611,000	-
Corporate debt securities	8,889,000	5,128,000	3,761,000	-
Equity securities	16,613,000	16,613,000	-	-
Total assets	$ 28,434,000	$ 21,741,000	$ 6,693,000	$ -

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. Rural Hospital Tax Credit Contributions

The State of Georgia (State) passed legislation which will allow individuals and corporations to receive a State tax credit for making a contribution to certain qualified rural hospital organizations during calendar years 2017 through 2021. The Hospital submitted the necessary documentation and was approved by the State to participate in the rural hospital tax credit program for calendar years 2018 and 2019. Contributions received under the program approximated $846,000 and $632,000, during fiscal years 2019 and 2018, respectively. The funds are included in contributions on the statements of operations and changes in net assets. The Hospital will have to be approved by the State to participate in the program each subsequent year.

18. Liquidity and Availability

As of July 31, 2019, the Hospital has working capital of approximately $44,048,000.

Financial assets available for general expenditures within one year of the balance sheet date, consists of the following at July 31, 2019:

Cash and cash equivalents	$ 37,463,000
Patient accounts receivable, net	10,430,000
Other current assets – other receivables	954,000
Internally designated for capital improvements	26,028,000
Total financial assets available	$ 74,875,000

None of the financial assets available are subject to donor or other contractual restrictions that make them unavailable for general expenditure within one year of the balance sheet date. The Hospital estimates that approximately 100% of the internally designated funds for capital improvements are available for general expenditure within one year in the normal course of operations. Accordingly, these assets have been included in the quantitative information above. The Hospital has other assets whose use is limited for donor restricted purposes. These assets whose use is limited are not available for general expenditure within the next year and are not reflected in the amounts above. The Hospital has a policy to structure its financial assets to be available as its general expenditures, liabilities, and other obligations come due.

Draffin Tucker

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, 2019 and 2018 and our report thereon dated January 30, 2020, 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 31 to 33, 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
January 30, 2020

PHOEBE SUMTER MEDICAL CENTER, INC.

SERVICE TO THE COMMUNITY
July 31, 2019

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.

The following table summarizes the amounts of charges foregone (i.e., contractual adjustments) and estimates the losses (computed by applying a total cost factor to charges foregone) 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	$ 104,000,000	$ 28,000,000
Medicaid	40,000,000	11,000,000
Indigent/charity	16,000,000	4,000,000
	$ 160,000,000	$ 43,000,000

Continued

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 2019.

I. Community Health Improvement Services

A. Community Health Education

Men's Health Fair

The Men's Health Conference was held on Saturday, September 15, 2018 and provided health screenings for PSA, cholesterol, blood pressure, hearing and vision, health information, speakers and fellowship to about 55 men who attended. PSMC incurred expenses of $7,849 for this event.

Children's Health Fair

PSMC held a Children's Health Fair on July 27, 2019 that provided health screenings for weight, BMI, blood pressure and blood sugar, health information, speakers and fellowship to more than 150 attendees. Soil screenings 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 $2,436 for this event.

Women's Health Conferences

PSMC held a Women's Health Fair on May 18, 2019 that provided health screenings for weight, BMI, blood pressure and blood sugar, health information, speakers and fellowship to more than 400 attendees at each fair. Dominque Dawes, gold medal gymnast, was a guest celebrity speaker at the fair held on May 18, 2019. The health conference programs provide outreach, health screenings and educational programs about nutrition and physical activity. The programs target uninsured and underinsured women without a primary care physician or knowledge of recommended preventive health care services. PSMC incurred expenses of $17,664 for this event.

Community Health Symposium

PSMC held a Community Health Symposium in April 2019 that provided health information and speakers from various health providers in the area such as Middle Flint Behavioral, Innovative Senior Solutions and Perry Wellness Center. Ron Clark was the keynote speaker. The program was attended by approximately 200 guests. PSMC incurred expenses of $17,936 for this event.

Continued

I. Community Health Improvement Services, Continued

B. Community Based Clinical Services

Flu Shots and Health Screenings

PSMC provides free flu shots to volunteers and students. In fiscal year 2019, PSMC administered 48 flu shots at an unreimbursed cost of $770.

School Nurse Program

PSMC places a nurse and two techs in the Sumter County School System. During the 2018/2019 school year, the school nurse program had 16,860 clinic visits and administered 27,633 doses of medication at a cost of $21,605.

Nurses/Nursing Students

In fiscal year 2019, PSMC provided an estimated $44,905 representing 1,283 hours in clinical supervision and training of 10 nursing students.

C. Health Care Support Services

PSMC will extend free or discounted care to eligible individuals for all urgent, emergent, or otherwise medically necessary services. Patients whose household income is at or below 125% of the Federal Poverty Guidelines are eligible for free care. Patients whose household income is between 126% and 400% of the Federal Poverty Guidelines qualify for discounted charges based on a sliding fee schedule in the FAP. PSMC will not charge eligible individuals more for emergency or other medically necessary care than the Amount Generally Billed (AGB) to individuals who have insurance coverage, and is compliant with the requirements for a not-for-profit charitable corporation in accordance with Internal Revenue Service Regulation §1.501(r).

II. Community Benefit Operations

PSMC incurred $85,437 in support staff costs to support its community benefit efforts.