Transparency Completeness Checklist (HB 321 & HB 186)

Prepared by the Georgia Alliance of Community Hospitals and Georgia Hospital Association

HB 321 Document/List/Report Required:	General Instructions:	Special Requirements:	Date Posted:
Audited Financial Statements – Hospital	Most recent version (.pdf)	*Contain HB 321 required note (gross patient revenue, allowances, charity care, and net patient revenue?** Yes / No	09/30/2019
Alternative: Consolidated Financial Statements Including Hospital	Most recent version (.pdf)	List entities included? Yes / No	
Combining or Consolidating Schedules/Financial Information break out for Hospital Subsidiaries	Required for hospitals with subsidiaries and consolidating financial statements. Have balance sheet, statement of operations, or statement of net position?	*Contain GAAS required report?** Yes / No	09/30/2019
Audited Financial Statements – Hospital Parent Company	Most recent version (.pdf). Only post for a Georgia entity that directly owns or controls the entity that operates the hospital.		09/30/2019
Combining or Consolidating Schedules/Financial Information break out for Hospital & Brother/Sister Co.	Required for hospitals with parent company and consolidating financial statements. Have balance sheet, statement of operations, or statement of net position?	*Contain GAAS required report?** Yes / No	09/30/2019
Audited Financial Statements – Hospital Subsidiaries	Most recent version (.pdf). Only post for entities directly owned and controlled by the entity that operates the hospital. Do not post audited financial statements for subsidiaries that were inactive or where total assets of subsidiary constitute < 20% of the total assets of the entity that operates the hospital. If subsidiary does not have financial statements per GAAP, state "N/A"		09/30/2019
IRS Form 990	As filed with IRS, including Schedule H, but	Post copies of Schedule H and other	09/30/2019

	exclude Schedule B. May be individual or consolidated.	filed Schedules (except Schedule B)? (Yes) / No	
Alternative IRS Form 990 (if available from DCH)	Form not yet available from DCH.		
AHQ	As filed with DCH.		09/30/2019
Community Benefit Report	As filed with Superior Court Clerk. If none required under O.C.G.A. §31-7-90.1, state "N/A"		See www.urmc.org
Medicaid DSH Survey	If not required, state "N/A"		09/30/2019
(NEW) List of Real Property Holdings Owned by Hospital Note: Reconcile with Form 990 (Part X and Schedule D, Part IV – high level listing of land and buildings as assets)	GACH/GHA template available if required information not contained in existing report. Do not include leased property.		09/30/2019
(NEW) List of Hospital JVs and Ownership Interests Note: Reconcile with Form 990 (Part VI, Section B – JV with taxable entity, Schedule H, Part IV – JV with certain persons, and Schedule R - % ownership).	GACH/GHA template available if required information not contained in audited financial statement or existing report. If contained in financial statements, state "F/S" and indicate page or section reference.		09/30/2019 See Audited Financial Statements Page 8 and 23
(NEW) Listing of Hospital Indebtedness Note: Reconcile with Form 990 (Part IV/Schedule K – tax exempt bonds and Part X/Schedule L – loans with interested persons) Note: Reconcile with CON Applications recently filed (Question 26 – existing indebtedness)	GACH/GHA template available if required information not contained in audited financial statements or existing report. If contained in financial statements, state "F/S" and indicate page or section reference.	Include names of any bond disclosure sites to which hospital submitted info? Yes / No	09/30/2019 See Audited Financial Statements Page 16 -17
(NEW) Report of End of Year Net Assets	GACH/GHA template available if required information not contained in audited financial statements. If contained in financial statements, state "F/S" and indicate page or section reference.	Included for hospital, parent, subsidiaries, and foundation controlled or owned by hospital or parent? (Yes) / No	09/30/2019 See Audited Financial Statements Page 23
Copy of any "going concern" note in Hospital Financial Statements	Provide reference (page or section) to portion of financial statements containing note.		N/A
Alternative: Statement that there is no going concern disclosure in the hospital's audited financial statements			
(NEW) Dated Organizational Chart		Includes hospital, parent, subsidiaries and brother/sister companies? (Yes) / No	09/30/2019
(NEW) Compensation/Benefits Report Note: Reconcile with Form 990 (Part VII, Section A & Schedule J (Part II))	Template available if required information not contained in Form 990. List positions, not names.		09/30/2019 See URMC Form 990
Evidence of Hospital Accreditation (*e.g.*, the Joint Commission or DNV)	Copy of certificate or accreditation decision award letter		09/30/2019
Indigent and Charity Care Policy			09/30/2019

Debt Collection Policy			09/30/2019
HB 186 Documents Required:	**General Instructions:**	**Special Requirements:**	**Date Posted:**
Hospital Financial Survey			09/30/2019
Any ASC Surveys Filed by Hospital			N/A
Any Imaging Center Surveys Filed by Hospital			N/A
** GHA and GACH advised DCH that these notes/reports likely would be contained only in audited financial statements prepared and finalized after July 1, 2019 (i.e. the effective date of HB 321) based on definitions of key terms.*			
Date: July 22, 2019			

Upson County Hospital, Inc. and Affiliates d/b/a Upson Regional Medical Center

Consolidated Financial Statements

Years Ended December 31, 2018 and 2017

DIXON HUGHES GOODMAN LLP

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DIXON HUGHES GOODMAN LLP

Independent Auditors' Report

Board of Directors
Upson County Hospital, Inc. and Affiliates
Thomaston, Georgia

We have audited the accompanying consolidated financial statements of Upson County Hospital, Inc. and Affiliates (d/b/a Upson Regional Medical Center), which comprise the consolidated balance sheets as of December 31, 2018 and 2017, and the related consolidated statements of operations, 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 consolidated 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 consolidated 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 consolidated financial statements based on our audits. We did not audit the financial statements of Upson Regional Segregated Portfolio, a segregated portfolio insurance cell in which Upson County Hospital, Inc. has a controlling financial interest, which statements reflect total assets of approximately $2,793,000 and $3,433,000 as of December 31, 2018 and 2017, respectively. Those statements were audited by other auditors, whose report has been furnished to us, and our opinion, insofar as it relates to the amounts included for Upson Regional Segregated Portfolio, is based solely on the report of the other auditors. 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 consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to Upson Regional Medical Center's preparation and fair presentation of the consolidated 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 Upson Regional Medical Center'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 consolidated financial statements.

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

DHG
DIXON HUGHES GOODMAN LLP

Opinion

In our opinion, based on our audits and the report of the other auditors, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Upson County Hospital, Inc. and Affiliates (d/b/a Upson Regional Medical Center) at December 31, 2018 and 2017, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter – New Accounting Pronouncement

As discussed in Note 1 to the financial statements, during the year ended December 31, 2018, Upson Regional Medical Center implemented new accounting guidance (Accounting Standards Update 2016-14, Not-for-Profit Entities (Topic 958): *Presentation of Financial Statements of Not-for-Profit Entities*) that requires changes to the classification of net assets, as well as additional footnote disclosures over liquidity and financial performance. As required, these changes have been applied to amounts previously reported as of and for the year ended December 31, 2017. Our opinion is not modified with respect to this matter.

Other Matter

Our audit was conducted for the purpose of forming an opinion on the financial statements as a whole. The supplementary consolidating information referred to in the table of contents is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, which insofar as it relates to Upson Regional Segregated Portfolio is based on the report of other auditors, the consolidating information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Dixon Hughes Goodman LLP

Atlanta, Georgia
April 12, 2019

Upson County Hospital, Inc. and Affiliates
d/b/a Upson Regional Medical Center
Consolidated Balance Sheets
December 31, 2018 and 2017

	2018	2017
ASSETS		
Current assets:		
Cash and cash equivalents	**$ 1,751,442**	$ 2,336,387
Patient accounts receivable, net of allowance for doubtful accounts of $15,125,000 in 2018 and $15,975,000 in 2017	**12,396,982**	11,090,353
Other receivables	**859,827**	1,972,925
Supplies	**1,967,656**	2,416,782
Prepaid expenses	**1,293,502**	1,389,508
Total current assets	**18,269,409**	19,205,955
Assets limited as to use internally designated for:		
Capital acquisition	**65,177,545**	72,309,567
Hospital insurance	**2,792,855**	3,432,691
Total assets limited as to use	**67,970,400**	75,742,258
Investments	**31,786,503**	34,173,830
Property and equipment, net	**59,362,720**	60,711,084
Other assets	**1,688,011**	186,052
Total assets	**$ 179,077,043**	$ 190,019,179

See accompanying notes.

	2018	2017
LIABILITIES AND NET ASSETS		
Current liabilities:		
Current portion of long-term debt	**$ 2,924,382**	$ 2,894,382
Accounts payable	**2,575,222**	3,029,307
Accrued payroll	**1,019,725**	788,101
Accrued payroll taxes	**92,909**	68,351
Accrued benefits	**1,168,074**	1,015,875
Other accrued liabilities	**725,421**	844,549
Estimated third-party payor settlements	**38,879**	297,397
Total current liabilities	**8,544,612**	8,937,962
Long-term debt, net of current portion	**7,357,958**	10,429,803
Accrued insurance reserves	**905,772**	1,295,512
Total liabilities	**16,808,342**	20,663,277
Net assets:		
Net assets without donor restrictions	**162,268,701**	169,355,902
Total liabilities and net assets	**$ 179,077,043**	$ 190,019,179

Upson County Hospital, Inc. and Affiliates
d/b/a Upson Regional Medical Center
Consolidated Statements of Operations
Years Ended December 31, 2018 and 2017

	2018	2017
Revenues:		
Patient service revenue (net of contractual allowances and discounts)	**$ 102,925,857**	$ 96,922,671
Provision for doubtful accounts	**(19,593,823)**	(21,814,299)
Net patient service revenue	**83,332,034**	75,108,372
Other revenue	**1,396,165**	1,798,387
Total revenues	**84,728,199**	76,906,759
Operating expenses:		
Salaries	**35,642,616**	32,031,973
Employee benefits	**9,132,314**	9,467,537
Contract labor	**3,292,688**	3,025,684
Physicians fees	**3,511,913**	2,402,808
Purchased services	**9,124,071**	7,083,013
Legal fees	**695,179**	684,757
Supply expense	**11,925,847**	10,285,896
Utilities	**1,872,390**	1,770,916
Repairs and maintenance	**2,498,916**	2,397,022
Insurance expense	**487,904**	483,602
Leases and rentals	**528,939**	421,592
Depreciation	**7,619,223**	6,692,487
Interest	**399,157**	474,124
Other	**2,515,382**	2,298,028
Total operating expenses	**89,246,539**	79,519,439
Operating loss	**(4,518,340)**	(2,612,680)
Other income (expense):		
Investment income	**8,541,198**	4,567,376
Other	**6,629**	(27,855)
Contributions	**1,157,595**	66,664
Total other income	**9,705,422**	4,606,185
Excess of revenues over expenses	**$ 5,187,082**	$ 1,993,505

See accompanying notes.

Upson County Hospital, Inc. and Affiliates
d/b/a Upson Regional Medical Center
Consolidated Statements of Changes in Net Assets
Years Ended December 31, 2018 and 2017

	2018	2017
Excess of revenues over expenses	**$ 5,187,082**	$ 1,993,505
Unrealized (loss) gain on other than trading securities	**(12,274,283)**	12,192,379
Change in net assets	**(7,087,201)**	14,185,884
Net assets, beginning of year	**169,355,902**	155,170,018
Net assets, end of year	**$ 162,268,701**	$ 169,355,902

See accompanying notes.

Upson County Hospital, Inc. and Affiliates
d/b/a Upson Regional Medical Center
Consolidated Statements of Cash Flows
Years Ended December 31, 2018 and 2017

	2018	2017
Cash flows from operating activities:		
Change in net assets	**$ (7,087,201)**	$ 14,185,884
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation	**7,619,223**	6,692,487
Net realized and unrealized gains and losses on investments, other than trading	**8,675,022**	(13,301,294)
Provision for bad debts	**19,593,823**	21,814,299
(Loss) gain on disposal of assets	**(6,629)**	27,855
Changes in:		
Patient accounts receivable	**(20,900,452)**	(22,742,099)
Supplies	**449,126**	(504,790)
Other assets	**(292,855)**	366,889
Accounts payable and accrued expenses	**(164,832)**	448,351
Accrued insurance reserves	**(389,740)**	(186,164)
Estimated third-party payor settlements	**(258,518)**	(256,628)
Net cash provided by operating activities	**7,236,967**	6,544,790
Cash flows from investing activities:		
Purchase of property and equipment	**(6,270,859)**	(12,155,047)
Proceeds from disposal of assets	**6,629**	2,130
Purchase of investments and assets limited as to use	**1,484,163**	5,345,850
Net cash used by investing activities	**(4,780,067)**	(6,807,067)
Cash flows from financing activities:		
Payments on long-term debt	**(3,041,845)**	(2,642,170)
Net cash used by financing activities	**(3,041,845)**	**(2,642,170)**
Decrease in cash and cash equivalents	**(584,945)**	(2,904,447)
Cash and cash equivalents at beginning of year	**2,336,387**	5,240,834
Cash and cash equivalents at end of year	**$ 1,751,442**	$ 2,336,387
Supplementary disclosure of cash flow information:		
Cash paid during the year for interest	**$ 381,587**	$ 451,800

See accompanying notes.

Notes to Consolidated Financial Statements

1. Summary of Significant Accounting Policies

Principles of Consolidation

The accompanying financial statements reflect the consolidated financial statements of Upson County Hospital, Inc.; Upson Medical Associates, LLC; Upson County Hospital Wellness Center; Upson Regional Medical Center Health Foundation, Inc.; Orthopedics Sports Medicine and Surgery, LLC; Upson Women's Services, LLC; Upson Family Physicians, LLC; Upson Regional Segregated Portfolio; Upson Regional Medical Office Building; Upson Family Medical Center and Upson Surgical Associates, LLC, (collectively referred to as the "Hospital"). Material intercompany transactions and balances have been eliminated.

Organization

On December 31, 1987, the Hospital Authority of Upson County (Authority) implemented a reorganization plan whereby all assets, liabilities, and management of the Hospital were transferred to Upson County Hospital, Inc. (d/b/a Upson Regional Medical Center) under a forty year lease.

The Hospital, located in Thomaston, Georgia, is a not-for-profit acute care hospital. The Hospital provides inpatient, outpatient, and emergency care services for residents in Upson County and contiguous areas.

On March 1, 2010, the Hospital established a segregated portfolio plan in the Georgia Health Care Insurance Company, SPC (GHCIC), which is incorporated under the provisions of the laws of the Cayman Islands (the "SPC Law"). The name of the plan is Upson Regional Segregated Portfolio (Segregated Portfolio). The Segregated Portfolio provides professional and general liability self-insurance to the Hospital. The Segregated Portfolio is managed by Willis Management, Ltd. (Cayman) in Grand Cayman, Cayman Islands. Pursuant to the SPC Law, the assets, liabilities, and equity of the Segregated Portfolio are kept separate and segregated from the general assets of GHCIC and other cells.

Accounting Standards

The Hospital follows accounting principles generally accepted in the United States of America ("GAAP") to ensure consistent reporting of its financial condition, results of activities, and cash flows. References to GAAP issued by the Financial Accounting Standards Board (FASB) are to the FASB Accounting Standards Codification, sometimes referred to as the "Codification" or "ASC".

Net Asset - Prior Year Reclassifications and Adoption of New Accounting Standard Update

Certain reclassifications have been made to the fiscal year 2017 financial statements and footnote disclosures to conform to the 2018 presentation due to the adoption of a new accounting standard update on the presentation of financial statements of not-for-profit entities. The provisions of the update are intended to simplify and improve the presentation of net assets, as well as information regarding liquidity and financial performance. Amounts previously reported as unrestricted net assets are now classified as net assets without donor restrictions. These reclassifications had no impact on the total net assets or total changes in net assets in the accompanying consolidated financial statements.

Net Assets Without Donor Restrictions – Net assets available for use in general operations and not subject to donor restrictions.

Use of Estimates

The preparation of the consolidated 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. Estimates also affect 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 highly liquid debt instruments with original maturities of three months or less. The Hospital routinely invests its surplus operating funds in money market accounts. At December 31, 2018 and 2017, the Hospital had cash and cash equivalents in financial institutions in amounts that exceed federal depository insurance limits. Management believes the credit risk related to these deposits is minimal.

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 the excess of revenues over expenses unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are excluded from the excess of revenues over expenses unless the investments are trading securities.

Allowance for Estimated Uncollectible Accounts

Accounts receivable are reduced by an allowance for estimated uncollectible 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 estimated uncollectible 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 estimated uncollectible 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 estimated uncollectible accounts and a provision for bad debts, if necessary (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party 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 estimated uncollectible accounts.

The Hospital's allowance for doubtful accounts for self-pay patients was approximately 88% for both 2018 and 2017. In addition, the Hospital's self-pay write-offs decreased approximately $2,221,000 from $21,815,000 for fiscal year 2017 to $19,594,000 for fiscal year 2018.

Assets Limited as to Use

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

Other Assets

Other assets includes goodwill of approximately $1,639,000 related to the purchase of Upson Family Medicine (“UFM”) during 2018. Goodwill will be evaluated for impairment on an annual basis or whenever certain triggering events or circumstances are identified that would more likely than not reduce the fair value of UFM below its carrying value.

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 using the straight-line method.

Gifts of long-lived assets such as land, buildings, or equipment are reported as unrestricted support, and are excluded from the excess of revenues over expenses, 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.

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 consolidated statements of operations for the years ended December 31, 2018 and 2017.

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. Amounts received from state charity care programs are reported in net patient service revenue.

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.

Debt Issuance Costs

Costs related to the issuance of long-term debt were deferred and are being amortized over the life of the debt using the straight-line method, which approximates the effective interest method.

Income Taxes

The Hospital and Foundation are not-for-profit corporations and are tax-exempt pursuant to Section 501(c)(3) of the Internal Revenue Code. The Segregated Portfolio intends to conduct its affairs in a manner in which it will not be subject to U.S. federal income tax or Georgia income tax. The remaining wholly owned subsidiaries are considered disregarded entities and are included in the Hospital's tax filings. Therefore, no provision for federal income taxes has been made in the accompanying financial statements.

The Hospital and Foundation apply 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 and Foundation only recognize 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 December 31, 2018 and 2017 or for the years then ended. The Hospital and Foundation'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.

Excess of Revenues over Expenses

The statement of operations includes excess of revenues over expenses. Changes in net assets without donor restrictions which are excluded from excess of revenues over expenses, 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).

Fair Value Measurements

GAAP 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. GAAP 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. GAAP 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 consolidated financial statements, the Hospital has evaluated events and transactions for potential recognition or disclosure through April 12, 2019, the date the consolidated financial statements were issued.

2. 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. 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.

Revenue from the Medicare and Medicaid programs accounted for approximately 43% and 17%, respectively, of the Hospital's net patient revenue for the year ended December 31, 2018 and 41% and 19%, respectively, of the Hospital's net patient revenue for the year ended December 31, 2017. 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.

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

The Hospital is reimbursed for cost 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 December 31, 2017.

Medicaid

Inpatient acute care services rendered to Medicaid program beneficiaries are paid at a prospectively determined rate per discharge. 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 December 31, 2016.

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.

Other Agreements

The Hospital has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The bases for payment to the Hospital

under these agreements include prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

3. Liquidity and Availability of Resources

Financial assets available for general expenditure, without donor or other restrictions limiting their use, within one year of the balance sheet date are reflected in the balance sheets as current assets and include the following balances at December 31, 2018 and 2017:

	2018	2017
Cash and cash equivalents	**$ 1,751,442**	$ 2,336,387
Accounts receivable	**12,396,982**	11,090,353
Other receivables	**859,827**	1,972,925
Total	**$ 15,008,251**	$ 15,399,665

The Hospital funds its operations primarily through service charges to patients. At the discretion of Hospital management, excess cash not needed for operating expenditures are invested in various investment funds.

4. Uncompensated Services

The Hospital was compensated for services at amounts less than its established rates. Charges for uncompensated services for 2018 and 2017 were approximately $235,888,000 and $212,256,000, respectively.

Uncompensated care includes charity and indigent care services of approximately $17,592,000 and $13,981,000 in 2018 and 2017, respectively. The cost of charity and indigent care services provided during 2018 and 2017 was approximately $4,994,000 and $3,931,000, 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 2018 and 2017.

	2018	2017
Gross patient charges	**$ 319,219,717**	$ 287,363,885
Uncompensated services:		
Charity and indigent care	**17,591,612**	13,980,946
Medicare	**105,002,661**	88,613,033
Medicaid	**48,420,284**	46,575,817
Other allowances	**45,279,303**	41,271,418
Bad debts	**19,593,823**	21,814,299
Total uncompensated care	**235,887,683**	212,255,513
Net patient service revenue	**$ 83,332,034**	$ 75,108,372

The Hospital accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to certain established policies of the Hospital. Essentially, these policies define charity services as those services for which no payment is anticipated. In assessing a patient's ability to pay, the Hospital utilizes the generally recognized Federal Poverty Guidelines, but also includes certain cases where incurred charges are significant when compared to the patient's income. These charges are not included in net patient service revenues. The costs and

expenses incurred in providing these services are included in the Hospital's revenues over expenses in the consolidated statements of operations.

5. Assets Limited as to Use

The composition of assets limited as to use at December 31, 2018 and 2017, is set forth in the following table. Assets limited as to use are classified as other than trading and are stated at fair value.

	2018	2017
Internally designated for capital acquisition:		
Cash and cash equivalents	**$ 396,810**	$ 136,137
U.S. Corporate bonds and notes	**3,391,450**	3,980,680
Municipal securities	**443,738**	622,311
Mutual funds - fixed	**7,432,678**	7,709,909
Mutual funds - equities	**48,937,421**	55,717,985
Government securities	**4,520,693**	4,084,702
Interest receivable	**54,755**	57,843
	65,177,545	72,309,567
Internally designated for Hospital insurance:		
Cash and cash equivalents	**32,381**	591,577
U.S. Corporate bonds and notes	**1,270,013**	-
Mutual funds - fixed	**642,260**	1,710,125
Mutual funds - equities	**364,529**	445,159
Equity securities	**477,085**	685,830
Interest receivable	**6,587**	-
	2,792,855	3,432,691
Total assets limited as to use	**$ 67,970,400**	$ 75,742,258

6. Investments

Investments, stated at fair value, at December 31, 2018 and 2017, include:

	2018	2017
Other than trading securities:		
Cash and cash equivalents	**$ 247,006**	$ 232,533
Certificate of deposit	**175,000**	166,576
U.S. Corporate bonds and notes	**5,144,673**	5,533,840
Municipal securities	**253,214**	406,570
Mutual funds - fixed	**6,790,269**	6,627,067
Mutual funds - equities	**12,241,837**	14,484,106
Government securities	**4,766,594**	4,380,966
Interest receivable	**57,246**	66,360
Equity securities	**2,110,664**	2,275,812
	$ 31,786,503	$ 34,173,830

Investment income and gains and losses for assets limited as to use, cash and cash equivalents, and other investments are comprised of the following for the years ending December 31, 2018 and 2017:

	2018	2017
Income:		
Interest and dividend income	**$ 4,941,937**	$ 3,458,461
Realized gains on sale of investments	**3,599,261**	1,108,915
	$ 8,541,198	$ 4,567,376
Unrealized (losses) gains on other than trading securities	**$ (12,274,283)**	$ 12,192,379

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 change could materially affect the amounts.

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.

Management has considered the nature of investments in an unrealized loss position, the cause of potential impairment, the severity and duration of potential 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, the Hospital has concluded that at December 31, 2018 and 2017, no investments are considered to be other-than-temporarily impaired, and accumulated losses are not significant.

7. Property and Equipment

A summary of property and equipment at December 31, 2018 and 2017 follows:

	2018	2017
Land	**$ 1,922,815**	$ 1,922,815
Land improvements	**896,431**	896,431
Buildings and improvements	**70,232,270**	66,225,864
Equipment	**64,660,538**	60,028,248
	137,712,054	129,073,358
Less accumulated depreciation	**79,239,417**	71,729,536
	58,472,637	57,343,822
Construction-in-progress	**890,083**	3,367,262
Total property and equipment, net	**$ 59,362,720**	$ 60,711,084

Depreciation expense for the years ended December 31, 2018 and 2017 amounted to approximately $7,619,000 and $6,692,000, respectively.

8. Long-Term Debt

A summary of long-term debt at December 31, 2018 and 2017 follows:

	2018	2017
Revenue Certificates Series 2004, principal maturing in installments ranging from $460,000 to $710,000 due each January 1 until 2025. The certificates bear interest of 4.08% payable semi-annually on January 1 and July 1.	**$ 3,875,000**	$ 4,435,000
Revenue Certificates Series 2005, principal maturing in installments ranging from $275,000 to $430,000 due each January 1 until 2025. The certificates bear interest of 4.10% payable semi-annually on January 1 and July 1.	**2,330,000**	2,665,000
Capital lease obligations	**4,105,815**	6,270,231
	10,310,815	13,370,231
Less bond discount	**7,487**	9,887
Less unamortized issuance costs	**20,988**	36,159
Less current portion	**2,924,382**	2,894,382
Total	**$ 7,357,958**	$ 10,429,803

In December 2004, the Authority issued the Series 2004 Revenue Certificates totaling $10,000,000. The Series 2004 Certificates were issued by the Authority for the purpose of financing renovation and expansion of Upson Regional Medical Center. The Series 2004 Revenue Certificates are obligations of the Authority payable from and secured by a pledge of and lien on the gross revenues of the Hospital. The 2004 Revenue Certificates' note indenture places limits on the incurrence of additional borrowings and requires that the Hospital satisfy certain measures of financial performance as long as the notes are outstanding.

In January 2005, the Authority issued the Series 2005 Revenue Certificates totaling $6,000,000. The Series 2005 Certificates were issued on a parity with the 2004 Certificates. The Series 2005 Certificates were issued by the Authority for the purpose of financing a remaining portion of its renovation and expansion of Upson Regional Medical Center.

In December 2015, the Authority entered into a capital lease with Banc of America Public Capital Corp for $10,000,000. The capital lease was entered into by the Authority for the purpose of financing equipment and property purchases of Upson Regional Medical Center. Principal payments mature in installments due monthly beginning February 2016, and ending January 2021. The capital lease bears interest at an annual rate of 1.76%.

Scheduled principal repayments on long-term debt and capital lease obligations are as follows:

	Bonds	Capital Lease
2019	$ 935,000	$ 2,090,756
2020	970,000	2,090,756
2021	1,010,000	6,267
2022	1,055,000	-
2023	1,095,000	-
Thereafter	1,140,000	-
Total	$ 6,205,000	4,187,779
Less amounts representing interest		81,964
		$ 4,105,815

9. Employee Health Insurance

The Hospital has a self-insurance program under which a third-party administrator processes and pays claims. The Hospital reimburses the third-party administrator monthly for claims incurred and paid. The Hospital has purchased stop-loss insurance coverage for claims in excess of $125,000 for each individual employee. Under this self-insurance program, the Hospital paid or accrued and expensed approximately $5,749,000 and $6,311,000 during the years ended December 31, 2018 and 2017, respectively.

10. Malpractice Insurance

On January 1, 2010, the Hospital became self-insured for medical professional liability and commercial general liability coverage through the Segregated Portfolio. The Segregated Portfolio has agreed to provide coverage of $1,000,000 per claim with a $3,000,000 aggregate. The Segregated Portfolio has accrued a reserve for estimated claims incurred but not reported (IBNR) at December 31, 2018 and 2017. In the event that a claim exceeds the $3,000,000 limit, the Hospital has purchased an umbrella insurance policy with a $50,000 deductible and a $10,000,000 aggregate limit. The accrued reserve affiliated with this insurance is reported as other liabilities on the balance sheet and is discounted at 3%.

Various claims and assertions are 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.

11. Pension Plans

The Hospital has a defined contribution plan, Upson Regional Medical 401(k) Retirement Plan (Plan) covering all eligible employees. Each year, participants may contribute up to 100% of pre-tax annual compensation as defined in the Plan. Participants who have attained age 50 before the end of the Plan year are eligible to make catch-up contributions. Participants may also contribute amounts representing distributions from other qualified defined benefit or defined contribution plans. Participants direct the investment of their contributions into various investment options offered by the Plan. The Plan offers various mutual funds and a guaranteed investment account as investment options for participants. The Plan includes an auto-enrollment provision whereby all newly eligible employees are automatically enrolled in the Plan unless they affirmatively elect not to participate in the Plan. Automatically enrolled participants have their deferral rate set at 3% of eligible compensation and their contributions invested in a designated balanced fund until changed by the participant.

The Sponsor will match 100% of the first 1%, 50% of the second 1%, and 25% of each of the third and fourth 1% of base compensation that a participant contributes to the Plan. The Sponsor may also make an incremental discretionary contribution to the Plan based on each participant's annual compensation. In order to qualify for the discretionary contribution, the participant must have completed 1,000 hours of service during the Plan year and be employed by the Sponsor on the last day of the Plan year. No discretionary contribution was made for 2018 or 2017. Contributions are subject to certain IRS limitations.

The cost of the Plan to the Hospital was approximately $514,000 and $470,000 for the years ended December 31, 2018 and 2017, respectively.

12. Concentrations of Credit Risk

The Hospital grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at December 31, 2018 and 2017, was as follows:

	2018	2017
Medicare	**31%**	30%
Medicaid	**10%**	8%
Other third-party payors	**40%**	41%
Patients	**19%**	21%
Total	**100%**	100%

13. Commitments and Contingencies

Compliance Plan

The healthcare industry has recently been subjected to increased scrutiny from governmental agencies at both the national 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. The Hospital has implemented a compliance plan focusing on such issues. No assurance can be made that the Hospital will not be subjected to future investigations with accompanying monetary damages.

Health Care Reform

In recent years, there has been increasing pressure on Congress and some state legislatures to control and reduce the cost of healthcare on the national or at the state level. In 2010, legislation was enacted which included cost controls on hospitals, insurance market reforms, delivery system reforms, and various individual and business mandates among other provisions. The costs of certain provisions 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.

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 10.

14. Accrued Insurance Reserves

Activity in accrued insurance reserves is summarized as follows:

	2018	2017
Balance, January 1	**$ 1,295,512**	$ 1,481,676
Incurred related to current year	**326,200**	389,255
Incurred related to prior years	**164,292**	(516,842)
Paid related to current year	**-**	(1,485)
Paid related to prior years	**(880,232)**	(57,092)
Balance, December 31	**$ 905,772**	$ 1,295,512

The provision for outstanding claims is recorded based upon estimates of Upson Regional Segregated Portfolio's ultimate liability made by Upson Regional Segregated Portfolio's independent consulting actuaries, Madison Consulting Group, Inc., in their report dated in January 2019. In the opinion of management, the provision for outstanding claims at the balance sheet date is adequate to cover the expected ultimate liability under the insurance assumed. The provision for outstanding claims is subject to changes in loss severity, frequency and other factors. Accordingly, the recorded provision is necessarily an estimate, and actual loss payments may be less than, or in excess of, the amount provided, and such differences may be significant.

15. Fair Value 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, accounts payable, accrued expenses, and estimated third-party payor settlements:* The carrying amount reported in the balance sheet approximates its fair value due to the short-term nature of these instruments.
- *Assets limited as to use and investments:* Amounts reported in the balance sheet are at fair value.
- *Long-term debt:* The fair value of the Hospital's long-term debt is estimated using discounted cash flow analyses, based on the Hospital's current incremental borrowing rates for similar types of borrowing arrangements. Based on inputs used in determining the estimated fair value, the Hospital's long-term debt would be classified as Level 2 in the fair value hierarchy.

Fair values of investments and assets limited as to use are as follows at December 31, 2018 and 2017.

December 31, 2018	Fair Value	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Cash and cash equivalents	$ 676,197	$ 676,197	$ -	$ -
Certificates of deposit	175,000	-	175,000	-
U.S. Corporate bonds and notes	9,806,136	-	9,806,136	-
Municipal securities	696,952	696,952	-	-
Mutual funds - fixed	14,865,207	14,865,207	-	-
Mutual funds - equities	61,543,787	61,543,787	-	-
Government securities	9,287,287	-	9,287,287	-
Interest receivable	118,588	118,588	-	-
Equity securities	2,587,749	2,587,749	-	-
Total	$ 99,756,903	$ 80,488,480	$ 19,268,423	$ -

December 31, 2017	Fair Value	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Cash and cash equivalents	$ 960,247	$ 960,247	$ -	$ -
Certificates of deposit	166,576	-	166,576	-
U.S. Corporate bonds and notes	9,514,520	-	9,514,520	-
Municipal securities	1,028,881	1,028,881	-	-
Mutual funds - fixed	16,047,101	16,047,101	-	-
Mutual funds - equities	70,647,250	70,647,250	-	-
Government securities	8,465,668	-	8,465,668	-
Interest receivable	124,203	124,203	-	-
Equity securities	2,961,642	2,961,642	-	-
Total	$109,916,088	$ 91,769,324	$ 18,146,764	$ -

16. Functional Expenses

The Hospital provides healthcare services to residents within its geographic area. Expenses related to providing these services for the year ended December 31, 2018 are as follows:

	Healthcare Services	General & Admin	Total
Salaries	$ 25,101,626	$ 10,540,990	$ 35,642,616
Employee benefits	9,132,314	-	9,132,314
Contract labor	2,505,069	787,619	3,292,688
Physicians fees	3,511,913	-	3,511,913
Purchased services	2,341,149	6,782,922	9,124,071
Legal fees	-	695,179	695,179
Supply expense	11,249,074	676,773	11,925,847
Utilities	1,803,659	68,731	1,872,390
Repairs and maintenance	1,259,756	1,239,160	2,498,916
Insurance expense	487,904	-	487,904
Leases and rentals	497,957	30,982	528,939
Depreciation	7,619,223	-	7,619,223
Interest	-	399,157	399,157
Other	875,007	1,640,375	2,515,382
Total	$ 66,384,651	$ 22,861,888	$ 89,246,539

Expenses related to providing these services for the year ended December 31, 2017 are as follows:

	Healthcare Services	General & Admin	Total
Salaries	$ 21,946,136	$ 10,085,837	$ 32,031,973
Employee benefits	9,467,537	-	9,467,537
Contract labor	1,715,313	1,310,371	3,025,684
Physicians fees	2,402,808	-	2,402,808
Purchased services	1,950,507	5,132,506	7,083,013
Legal fees	-	684,757	684,757
Supply expense	9,667,764	618,132	10,285,896
Utilities	1,706,259	64,657	1,770,916
Repairs and maintenance	1,116,784	1,280,238	2,397,022
Insurance expense	483,602	-	483,602
Leases and rentals	393,476	28,116	421,592
Depreciation	6,692,487	-	6,692,487
Interest	-	474,124	474,124
Other	700,454	1,597,574	2,298,028
Total	$ 58,243,127	$ 21,276,312	$ 79,519,439

17. Indigent Care Trust Fund

The Hospital qualified as a Medicaid disproportionate share hospital for the years ended December 31, 2018 and 2017. By qualifying, the Hospital received payment adjustments of approximately $1,054,000 and $865,000 in 2018 and 2017, respectively. These payments are reflected in net patient service revenue. The Hospital must meet certain Department of Medical Assistance requirements in order to retain payment adjustments. It is management's opinion that the Hospital is in compliance with these requirements.

18. Medicaid Upper Payment Limit

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) provides for enhanced payments to Medicaid providers under the Upper Payment Limit (UPL) methodology. Subsequent to the implementation of the UPL methodology, federal budget concerns have led to reconsideration of the BIPA legislation with possible elimination of enhanced Medicaid payments. Legislation has been enacted to reduce the level of UPL payments in future periods. The Hospital received enhanced payments of approximately $704,000 and $570,000 in 2018 and 2017, respectively.

19. Provider Payment Agreement Act

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 resulted in an increase in hospital payments on Medicaid services of approximately 11.88%. Approximately $953,000 and $876,000 relating to the Act is included in other operating expenses in the accompanying statement of operations for the years ended December 31, 2018 and 2017, respectively.

20. Related Parties

The Hospital has a management contract with HealthTech Management, LLC. The Hospital paid management fees and contract labor costs of approximately $525,000 and $358,000 in 2018 and 2017, respectively.

Supplementary Consolidating Information

Upson County Hospital, Inc. and Affiliates
d/b/a Upson Regional Medical Center
Consolidating Balance Sheet
December 31, 2018

	Upson Regional Medical Center	Upson Medical Associates	Wellness Center	Hospital Foundation	Orthopedic Sports Medicine and Surgery	Upson Women's Services	Upson Family Physicians	Upson Regional Segregated Portfolio	Upson Surgical Associates	MOB	Upson Family Medical Center	Eliminations	Total
ASSETS													
Current assets:													
Cash and cash equivalents	$ 1,548,067	$ 16,109	$ 7,118	$ 8,475	$ 28,719	$ 30,950	$ 31,628	$ -	$ 33,788	$ 5,000	$ 41,588	$ -	$ 1,751,442
Patient accounts receivable, net	10,869,474	22,268	-	-	246,958	259,924	298,477	-	576,380	-	123,501	-	12,396,982
Other receivables	827,624	11,457	5,988	-	225	-	5,524	-	253	-	8,756	-	859,827
Supplies	1,967,656	-	-	-	-	-	-	-	-	-	-	-	1,967,656
Prepaid expenses	1,030,210	731	11,334	-	30,238	126,431	23,379	-	70,004	-	1,175	-	1,293,502
Total current assets	16,243,031	50,565	24,440	8,475	306,140	417,305	359,008	-	680,425	5,000	175,020	-	18,269,409
Assets limited as to use internally designated for:													
Capital acquisition	65,177,545	-	-	-	-	-	-	-	-	-	-	-	65,177,545
Hospital insurance	-	-	-	-	-	-	-	2,792,855	-	-	-	-	2,792,855
Total assets limited as to use	65,177,545	-	-	-	-	-	-	2,792,855	-	-	-	-	67,970,400
Intercompany receivables	58,566,048	-	-	10,864	-	-	-	-	-	-	-	(58,576,912)	-
Investments	29,426,201	-	-	4,172,615	-	-	-	-	-	-	-	(1,812,313)	31,786,503
Property and equipment, net	53,255,038	60,159	125,850	-	13,719	193,238	129,765	-	357,040	5,213,610	14,301	-	59,362,720
Other assets	48,808	-	-	-	-	-	-	-	-	-	1,639,203	-	1,688,011
Total assets	$ 222,716,671	$ 110,724	$ 150,290	$ 4,191,954	$ 319,859	$ 610,543	$ 488,773	$ 2,792,855	$ 1,037,465	$ 5,218,610	$ 1,828,524	$(60,389,225)	$ 179,077,043
LIABILITIES AND NET ASSETS													
Current liabilities:													
Current portion of long-term debt	$ 2,924,382	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,924,382
Accounts payable	2,262,144	33,073	4,632	-	33,266	32,297	49,252	58,516	91,169	440	10,433		2,575,222
Accrued payroll	796,496	2,593	7,331	-	22,638	36,103	61,424	-	74,647	-	18,493	-	1,019,725
Accrued payroll taxes	83,404	193	-	-	944	2,509	1,846	-	2,565	-	1,448	-	92,909
Accrued benefits	1,105,523	2,453	-	-	11,077	17,930	11,356	-	13,506	-	6,229	-	1,168,074
Other accrued liabilities	500,498	418	25,930	-	35,556	22,813	1,737	16,254	119,645	-	2,570	-	725,421
Estimated third-party payor settlements	38,879	-	-	-	-	-	-	-	-	-	-	-	38,879
Total current liabilities	7,711,326	38,730	37,893	-	103,481	111,652	125,615	74,770	301,532	440	39,173	-	8,544,612
Long-term debt, net of current portion	7,357,958	-	-	-	-	-	-	-	-	-	-	-	7,357,958
Intercompany payables	-	20,343,316	1,647,356	-	4,380,894	9,106,960	5,197,055	-	10,013,146	5,683,736	2,204,449	(58,576,912)	-
Accrued insurance reserves	-	-	-	-	-	-	-	905,772	-	-	-	-	905,772
Total liabilities	15,069,284	20,382,046	1,685,249	-	4,484,375	9,218,612	5,322,670	980,542	10,314,678	5,684,176	2,243,622	(58,576,912)	16,808,342
Net assets:													
Net assets without donor restrictions	207,647,387	(20,271,322)	(1,534,959)	4,191,954	(4,164,516)	(8,608,069)	(4,833,897)	1,812,313	(9,277,213)	(465,566)	(415,098)	(1,812,313)	162,268,701
Total liabilities and net assets	$ 222,716,671	$ 110,724	$ 150,290	$ 4,191,954	$ 319,859	$ 610,543	$ 488,773	$ 2,792,855	$ 1,037,465	$ 5,218,610	$ 1,828,524	$(60,389,225)	$ 179,077,043

See accompanying notes.

Upson County Hospital, Inc. and Affiliates
d/b/a Upson Regional Medical Center
Consolidating Statement of Operations and Changes in Net Assets
Year Ended December 31, 2018

	Upson Regional Medical Center	Upson Medical Associates	Wellness Center	Hospital Foundation	Orthopedic Sports Medicine and Surgery	Upson Women's Services	Upson Family Physicians	Upson Regional Segregated Portfolio	Upson Surgical Associates	MOB	Upson Family Medical Center	Eliminations	Total
Revenues:													
Patient service revenue, net	$ 93,697,720	$ 167,173	$ -	$ -	$ 1,325,409	$ 1,729,496	$ 1,866,665	$ -	$ 3,517,603	$ -	$ 621,791	$ -	$ 102,925,857
Provision for doubtful accounts	(18,507,405)	(48,213)	-	-	(194,752)	(63,927)	(131,852)	-	(620,389)	-	(27,285)	-	(19,593,823)
Net patient service revenue	75,190,315	118,960	-	-	1,130,657	1,665,569	1,734,813	-	2,897,214	-	594,506	-	83,332,034
Other revenue	1,209,986	467,358	652,737	-	92	16,208	1,375	531,564	786	-	3,702	(1,487,643)	1,396,165
Total revenues	76,400,301	586,318	652,737	-	1,130,749	1,681,777	1,736,188	531,564	2,898,000	-	598,208	(1,487,643)	84,728,199
Operating expenses:													
Salaries	27,771,523	108,931	-	-	1,436,709	1,509,863	1,589,685	-	2,671,404	-	554,501	-	35,642,616
Employee benefits	7,623,452	22,931	-	-	191,949	260,565	345,948	-	577,908	1,370	108,191	-	9,132,314
Contract labor	2,988,359	-	302,169	-	-	-	-	-	-	-	2,160	-	3,292,688
Physicians fees	3,334,993	-	-	-	-	133,926	-	-	-	-	42,994	-	3,511,913
Purchased services	7,221,024	40,550	58,729	-	89,760	113,508	150,646	490,492	1,229,668	2,400	72,839	(345,545)	9,124,071
Legal fees	667,932	-	-	-	-	-	-	-	27,247	-	-	-	695,179
Supply expense	11,284,085	-	22,484	-	101,917	91,848	138,488	-	212,716	-	74,309	-	11,925,847
Utilities	1,631,312	98,394	-	-	28,198	31,501	49,506	-	53,712	12,891	37,882	(71,006)	1,872,390
Repairs and maintenance	2,447,386	18,264	10,924	-	771	3,184	2,204	-	7,308	2,699	6,176	-	2,498,916
Insurance expense	822,255	16,525	-	-	22,669	97,517	-	-	60,703	-	-	(531,765)	487,904
Leases and rentals	270,201	-	189,992	-	70,466	96,256	151,740	-	163,450	-	94,129	(507,295)	528,939
Depreciation	6,693,006	483,756	33,505	-	6,297	36,854	17,001	-	130,997	217,618	189	-	7,619,223
Interest	399,157	-	-	-	-	-	-	-	-	-	-	-	399,157
Other	2,080,254	9,787	52,678	26,923	13,921	25,226	15,745	164,353	135,379	3,212	19,936	(32,032)	2,515,382
Total operating expenses	75,234,939	799,138	670,481	26,923	1,962,657	2,400,248	2,460,963	654,845	5,270,492	240,190	1,013,306	(1,487,643)	89,246,539
Operating income (loss)	1,165,362	(212,820)	(17,744)	(26,923)	(831,908)	(718,471)	(724,775)	(123,281)	(2,372,492)	(240,190)	(415,098)	-	(4,518,340)
Other income (expense):													
Investment income	7,977,214	3	-	237,188	113	689	140	76,538	302	-	-	249,011	8,541,198
Other	6,629	-	-	-	-	-	-	-	-	-	-	-	6,629
Contributions	1,001,679	-	-	155,916	-	-	-	-	-	-	-	-	1,157,595
Total other income	8,985,522	3	-	393,104	113	689	140	76,538	302	-	-	249,011	9,705,422
Excess of revenue over expenses	10,150,884	(212,817)	(17,744)	366,181	(831,795)	(717,782)	(724,635)	(46,743)	(2,372,190)	(240,190)	(415,098)	249,011	5,187,082
Unrealized gain													
Unrealized gain (loss) on other than trading securities	(11,659,917)	-	-	(412,098)	-	-	-	(202,268)	-	-	-	-	(12,274,283)
Change in net assets	(1,509,033)	(212,817)	(17,744)	(45,917)	(831,795)	(717,782)	(724,635)	(249,011)	(2,372,190)	(240,190)	(415,098)	249,011	(7,087,201)
Net assets, beginning of year	209,156,420	(20,058,505)	(1,517,215)	4,237,871	(3,332,721)	(7,890,287)	(4,109,262)	2,061,324	(6,905,023)	(225,376)	-	(2,061,324)	169,355,902
Net assets, end of year	$ 207,647,387	$(20,271,322)	$ (1,534,959)	$ 4,191,954	$ (4,164,516)	$ (8,608,069)	$ (4,833,897)	$ 1,812,313	$ (9,277,213)	$ (465,566)	$ (415,098)	$ (1,812,313)	$ 162,268,701

See accompanying notes.

** PUBLIC DISCLOSURE COPY **

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

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

OMB No. 1545-0047

2017

Open to Public Inspection

A For the 2017 calendar year, or tax year beginning **and ending**

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

C Name of organization
UPSON COUNTY HOSPITAL INC
Doing business as UPSON REGIONAL MEDICAL CENTER

Number and street (or P.O. box if mail is not delivered to street address) Room/suite
801 WEST GORDON STREET

City or town, state or province, country, and ZIP or foreign postal code
THOMASTON, GA 30286-0027

F Name and address of principal officer: JOHN WILLIAMS
801 WEST GORDON STREET, THOMASTON, GA 30286

D Employer identification number
58-1734026

E Telephone number
706-647-8111

G Gross receipts $ 102,914,264.

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

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

H(c) Group exemption number ▶

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

J Website: ▶ WWW.URMC.ORG

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 1951 **M** State of legal domicile: GA

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities: UPSON REGIONAL MEDICAL CENTER'S MISSION IS TO PROVIDE QUALITY HEALTH CARE SERVICES TO THE

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

3	Number of voting members of the governing body (Part VI, line 1a)	3	9
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	8
5	Total number of individuals employed in calendar year 2017 (Part V, line 2a)	5	735
6	Total number of volunteers (estimate if necessary)	6	66
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	569,527.
b	Net unrelated business taxable income from Form 990-T, line 34	7b	-19,181.

Revenue

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	93,381.	62,520.
9	Program service revenue (Part VIII, line 2g)	94,883,687.	96,958,002.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	4,090,379.	4,405,758.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	860,516.	1,487,984.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	99,927,963.	102,914,264.

Expenses

13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	40,993.	118,881.
14	Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	39,198,309.	41,169,234.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 0.		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	56,070,666.	59,859,655.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	95,309,968.	101,147,770.
19	Revenue less expenses. Subtract line 18 from line 12	4,617,995.	1,766,494.

Net Assets or Fund Balances

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	174,851,593.	185,781,308.
21	Total liabilities (Part X, line 26)	23,307,987.	20,663,277.
22	Net assets or fund balances. Subtract line 21 from line 20	151,543,606.	165,118,031.

Part II Signature Block

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

Sign Here

▶ Signature of officer Date

▶ JOHN WILLIAMS, CFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check if self-employed	PTIN
AMY BIBBY	AMY BIBBY		☐	P00445891

Firm's name ▶ DIXON HUGHES GOODMAN LLP — Firm's EIN ▶ 56-0747981

Firm's address ▶ 500 RIDGEFIELD COURT
ASHEVILLE, NC 28806 — Phone no. (828) 254-2254

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

SEE SCHEDULE O FOR ORGANIZATION MISSION STATEMENT CONTINUATION

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:
UPSON REGIONAL MEDICAL CENTER'S MISSION IS TO PROVIDE QUALITY HEALTH CARE SERVICES TO THE SURROUNDING AREA, REGARDLESS OF THE ABILITY TO PAY.

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? ☐ Yes ☒ No
If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? ☐ Yes ☒ No
If "Yes," describe these changes on Schedule O.

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

4a (Code:) (Expenses $ 77,198,725. including grants of $ 118,881.) (Revenue $ 96,958,002.)
UPSON REGIONAL MEDICAL CENTER OFFERS A COMPLETE LINE OF MEDICAL SERVICES INCLUDING 24-HOUR EMERGENCY CENTER, MEDICAL-SURGICAL CARE, OBSTETRICS, PEDIATRICS, WOMEN'S HEALTH SERVICES, AND MORE. PATIENT DAYS FOR THE YEAR TOTALED 15,689 IN 2017

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

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

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

4e Total program service expenses ▶ 77,198,725.

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b	X	
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21	X	
22	Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22	X	
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	23	X	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No", go to line 25a*	24a	X	
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		X
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		X
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		X
25a	**Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	25a		X
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	25b		X
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? *If "Yes," complete Schedule L, Part II*	26		X
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	27		X
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28a		X
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28b	X	
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	28c		X
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29		X
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		X
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? *If "Yes," complete Schedule R, Part I*	33	X	
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	34	X	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a		X
b	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	35b		
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		X
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	37		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	38	X	

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	174		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c		X	
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	735		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b		X	
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?	3a		X	
b	If "Yes," has it filed a Form 990-T for this year? *If "No," to line 3b, provide an explanation in Schedule O*	3b		X	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a		X	
b	If "Yes," enter the name of the foreign country: ▶ CAYMAN ISLANDS				
	See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a			X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b			X
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	5c			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a			X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	7a			X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b			
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c			X
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e			X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f			X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h			
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	8			
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the sponsoring organization make any taxable distributions under section 4966?	9a			
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	9b			
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	12a			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state?	13a			
	Note. See the instructions for additional information the organization must report on Schedule O.				
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a			X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*	14b			

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

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

Section A. Governing Body and Management

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

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

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

Section C. Disclosure

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

18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

☐ Own website ☐ Another's website ☒ Upon request ☐ Other *(explain in Schedule O)*

19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.

20 State the name, address, and telephone number of the person who possesses the organization's books and records: ▶

JOHN WILLIAMS CFO - 706-647-8111
801 WEST GORDON ST, THOMASTON, GA 30286-0227

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) WILLIAM HIGHTOWER	0.75									
CHAIRMAN	0.15	X		X				0.	0.	0.
(2) JAMES J. EDWARDS	0.75									
VICE CHAIRMAN/VICE PRESIDE	0.15	X		X				0.	0.	0.
(3) BARNEY HANCOCK	0.75									
SECRETARY/TREASURER	0.15	X		X				0.	0.	0.
(4) DR. RALPH WARNOCK	0.75									
ASSISTANT SECRETARY	0.15	X		X				0.	0.	0.
(5) KAY ROBINSON	0.75									
BOARD MEMBER	0.15	X						0.	0.	0.
(6) STEVE KEADLE	0.75									
BOARD MEMBER	0.15	X						0.	0.	0.
(7) KAY SEARCY	0.75									
BOARD MEMBER	0.15	X						0.	0.	0.
(8) SCOTT BLACKSTOCK	0.75									
BOARD MEMBER	0.15	X						0.	0.	0.
(9) DR. JOANTHAN BUSBEE	0.75									
BOARD MEMBER	0.15	X						0.	0.	0.
(10)	40.00									
CEO	1.00			X				284,902.	0.	38,135.
(11)	40.00									
CFO	1.00			X				224,786.	0.	13,669.
(12)	40.00									
ORTHOPEDIC SURGEON						X		1,083,753.	0.	36,872.
(13)	40.00									
UROLOGY SURGEON						X		550,189.	0.	36,251.
(14)	40.00									
ENT SURGEON						X		557,171.	0.	21,362.
(15)	40.00									
SURGEON						X		532,206.	0.	36,872.
(16)	40.00									
SURGEON						X		414,272.	0.	34,346.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
1b Sub-total ▶								3,647,279.	0.	217,507.
c Total from continuation sheets to Part VII, Section A ▶								0.	0.	0.
d Total (add lines 1b and 1c) ▶								3,647,279.	0.	217,507.

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 26

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
NAVIN, HAFFTY & ASSOCIATES, LLC, 1900 WEST PARK DRIVE, SUITE 180, WESTBOROUGH, MA	CONSULTANTS	2,765,628.
MEDICAL INFORMATION TECHNOLOGY, INC ONE MEDI TECH CIRCLE, WESTWOOD, MA 02090	OPERATING SYSTEM	1,714,927.
BATSON-COOK COMPANY 817 FOURTH AVENUE, WEST POINT, GA 31833	CONSTRUCTION CONTRACTORS	1,397,097.
CHRIS R. SHERIDAN & CO. 1572 SCHOFIELD STREET, MACON, GA 31201	CONSTRUCTION CONTRACTORS	1,221,923.
INNOVATIVE THERAPY CONCEPTS, LLC, 2 MASHBURN STREET, SUITE 102, HAWKINSVILLE,	PHYSICAL THERAPY	1,221,204.

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 26

Part VIII Statement of Revenue

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a				
	b Membership dues	1b				
	c Fundraising events	1c				
	d Related organizations	1d				
	e Government grants (contributions)	1e				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	62,520.			
	g Noncash contributions included in lines 1a-1f: $					
	h **Total.** Add lines 1a-1f		62,520.			
Program Service Revenue		**Business Code**				
	2a GROSS PATIENT SERVICE REVENUE	621990	96,922,667.	96,922,667.		
	b EHR INCENTIVES	621990	35,335.	35,335.		
	c					
	d					
	e					
	f All other program service revenue					
	g **Total.** Add lines 2a-2f		96,958,002.			
	3 Investment income (including dividends, interest, and other similar amounts)		3,979,023.			3,979,023.
	4 Income from investment of tax-exempt bond proceeds					
	5 Royalties					
		(i) Real / (ii) Personal				
	6a Gross rents	109,000.				
	b Less: rental expenses	0.				
	c Rental income or (loss)	109,000.				
	d Net rental income or (loss)		109,000.			109,000.
		(i) Securities / (ii) Other				
	7a Gross amount from sales of assets other than inventory	426,735.				
	b Less: cost or other basis and sales expenses	0.				
	c Gain or (loss)	426,735.				
	d Net gain or (loss)		426,735.			426,735.
Other Revenue	8a Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18	a				
	b Less: direct expenses	b				
	c Net income or (loss) from fundraising events					
	9a Gross income from gaming activities. See Part IV, line 19	a				
	b Less: direct expenses	b				
	c Net income or (loss) from gaming activities					
	10a Gross sales of inventory, less returns and allowances	a				
	b Less: cost of goods sold	b				
	c Net income or (loss) from sales of inventory					
	Miscellaneous Revenue	**Business Code**				
	11a MISCELLANEOUS	561499	743,330.			743,330.
	b WELLNESS CENTER	713940	621,707.		555,580.	66,127.
	c OUTSIDE CATERING	722320	13,947.		13,947.	
	d All other revenue					
	e **Total.** Add lines 11a-11d		1,378,984.			
	12 **Total revenue.** See instructions.		102,914,264.	96,958,002.	569,527.	5,324,215.

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	60,500.	60,500.		
2 Grants and other assistance to domestic individuals. See Part IV, line 22	58,381.	58,381.		
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees	509,688.		509,688.	
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	28,994.	28,994.		
7 Other salaries and wages	31,214,505.	22,499,348.	8,715,157.	
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	469,834.	333,339.	136,495.	
9 Other employee benefits	6,734,758.	4,778,196.	1,956,562.	
10 Payroll taxes	2,211,455.	1,568,990.	642,465.	
11 Fees for services (non-employees):				
a Management	426,822.	39,264.	387,558.	
b Legal	684,757.		684,757.	
c Accounting	229,820.		229,820.	
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)	12,142,657.	6,477,283.	5,665,374.	
12 Advertising and promotion	169,196.	138.	169,058.	
13 Office expenses	3,030,223.	828,189.	2,202,034.	
14 Information technology	1,725,186.	263,401.	1,461,785.	
15 Royalties				
16 Occupancy	1,606,629.	1,606,629.		
17 Travel	185,023.	52,272.	132,751.	
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings				
20 Interest	474,124.		474,124.	
21 Payments to affiliates				
22 Depreciation, depletion, and amortization	6,692,487.	6,692,487.		
23 Insurance	309,990.	309,990.		
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a BAD DEBT EXPENSE	21,814,299.	21,814,299.		
b MEDICAL SUPPLIES	9,399,351.	9,399,351.		
c MISCELLANEOUS	834,649.	253,232.	581,417.	
d FOOD EXPENSE	134,442.	134,442.		
e All other expenses				
25 **Total functional expenses.** Add lines 1 through 24e	101,147,770.	77,198,725.	23,949,045.	0.
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

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

				(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing		5,451.	1	5,446.
	2	Savings and temporary cash investments		5,228,384.	2	2,319,658.
	3	Pledges and grants receivable, net			3	
	4	Accounts receivable, net		12,793,209.	4	13,063,278.
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L			5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instr). Complete Part II of Sch L			6	
	7	Notes and loans receivable, net			7	
	8	Inventories for sale or use		1,911,992.	8	2,416,782.
	9	Prepaid expenses and deferred charges		1,195,936.	9	1,389,508.
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D	10a 132,440,620.			
	b	Less: accumulated depreciation	10b 71,729,536.	55,278,509.	10c	60,711,084.
	11	Investments - publicly traded securities		98,349,330.	11	105,689,500.
	12	Investments - other securities. See Part IV, line 11			12	
	13	Investments - program-related. See Part IV, line 11			13	
	14	Intangible assets			14	
	15	Other assets. See Part IV, line 11		88,782.	15	186,052.
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)		174,851,593.	16	185,781,308.
Liabilities	17	Accounts payable and accrued expenses		5,305,931.	17	5,746,183.
	18	Grants payable			18	
	19	Deferred revenue			19	
	20	Tax-exempt bond liabilities		7,928,947.	20	7,072,363.
	21	Escrow or custodial account liability. Complete Part IV of Schedule D			21	
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L			22	
	23	Secured mortgages and notes payable to unrelated third parties			23	
	24	Unsecured notes and loans payable to unrelated third parties			24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D		10,073,109.	25	7,844,731.
	26	**Total liabilities.** Add lines 17 through 25		23,307,987.	26	20,663,277.
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ [X] and complete lines 27 through 29, and lines 33 and 34.**				
	27	Unrestricted net assets		151,543,606.	27	165,118,031.
	28	Temporarily restricted net assets			28	
	29	Permanently restricted net assets			29	
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.				
	30	Capital stock or trust principal, or current funds			30	
	31	Paid-in or capital surplus, or land, building, or equipment fund			31	
	32	Retained earnings, endowment, accumulated income, or other funds			32	
	33	Total net assets or fund balances		151,543,606.	33	165,118,031.
	34	Total liabilities and net assets/fund balances		174,851,593.	34	185,781,308.

Form **990** (2017)

732011 11-28-17

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	102,914,264.
2	Total expenses (must equal Part IX, column (A), line 25)	2	101,147,770.
3	Revenue less expenses. Subtract line 2 from line 1	3	1,766,494.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	151,543,606.
5	Net unrealized gains (losses) on investments	5	11,807,931.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	0.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	165,118,031.

Part XII Financial Statements and Reporting

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

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

SCHEDULE A (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

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

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

OMB No. 1545-0047

2017

Open to Public Inspection

Name of the organization

UPSON COUNTY HOSPITAL INC

Employer identification number

58-1734026

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

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

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

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

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

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

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

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

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

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

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

10 ☐ An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)

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

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

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

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

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

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

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

f Enter the number of supported organizations .....

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

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

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 **Total support.** Add lines 7 through 10						

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

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2017 (line 6, column (f) divided by line 11, column (f)) 14 %

15 Public support percentage from 2016 Schedule A, Part II, line 14 15 %

16a **33 1/3% support test - 2017.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support test - 2016.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

17a **10% -facts-and-circumstances test - 2017.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐

b **10% -facts-and-circumstances test - 2016.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ ☐

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support.** (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 **Total support.** (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15 Public support percentage for 2017 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2016 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for **2017** (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from **2016** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2017.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support tests - 2016.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations *(continued)*

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally Integrated Supporting Organizations

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

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

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

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

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

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

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

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

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

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

Section D - Distributions		Current Year
1	Amounts paid to supported organizations to accomplish exempt purposes	
2	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3	Administrative expenses paid to accomplish exempt purposes of supported organizations	
4	Amounts paid to acquire exempt-use assets	
5	Qualified set-aside amounts (prior IRS approval required)	
6	Other distributions (describe in **Part VI**). See instructions.	
7	**Total annual distributions.** Add lines 1 through 6.	
8	Distributions to attentive supported organizations to which the organization is responsive (provide details in **Part VI**). See instructions.	
9	Distributable amount for 2017 from Section C, line 6	
10	Line 8 amount divided by line 9 amount	

Section E - Distribution Allocations (see instructions)		(i) Excess Distributions	(ii) Underdistributions Pre-2017	(iii) Distributable Amount for 2017
1	Distributable amount for 2017 from Section C, line 6			
2	Underdistributions, if any, for years prior to 2017 (reasonable cause required- explain in **Part VI**). See instructions.			
3	Excess distributions carryover, if any, to 2017			
a				
b	From 2013			
c	From 2014			
d	From 2015			
e	From 2016			
f	**Total** of lines 3a through e			
g	Applied to underdistributions of prior years			
h	Applied to 2017 distributable amount			
i	Carryover from 2012 not applied (see instructions)			
j	Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4	Distributions for 2017 from Section D, line 7: $			
a	Applied to underdistributions of prior years			
b	Applied to 2017 distributable amount			
c	Remainder. Subtract lines 4a and 4b from 4.			
5	Remaining underdistributions for years prior to 2017, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, explain in **Part VI.** See instructions.			
6	Remaining underdistributions for 2017. Subtract lines 3h and 4b from line 1. For result greater than zero, explain in **Part VI**. See instructions.			
7	**Excess distributions carryover to 2018.** Add lines 3j and 4c.			
8	Breakdown of line 7:			
a	Excess from 2013			
b	Excess from 2014			
c	Excess from 2015			
d	Excess from 2016			
e	Excess from 2017			

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

Schedule B
(Form 990, 990-EZ, or 990-PF)
Department of the Treasury
Internal Revenue Service

Schedule of Contributors

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

OMB No. 1545-0047

2017

Name of the organization

UPSON COUNTY HOSPITAL INC

Employer identification number

58-1734026

Organization type (check one):

Filers of:	Section:
Form 990 or 990-EZ	[X] 501(c)(3) (enter number) organization
	[ ] 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
	[ ] 527 political organization
Form 990-PF	[ ] 501(c)(3) exempt private foundation
	[ ] 4947(a)(1) nonexempt charitable trust treated as a private foundation
	[ ] 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule.**
Note: Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

[X] For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, contributions totaling $5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

Special Rules

[ ] For an organization described in section 501(c)(3) filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), that checked Schedule A (Form 990 or 990-EZ), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions of the greater of **(1)** $5,000; or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h; or (ii) Form 990-EZ, line 1. Complete Parts I and II.

[ ] For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than $1,000 *exclusively* for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I, II, and III.

[ ] For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled more than $1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Don't complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions totaling $5,000 or more during the year ..... ▶ $ _____

Caution: An organization that isn't covered by the General Rule and/or the Special Rules doesn't file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it doesn't meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization: UPSON COUNTY HOSPITAL INC

Employer identification number: 58-1734026

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1		$ 62,520.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization	Employer identification number
UPSON COUNTY HOSPITAL INC	58-1734026

Part II **Noncash Property** (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
		$	
(a) No. from Part I	**(b) Description of noncash property given**	**(c) FMV (or estimate) (See instructions.)**	**(d) Date received**
		$	
(a) No. from Part I	**(b) Description of noncash property given**	**(c) FMV (or estimate) (See instructions.)**	**(d) Date received**
		$	
(a) No. from Part I	**(b) Description of noncash property given**	**(c) FMV (or estimate) (See instructions.)**	**(d) Date received**
		$	
(a) No. from Part I	**(b) Description of noncash property given**	**(c) FMV (or estimate) (See instructions.)**	**(d) Date received**
		$	
(a) No. from Part I	**(b) Description of noncash property given**	**(c) FMV (or estimate) (See instructions.)**	**(d) Date received**
		$	

Name of organization	Employer identification number
UPSON COUNTY HOSPITAL INC	58-1734026

Part III *Exclusively* **religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than $1,000 for the year from any one contributor.** Complete columns **(a)** through **(e)** and the following line entry. For organizations completing Part III, enter the total of exclusively religious, charitable, etc., contributions of $1,000 or less for the year. (Enter this info. once.) ▶ $

Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

SCHEDULE C
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527

▶ **Complete if the organization is described below.** ▶ **Attach to Form 990 or Form 990-EZ.**

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

OMB No. 1545-0047

2017

Open to Public Inspection

If the organization answered "Yes," on Form 990, Part IV, line 3, or Form 990-EZ, Part V, line 46 (Political Campaign Activities), then

- Section 501(c)(3) organizations: Complete Parts I-A and B. Do not complete Part I-C.
- Section 501(c) (other than section 501(c)(3)) organizations: Complete Parts I-A and C below. Do not complete Part I-B.
- Section 527 organizations: Complete Part I-A only.

If the organization answered "Yes," on Form 990, Part IV, line 4, or Form 990-EZ, Part VI, line 47 (Lobbying Activities), then

- Section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)): Complete Part II-A. Do not complete Part II-B.
- Section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)): Complete Part II-B. Do not complete Part II-A.

If the organization answered "Yes," on Form 990, Part IV, line 5 (Proxy Tax) (see separate instructions) or Form 990-EZ, Part V, line 35c (Proxy Tax) (see separate instructions), then

- Section 501(c)(4), (5), or (6) organizations: Complete Part III.

Name of organization	Employer identification number
UPSON COUNTY HOSPITAL INC	58-1734026

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

1 Provide a description of the organization's direct and indirect political campaign activities in Part IV.

2 Political campaign activity expenditures ▶ $

3 Volunteer hours for political campaign activities

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

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

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

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

4a Was a correction made? ☐ Yes ☐ No

b If "Yes," describe in Part IV.

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

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

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

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

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

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

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

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

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

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

Limits on Lobbying Expenditures (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount. Enter the amount from the following table in both columns.		

If the amount on line 1e, column (a) or (b) is:	The lobbying nontaxable amount is:
Not over $500,000	20% of the amount on line 1e.
Over $500,000 but not over $1,000,000	$100,000 plus 15% of the excess over $500,000.
Over $1,000,000 but not over $1,500,000	$175,000 plus 10% of the excess over $1,000,000.
Over $1,500,000 but not over $17,000,000	$225,000 plus 5% of the excess over $1,500,000.
Over $17,000,000	$1,000,000.

g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a. If zero or less, enter -0-		
i Subtract line 1f from line 1c. If zero or less, enter -0-		

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

4-Year Averaging Period Under section 501(h)

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

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	(a) 2014	(b) 2015	(c) 2016	(d) 2017	(e) Total
2a Lobbying nontaxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots nontaxable amount					
e Grassroots ceiling amount (150% of line 2d, column (e))					
f Grassroots lobbying expenditures					

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

For each "Yes," response on lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.	(a) Yes	(a) No	(b) Amount
1 During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a Volunteers?		X	
b Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
c Media advertisements?		X	
d Mailings to members, legislators, or the public?		X	
e Publications, or published or broadcast statements?		X	
f Grants to other organizations for lobbying purposes?		X	
g Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
h Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
i Other activities?	X		10,390.
j Total. Add lines 1c through 1i			10,390.
2a Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
b If "Yes," enter the amount of any tax incurred under section 4912			
c If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

Part III-A **Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6).**

			Yes	No
1	Were substantially all (90% or more) dues received nondeductible by members?	1		
2	Did the organization make only in-house lobbying expenditures of $2,000 or less?	2		
3	Did the organization agree to carry over lobbying and political campaign activity expenditures from the prior year?	3		

Part III-B **Complete if the organization is exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) and if either (a) BOTH Part III-A, lines 1 and 2, are answered "No," OR (b) Part III-A, line 3, is answered "Yes."**

1	Dues, assessments and similar amounts from members	1	
2	Section 162(e) nondeductible lobbying and political expenditures **(do not include amounts of political expenses for which the section 527(f) tax was paid).**		
a	Current year	2a	
b	Carryover from last year	2b	
c	Total	2c	
3	Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	3	
4	If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?	4	
5	Taxable amount of lobbying and political expenditures (see instructions)	5	

Part IV **Supplemental Information**

Provide the descriptions required for Part I-A, line 1; Part I-B, line 4; Part I-C, line 5; Part II-A (affiliated group list); Part II-A, lines 1 and 2 (see instructions); and Part II-B, line 1. Also, complete this part for any additional information.

PART II-B, LINE 1, LOBBYING ACTIVITIES:

THE ORGANIZATION PAYS ANNUAL DUES TO NATIONAL AND STATE INDUSTRY ORGANIZATIONS. A PORTION OF THOSE DUES ARE ATTRIBUTABLE TO THE LOBBYING ACTIVITIES OF THESE ORGANIZATIONS FOR THE BENEFIT OF THEIR MEMBERS.

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

OMB No. 1545-0047

2017

Open to Public Inspection

Name of the organization
UPSON COUNTY HOSPITAL INC

Employer identification number
58-1734026

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

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

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

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

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

Part II Conservation Easements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:

a Board designated or quasi-endowment ▶ _____%
b Permanent endowment ▶ _____%
c Temporarily restricted endowment ▶ _____%

The percentages on lines 2a, 2b, and 2c should equal 100%.

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

		Yes	No
(i) unrelated organizations	3a(i)		
(ii) related organizations	3a(ii)		
b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R?	3b		

4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land		1,922,815.		1,922,815.
b Buildings		66,133,589.	33,621,006.	32,512,583.
c Leasehold improvements		988,706.	765,296.	223,410.
d Equipment		60,028,248.	37,343,234.	22,685,014.
e Other		3,367,262.		3,367,262.
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10c.)* ▶				60,711,084.

Part VII Investments - Other Securities.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

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

Part VIII Investments - Program Related.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

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

Part IX Other Assets.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 15.)* ▶	

Part X Other Liabilities.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2) EST THIRD PARTY PAYOR SETTLEMENTS	297,397.
(3) CAPITAL LEASE OBLIGATION	6,251,822.
(4) CAP RESERVES	1,295,512.
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶	7,844,731.

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

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

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

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

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

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

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

Part XIII Supplemental Information.

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

PART X, LINE 2:

THE HOSPITAL AND FOUNDATION ARE NOT-FOR-PROFIT CORPORATIONS AND ARE TAX-EXEMPT PURSUANT TO SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE. THE SEGREGATED PORTFOLIO INTENDS TO CONDUCT ITS AFFAIRS IN A MANNER IN WHICH IT WILL NOT BE SUBJECT TO U.S. FEDERAL INCOME TAX OR GEORGIA INCOME TAX. THE REMAINING WHOLLY OWNED SUBSIDIARIES ARE CONSIDERED DISREGARDED ENTITIES AND ARE INCLUDED IN THE HOSPITAL'S TAX FILINGS. THEREFORE, NO PROVISION FOR FEDERAL INCOME TAXES HAS BEEN MADE IN THE ACCOMPANYING FINANCIAL STATEMENTS.

THE HOSPITAL AND FOUNDATION APPLY ACCOUNTING POLICIES THAT PRESCRIBE WHEN TO RECOGNIZE AND HOW TO MEASURE THE FINANCIAL STATEMENT EFFECTS OF INCOME

Part XIII Supplemental Information *(continued)*

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 AND FOUNDATION ONLY RECOGNIZE 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 DECEMBER 31, 2017 AND 2016 OR FOR THE YEARS THEN ENDED. THE HOSPITAL AND FOUNDATION'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.

SCHEDULE F (Form 990)

Department of the Treasury
Internal Revenue Service

Statement of Activities Outside the United States

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 14b, 15, or 16.**

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2017

Open to Public Inspection

Name of the organization

UPSON COUNTY HOSPITAL INC

Employer identification number

58-1734026

Part I General Information on Activities Outside the United States. Complete if the organization answered "Yes" on Form 990, Part IV, line 14b.

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

2 **For grantmakers.** Describe in Part V the organization's procedures for monitoring the use of its grants and other assistance outside the United States.

3 Activities per Region. (The following Part I, line 3 table can be duplicated if additional space is needed.)

(a) Region	**(b)** Number of offices in the region	**(c)** Number of employees, agents, and independent contractors in the region	**(d)** Activities conducted in the region (by type) (such as, fundraising, program services, investments, grants to recipients located in the region)	**(e)** If activity listed in (d) is a program service, describe specific type of service(s) in the region	**(f)** Total expenditures for and investments in the region
CENTRAL AMERICA & THE CARIBBEAN	1	1	CAPTIVE INSURANCE		3,432,692.
3 a Sub-total	1	1			3,432,692.
b Total from continuation sheets to Part I	0	0			0.
c **Totals** (add lines 3a and 3b)	1	1			3,432,692.

LHA **For Paperwork Reduction Act Notice, see the Instructions for Form 990.** **Schedule F (Form 990) 2017**

732071 10-06-17

Part II **Grants and Other Assistance to Organizations or Entities Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 15, for any recipient who received more than $5,000. Part II can be duplicated if additional space is needed.

1 (a) Name of organization	(b) IRS code section and EIN (if applicable)	(c) Region	(d) Purpose of grant	(e) Amount of cash grant	(f) Manner of cash disbursement	(g) Amount of noncash assistance	(h) Description of noncash assistance	(i) Method of valuation (book, FMV, appraisal, other)

2 Enter total number of recipient organizations listed above that are recognized as charities by the foreign country, recognized as tax-exempt by the IRS, or for which the grantee or counsel has provided a section 501(c)(3) equivalency letter ▶

3 Enter total number of other organizations or entities ▶

Part III **Grants and Other Assistance to Individuals Outside the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 16.
Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	**(b)** Region	**(c)** Number of recipients	**(d)** Amount of cash grant	**(e)** Manner of cash disbursement	**(f)** Amount of noncash assistance	**(g)** Description of noncash assistance	**(h)** Method of valuation (book, FMV, appraisal, other)

Part IV Foreign Forms

1	Was the organization a U.S. transferor of property to a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 926, Return by a U.S. Transferor of Property to a Foreign Corporation (see Instructions for Form 926)*	☐ Yes	☒ No
2	Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to separately file Form 3520, Annual Return To Report Transactions With Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U.S. Owner (see Instructions for Forms 3520 and 3520-A; don't file with Form 990)*	☐ Yes	☒ No
3	Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U.S. Persons With Respect To Certain Foreign Corporations (see Instructions for Form 5471)*	☒ Yes	☐ No
4	Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Information Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund (see Instructions for Form 8621)*	☐ Yes	☒ No
5	Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U.S. Persons With Respect to Certain Foreign Partnerships (see Instructions for Form 8865)*	☐ Yes	☒ No
6	Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to separately file Form 5713, International Boycott Report (see Instructions for Form 5713; don't file with Form 990)*	☐ Yes	☒ No

Part V **Supplemental Information**

Provide the information required by Part I, line 2 (monitoring of funds); Part I, line 3, column (f) (accounting method; amounts of investments vs. expenditures per region); Part II, line 1 (accounting method); Part III (accounting method); and Part III, column (c) (estimated number of recipients), as applicable. Also complete this part to provide any additional information. See instructions.

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

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

OMB No. 1545-0047

2017

Open to Public Inspection

Name of the organization
UPSON COUNTY HOSPITAL INC

Employer identification number
58-1734026

Part I Financial Assistance and Certain Other Community Benefits at Cost

		Yes	No
1a Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a	1a	X	
b If "Yes," was it a written policy?	1b	X	
2 If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year.			
[X] Applied uniformly to all hospital facilities [ ] Applied uniformly to most hospital facilities			
[ ] Generally tailored to individual hospital facilities			
3 Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.			
a Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care:	3a	X	
[ ] 100% [ ] 150% [ ] 200% [X] Other 125 %			
b Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care:	3b	X	
[ ] 200% [ ] 250% [X] 300% [ ] 350% [ ] 400% [ ] Other _____ %			
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.			
4 Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?	4	X	
5a Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?	5a	X	
b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?	5b		X
c If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?	5c		
6a Did the organization prepare a community benefit report during the tax year?	6a		X
b If "Yes," did the organization make it available to the public?	6b		

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

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			3762650.	865,000.	2897650.	3.65%
b Medicaid (from Worksheet 3, column a)			15198393.	11256776.	3941617.	4.97%
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs			18961043.	12121776.	6839267.	8.62%
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			7,711.		7,711.	.01%
f Health professions education (from Worksheet 5)			81,975.		81,975.	.10%
g Subsidized health services (from Worksheet 6)			7776682.	4376015.	3400667.	4.29%
h Research (from Worksheet 7)						
i Cash and in-kind contributions for community benefit (from Worksheet 8)						
j **Total.** Other Benefits			7866368.	4376015.	3490353.	4.40%
k **Total.** Add lines 7d and 7j			26827411.	16497791.	10329620.	13.02%

Part II Community Building Activities Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

		(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1	Physical improvements and housing						
2	Economic development						
3	Community support			10,184.		10,184.	.01%
4	Environmental improvements						
5	Leadership development and training for community members						
6	Coalition building						
7	Community health improvement advocacy						
8	Workforce development			250,332.		250,332.	.32%
9	Other						
10	Total			260,516.		260,516.	.33%

Part III Bad Debt, Medicare, & Collection Practices

Section A. Bad Debt Expense

			Yes	No
1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	1		
2	Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount	2 21,814,299.		
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit	3 0.		
4	Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.			

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5	14,008,967.	
6	Enter Medicare allowable costs of care relating to payments on line 5	6	16,911,817.	
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7	-2,902,850.	
8	Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used: ☐ Cost accounting system ☐ Cost to charge ratio ☒ Other			

Section C. Collection Practices

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

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

(a) Name of entity	(b) Description of primary activity of entity	(c) Organization's profit % or stock ownership %	(d) Officers, directors, trustees, or key employees' profit % or stock ownership %	(e) Physicians' profit % or stock ownership %

Part V Facility Information

Section A. Hospital Facilities (list in order of size, from largest to smallest) How many hospital facilities did the organization operate during the tax year? 1 — Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)	Licensed hospital	Gen. medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)	Facility reporting group
1 UPSON COUNTRY HOSPITAL 801 WEST GORDON STREET THOMASTON, GA 30286 HTTP://WWW.URMC.ORG/ 145-415	X	X					X			

Part V Facility Information *(continued)*

Section B. Facility Policies and Practices

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

Name of hospital facility or letter of facility reporting group UPSON COUNTY HOSPITAL INC

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

		Yes	No
Community Health Needs Assessment			
1 Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?	1		X
2 Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C	2		X
3 During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12	3	X	
If "Yes," indicate what the CHNA report describes (check all that apply):			
a [X] A definition of the community served by the hospital facility			
b [X] Demographics of the community			
c [X] Existing health care facilities and resources within the community that are available to respond to the health needs of the community			
d [X] How data was obtained			
e [X] The significant health needs of the community			
f [X] Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups			
g [X] The process for identifying and prioritizing community health needs and services to meet the community health needs			
h [X] The process for consulting with persons representing the community's interests			
i [ ] The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)			
j [ ] Other (describe in Section C)			
4 Indicate the tax year the hospital facility last conducted a CHNA: 20 15			
5 In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	5	X	
6a Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C	6a		X
b Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities? If "Yes," list the other organizations in Section C	6b		X
7 Did the hospital facility make its CHNA report widely available to the public?	7	X	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):			
a [X] Hospital facility's website (list url): SEE DISCLOSURE FOR WEBSITE			
b [ ] Other website (list url):			
c [ ] Made a paper copy available for public inspection without charge at the hospital facility			
d [ ] Other (describe in Section C)			
8 Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11	8	X	
9 Indicate the tax year the hospital facility last adopted an implementation strategy: 20 15			
10 Is the hospital facility's most recently adopted implementation strategy posted on a website?	10	X	
a If "Yes," (list url): SEE DISCLOSURE FOR WEBSITE			
b If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?	10b		
11 Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.			
12a Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?	12a		X
b If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?	12b		
c If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities? **$**			

Part V Facility Information *(continued)*

Financial Assistance Policy (FAP)

Name of hospital facility or letter of facility reporting group UPSON COUNTY HOSPITAL INC

			Yes	No
	Did the hospital facility have in place during the tax year a written financial assistance policy that:			
13	Explained eligibility criteria for financial assistance, and whether such assistance included free or discounted care?	13	X	
	If "Yes," indicate the eligibility criteria explained in the FAP:			
a	[X] Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 125 % and FPG family income limit for eligibility for discounted care of 300 %			
b	[ ] Income level other than FPG (describe in Section C)			
c	[ ] Asset level			
d	[ ] Medical indigency			
e	[ ] Insurance status			
f	[ ] Underinsurance status			
g	[ ] Residency			
h	[ ] Other (describe in Section C)			
14	Explained the basis for calculating amounts charged to patients?	14	X	
15	Explained the method for applying for financial assistance?	15	X	
	If "Yes," indicate how the hospital facility's FAP or FAP application form (including accompanying instructions) explained the method for applying for financial assistance (check all that apply):			
a	[X] Described the information the hospital facility may require an individual to provide as part of his or her application			
b	[X] Described the supporting documentation the hospital facility may require an individual to submit as part of his or her application			
c	[X] Provided the contact information of hospital facility staff who can provide an individual with information about the FAP and FAP application process			
d	[X] Provided the contact information of nonprofit organizations or government agencies that may be sources of assistance with FAP applications			
e	[X] Other (describe in Section C)			
16	Was widely publicized within the community served by the hospital facility?	16	X	
	If "Yes," indicate how the hospital facility publicized the policy (check all that apply):			
a	[X] The FAP was widely available on a website (list url): SEE PART V, PAGE 8			
b	[X] The FAP application form was widely available on a website (list url): SEE PART V, PAGE 8			
c	[X] A plain language summary of the FAP was widely available on a website (list url): SEE PART V, PAGE 8			
d	[X] The FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
e	[X] The FAP application form was available upon request and without charge (in public locations in the hospital facility and by mail)			
f	[X] A plain language summary of the FAP was available upon request and without charge (in public locations in the hospital facility and by mail)			
g	[X] Individuals were notified about the FAP by being offered a paper copy of the plain language summary of the FAP, by receiving a conspicuous written notice about the FAP on their billing statements, and via conspicuous public displays or other measures reasonably calculated to attract patients' attention			
h	[X] Notified members of the community who are most likely to require financial assistance about availability of the FAP			
i	[ ] The FAP, FAP application form, and plain language summary of the FAP were translated into the primary language(s) spoken by LEP populations			
j	[ ] Other (describe in Section C)			

Part V Facility Information *(continued)*

Billing and Collections

Name of hospital facility or letter of facility reporting group UPSON COUNTY HOSPITAL INC

		Yes	No
17 Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?	17	X	
18 Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:			
a ☐ Reporting to credit agency(ies)			
b ☐ Selling an individual's debt to another party			
c ☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d ☐ Actions that require a legal or judicial process			
e ☐ Other similar actions (describe in Section C)			
f ☒ None of these actions or other similar actions were permitted			
19 Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?	19		X
If "Yes," check all actions in which the hospital facility or a third party engaged:			
a ☐ Reporting to credit agency(ies)			
b ☐ Selling an individual's debt to another party			
c ☐ Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP			
d ☐ Actions that require a legal or judicial process			
e ☐ Other similar actions (describe in Section C)			

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

- **a** ☒ Provided a written notice about upcoming ECAs (Extraordinary Collection Action) and a plain language summary of the FAP at least 30 days before initiating those ECAs
- **b** ☒ Made a reasonable effort to orally notify individuals about the FAP and FAP application process
- **c** ☒ Processed incomplete and complete FAP applications
- **d** ☒ Made presumptive eligibility determinations
- **e** ☒ Other (describe in Section C)
- **f** ☐ None of these efforts were made

Policy Relating to Emergency Medical Care

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

Part V Facility Information *(continued)*

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

Name of hospital facility or letter of facility reporting group UPSON COUNTY HOSPITAL INC

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

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

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

UPSON COUNTY HOSPITAL INC:

PART V, SECTION B, LINE 5: UPSON SELECTED A GEOGRAPHIC SERVICE AREA DEFINITION. THIS DEFINITION WAS BASED UPON THE HOSPITAL'S PRIMARY SERVICE AREA IN A MANNER THAT INCLUDED THE BROAD INTERESTS OF THE COMMUNITY SERVED AND INCLUDED MEDICALLY UNDERSERVED POPULATIONS, LOW-INCOME PERSONS, MINORITY GROUPS, OR THOSE WITH CHRONIC DISEASE NEEDS. UPSON COUNTY WAS SELECTED AS THE COMMUNITY FOR INCLUSION IN THE CHNA.

UPSON IDENTIFIED COMMUNITY LEADERS, PARTNERS, AND REPRESENTATIVES TO INCLUDE IN THE CHNA PROCESS. INDIVIDUALS, AGENCIES, PARTNERS, POTENTIAL PARTNERS, AND OTHERS WERE REQUESTED TO WORK WITH THE HOSPITAL TO 1) ASSESS THE NEEDS OF THE COMMUNITY, 2) REVIEW AVAILABLE COMMUNITY RESOURCES AND 3) PRIORITIZE THE HEALTH NEEDS OF THE COMMUNITY. GROUPS OR INDIVIDUALS, WHO REPRESENT MEDICALLY-UNDERSERVED POPULATIONS, LOW INCOME POPULATIONS, MINORITY POPULATIONS, AND POPULATIONS WITH CHRONIC DISEASES WERE INCLUDED.

COMMUNITY STAKEHOLDERS (ALSO CALLED KEY INFORMANTS) ARE PEOPLE INVESTED OR INTERESTED IN THE WORK OF THE HOSPITAL, PEOPLE WHO HAVE SPECIAL KNOWLEDGE OF HEALTH ISSUES, PEOPLE IMPORTANT TO THE SUCCESS OF ANY HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENT OR HEALTH PROJECT, OR ARE FORMAL OR INFORMAL COMMUNITY LEADERS. THE HOSPITAL IDENTIFIED 10 COMMUNITY MEMBERS TO PARTICIPATE IN THE STAKEHOLDER INTERVIEWS.

UPSON COUNTY HOSPITAL INC:

PART V, SECTION B, LINE 11: INFORMATION GATHERED FROM COMMUNITY-WIDE

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

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

SURVEYS, STAKEHOLDER INTERVIEWS, DISCUSSIONS WITH THE HOSPITAL LEADERSHIP TEAM, REVIEW OF DEMOGRAPHIC AND HEALTH STATUS DATA, AND HOSPITAL UTILIZATION DATA WAS USED TO DETERMINE THE PRIORITY HEALTH NEEDS OF THE POPULATION.

URMC PROVIDED A WRITTEN REPORT OF THE OBSERVATIONS, COMMENTS, AND PRIORITIES RESULTING FROM THE STAKEHOLDER INTERVIEWS. THE LEADERSHIP TEAM REVIEWED THIS INFORMATION, FOCUSING ON THE IDENTIFIED NEEDS, PRIORITIES, AND CURRENT COMMUNITY RESOURCES AVAILABLE. LEADERSHIP DEBATED THE MERITS AND VALUES OF THESE PRIORITIES, AND CONSIDERED THE RESOURCES AVAILABLE TO MEET THESE NEEDS. FROM THIS INFORMATION AND DISCUSSIONS, THE HOSPITAL DEVELOPED THE PRIORITY NEEDS OF THE COMMUNITY, EACH OF WHICH ARE ADDRESSED SEPARATELY IN THE HOSPITAL'S IMPLEMENTATION STRATEGY DOCUMENT.

UPSON COUNTY HOSPITAL INC:
PART V, SECTION B, LINE 15E: INFORMATION IS MAILED TO ALL PATIENTS ON SUMMARY BILLS AND EACH STATEMENT AS LONG AS A BALANCE IS OUTSTANDING. IT IS AVAILABLE ON THE HOSPITAL WEBSITE AND ANY ENTRANCE POINT OF THE HOSPITAL.

UPSON COUNTY HOSPITAL INC
PART V, LINE 16A, FAP WEBSITE:
HTTP://WWW.URMC.ORG/DOCUMENTS?DOC_TYPE=PATIENT_DOCUMENTS

UPSON COUNTY HOSPITAL INC

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

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

PART V, LINE 16B, FAP APPLICATION WEBSITE:

HTTP://WWW.URMC.ORG/DOCUMENTS?DOC_TYPE=PATIENT_DOCUMENTS

UPSON COUNTY HOSPITAL INC

PART V, LINE 16C, FAP PLAIN LANGUAGE SUMMARY WEBSITE:

HTTP://WWW.URMC.ORG/DOCUMENTS?DOC_TYPE=PATIENT_DOCUMENTS

UPSON COUNTY HOSPITAL INC:

PART V, SECTION B, LINE 20E: ECA WILL NOT BEGIN UNTIL AFTER 240 DAYS.

Part V Facility Information *(continued)*

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

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

How many non-hospital health care facilities did the organization operate during the tax year? 6

Name and address	Type of Facility (describe)
1 UPSON MEDICAL ASSOCIATES, LLC 801 W. GORDON STREET THOMASTON, GA 30286	PHYSICIANS OFFICE
2 UPSON REGIONAL WELLNESS CENTER, LLC 801 W. GORDON STREET THOMASTON, GA 30286	WELLNESS CENTER
3 ORTHOPEDICS SPORTS MEDICINE AND SURGER 801 W. GORDON STREET THOMASTON, GA 30286	PHYSICIANS OFFICE
4 UPSON WOMEN'S SERVICES, LLC 801 W. GORDON STREET THOMASTON, GA 30286	PHYSICIANS OFFICE
5 UPSON FAMILY PHYSICIANS, LLC 801 W. GORDON STREET THOMASTON, GA 30286	PHYSICIANS OFFICE
6 UPSON SURGICAL ASSOCIATES, LLC 801 W. GORDON STREET THOMASTON, GA 30286	PHYSICIANS OFFICE

Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

PART I, LINE 7G:

SUBSIDIZED HEALTH SERVICES COSTS INCLUDE THOSE ATTRIBUTABLE TO UPSON MEDICAL ASSOCIATES, UPSON WOMEN'S SERVICES, UPSON SURGICAL ASSOCIATES, ORTHOPEDIC SPORTS MEDICINE, AND UPSON FAMILY PHYSICIANS. THESE CLINICS PROMOTE HEALTH CARE FOR UNDESERVED POPULATIONS IN THE AREA.

PART I, LINE 7, COLUMN (F):

THE BAD DEBT EXPENSE INCLUDED ON FORM 990, PART IX, LINE 25(A), BUT SUBTRACTED FOR PURPOSES OF CALCULATING THE PERCENTAGE IN THIS COLUMN IS $ 21,814,299.

PART II, COMMUNITY BUILDING ACTIVITIES:

HEALTH PROFESSIONALS RECRUITMENT AND STAFF MEMBER APPOINTED BY CITY MAYOR TO REPRESENT THOMASTON AND HEALTHCARE WORKFORCE NEEDS ON THE THREE RIVERS WORKFORCE INVESTMENT BOARD FOR REGION 4.

PART III, LINE 2:

THE BAD DEBT EXPENSE AMOUNT ABOVE REPRESENT THE AMOUNT OF CHARGES

Part VI **Supplemental Information** *(Continuation)*

CONSIDERED UNCOLLECTIBLE AFTER REASONABLE ATTEMPTS TO COLLECT, AND WRITTEN OFF TO BAD DEBT EXPENSE.

PART III, LINE 3:

BAD DEBT EXPENSE ATTRIBUTABLE TO THE PATIENTS ELIGIBLE UNDER THE ORGANIZATIONS FINANCIAL POLICY CANNOT BE REASONABLE ESTIMATED.

PART III, LINE 4:

ACCOUNTS RECEIVABLE ARE REDUCED BY AN ALLOWANCE FOR ESTIMATED UNCOLLECTIBLE 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 ESTIMATED UNCOLLECTIBLE 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 ESTIMATED UNCOLLECTIBLE 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 ESTIMATED UNCOLLECTIBLE ACCOUNTS AND A PROVISION FOR BAD DEBTS, IF NECESSARY (FOR EXAMPLE, FOR EXPECTED UNCOLLECTIBLE DEDUCTIBLES AND COPAYMENTS ON ACCOUNTS FOR WHICH THE THIRD-PARTY 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

Part VI **Supplemental Information** *(Continuation)*

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 ESTIMATED UNCOLLECTIBLE ACCOUNTS. THE HOSPITAL'S ALLOWANCE FOR DOUBTFUL ACCOUNTS FOR SELF-PAY PATIENTS WAS APPROXIMATELY 88% AND 91% FOR 2017 AND 2016, RESPECTIVELY. IN ADDITION, THE HOSPITAL'S SELF-PAY WRITE-OFFS INCREASED APPROXIMATELY $1,983,000 FROM $19,832,000 FOR FISCAL YEAR 2016 TO $21,815,000 FOR FISCAL YEAR 2017. DURING FY 2017 AND 2016, SELF-PAY WRITE-OFFS INCREASED DUE TO AN INCREASE IN SELF PAY APPORTIONED PIECE OF COMMERCIAL PAYOR RECEIVABLES.

PART III, LINE 8:

MEDICARE COSTS REFLECT ALLOWABLE COSTS PER THE MEDICARE COST REPORT USING ACCEPTABLE ALLOCATIONS OF INDIRECT COSTS BASED ON STATISTICAL BASIS.

PART III, LINE 9B:

ACCOUNTS KNOWN TO HAVE QUALIFIED FOR FINANCIAL ASSISTANCE ARE WRITTEN OFF WITH AN ADJUSTMENT INDICATING INDIGENT WRITEOFF.

PART V, SECTION B, LINES 7 AND 10

WEBSITE LINKS OF COMMUNITY HEALTH NEEDS ASSESSMENTS AND IMPLEMENTATION STRATEGY

2013

HTTP://WWW.URMC.ORG/UPLOADS/CONTENT_PAGE/PDF/122/2013CHNA.PDF

2015

HTTP://WWW.URMC.ORG/UPLOADS/CONTENT_PAGE/PDF/121/UPDATED_UPSON_CHNA_FINA

Part VI **Supplemental Information** *(Continuation)*

L_REPORT.PDF

2018

HTTP://WWW.URMC.ORG/UPLOADS/CONTENT_PAGE/PDF/125/CHNA_REPORT_UPSON_REGIO

NAL_MEDICAL_CENTER_2018_V2.PDF

PART VI, LINE 2:

UPSON COMPLETES A TRIENNIAL NEEDS ASSESSMENT. INFORMATION GATHERED FROM STAKEHOLDER INTERVIEWS, COMMUNITY-WIDE SURVEYS, DISCUSSIONS WITH THE HOSPITAL LEADERSHIP TEAM, REVIEW OF DEMOGRAPHIC AND HEALTH STATUS, AND HOSPITAL UTILIZATION DATA IS USED TO DETERMINE THE PRIORITY HEALTH NEEDS OF THE POPULATION. HEALTH PRIORITIES WERE FURTHER DEVELOPED BY THE CHNA HOSPITAL STEERING COMMITTEE (CHSC) AFTER CAREFUL REVIEW OF COMMUNITY RESOURCES AVAILABLE FOR THESE PRIORITIES AND THE FUTURE VALUE OF THE PRIORITY. THE FOLLOWING PRIORITIES WERE IDENTIFIED BY THE CHSC:

1. ACCESS TO CARE
2. OBESITY
3. HEART DISEASE AND STROKE
4. DIABETES
5. TEEN PREGNANCY
6. MENTAL HEALTH
7. DRUG ABUSE

PART VI, LINE 3:

UPSON REGIONAL MEDICAL CENTER INFORMS AND EDUCATES THE PATIENTS USING THE FOLLOWING PROCESSES: THE FINANCIAL ASSISTANCE POLICY AND FINANCIAL ASSISTANCE CONTACT INFORMATION IS POSTED IN THE ADMISSION AREAS, EMERGENCY

Part VI **Supplemental Information** *(Continuation)*

DEPARTMENTS AND OTHER AREAS OF THE FACILITY IN WHICH ELIGIBLE PATIENTS ARE PRESENT. WE PROVIDE A COPY OF THE POLICY AND FINANCIAL ASSISTANCE CONTACT INFORMATION TO THE PATIENTS AS PART OF THE ADMISSION PROCESS. ADDITIONALLY, THE POLICY IS AVAILABLE ON THE HOSPITAL WEBSITE - WITH PRINTABLE APPLICATION.

A SUMMARY OF THE POLICY IS ALSO INCLUDED IN THE PATIENT BILLING. WE DISCUSS WITH THE PATIENT THE AVAILABILITY OF VARIOUS GOVERNMENT BENEFITS, SUCH AS QUALIFYING FOR MEDICAID OR STATE PROGRAMS AND ASSIST THE PATIENT WITH QUALIFICATION FOR SUCH PROGRAMS, WHERE APPLICABLE. WE PROVIDE TRAINING TO THE STAFF ON FINANCIAL ASSISTANCE AND CONTRACT WITH CHAMBERLON & EDMONDS ON SCREENING OUR PATIENTS FOR MEDICAID AND/OR OTHER SOURCES OF ASSISTANCE. WE ALSO PROVIDE INFORMATION ON THE ADMISSIONS PACKAGE EXPLAINING THE AVAILABILITY, CRITERIA, AND THE PROCESS FOR APPLYING FOR FINANCIAL ASSISTANCE.

OUR EFFORTS TO INFORM NON-ENGLISH SPEAKING PATIENTS ABOUT THE FINANCIAL ASSISTANCE POLICY IS PROVIDED BY AN INTERPRETER THROUGH THE USE OF LANGUAGE LINE, A TELEPHONE INTERPRETATION SERVICE.

PART VI, LINE 4:

UPSON COUNTY IS LOCATED IN WEST CENTRAL GEORGIA AND HAS A POPULATION OF 26,740 AS OF 2017. IN 2014, THE POPULATION ESTIMATE WAS 26,256. THE POPULATION OF UPSON COUNTY IS EXPECTED TO DECREASE -.32% FROM 2017 TO 2022. THE RACIAL AND ETHNIC MAKE-UP OF UPSON COUNTY IS 68% WHITE, 28% BLACK, 1 % MIXED RACE, 2% OTHER, AND 2% HISPANIC ORIGIN. THE PERCENTAGE OF RESIDENTS AGED 55 AND OLDER IS SET TO INCREASE .6% BY 2022 ; THIS IDENTIFIED AN INCREASED NEED FOR DELIVERY OF HEALTHCARE THAT SERVES

Part VI **Supplemental Information** *(Continuation)*

INDIVIDUALS WITH CHRONIC CONDITIONS. UPSON REGIONAL MEDICAL CENTER, A REGIONAL HEALTH CARE PROVIDER WITH 115 ACUTE-CARE BEDS, SERVES THIS AREA OF GEORGIA. THE HOSPITAL IS LOCATED IN THE COUNTY SEAT OF THOMASTON.

PART VI, LINE 5:

SINCE 2015, UPSON HAS RECRUITED FAMILY PHYSICIANS, A CARDIOLOGIST, UROLOGIST, OBSTETRICIAN, AUDIOLOGIST, ENT, AND ADVANCED PRACTICE PROFESSIONALS. UPSON'S AWARD-WINNING DIETICIANS IMPLEMENT THE QUARTERLY SODEXO COMMUNITY EDUCATION PROGRAMMING AND ACTIVELY PARTICIPATE IN AT COMMUNITY EVENTS, HEALTH FAIRS, AND IN THE WELLNESS CENTER TO INCREASE AWARENESS OF GOOD EATING HABITS AND THEIR IMPACTS ON HEALTH. UPSON ALSO PROVIDES MONTHLY DIABETES EDUCATION ON DISEASE MANAGEMENT AND NUTRITION. IN 2017, UPSON WAS DESIGNATED AS A REMOTE STROKE TREATMENT CENTER, PROVIDING TIMELY CONSULTS WITH NEUROLOGISTS . UPSON CONSISTENTLY OFFERS BLOOD PRESSURE CHECKS AND EDUCATION AT COMMUNITY EVENTS AND HEALTH FAIRS. IN 2017, UPSON OPENED SILVERCARE, AN 18-BED INPATIENT GERIATRIC BEHAVIORAL HEALTH UNIT.

PART VI, LINE 7, LIST OF STATES RECEIVING COMMUNITY BENEFIT REPORT:

GA

SCHEDULE I (Form 990)

Department of the Treasury
Internal Revenue Service

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

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

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2017

Open to Public Inspection

Name of the organization
UPSON COUNTY HOSPITAL INC

Employer identification number
58-1734026

Part I **General Information on Grants and Assistance**

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

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

Part II **Grants and Other Assistance to Domestic Organizations and Domestic Governments.** Complete if the organization answered "Yes" on Form 990, Part IV, line 21, for any recipient that received more than $5,000. Part II can be duplicated if additional space is needed.

1 (a) Name and address of organization or government	(b) EIN	(c) IRC section (if applicable)	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of noncash assistance	(h) Purpose of grant or assistance
WARM SPRINGS MEDICAL CENTER 5995 SPRING STREET WARM SPRINGS, GA 31830			60,500.	0.			OPERATIONAL SUPPORT

2 Enter total number of section 501(c)(3) and government organizations listed in the line 1 table ..... ▶ 0.

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

Part III **Grants and Other Assistance to Domestic Individuals.** Complete if the organization answered "Yes" on Form 990, Part IV, line 22. Part III can be duplicated if additional space is needed.

(a) Type of grant or assistance	(b) Number of recipients	(c) Amount of cash grant	(d) Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of noncash assistance
EDUCATION SCHOLARSHIP / LOAN ASSISTANCE	7	27,191.	0.		
TUITION REIMBURSEMENT	12	31,190.	0.		

Part IV **Supplemental Information.** Provide the information required in Part I, line 2; Part III, column (b); and any other additional information.

PART I, LINE 2:

SCHOLARSHIP ASSISTANCE IS OFFERED TO UPSON COUNTY RESIDENTS AND FULL TIME, PART TIME AND PRN EMPLOYEES PURSUING A HEALTHCARE CAREER. EACH APPLICANT MUST COMPLETE AN APPLICATION, BE ACCEPTED BY AN ACCREDITED SCHOOL IN A HEALTHCARE PROGRAM OF THEIR CHOICE, SUBMIT TWO LETTERS OF RECOMMENDATION, A CERTIFIED COPY OF PREVIOUS EDUCATIONAL TRANSCRIPTS, AND A LETTER OF ACCEPTANCE IN THE HEALTHCARE CAREER PROGRAM, OBTAIN APPROVAL FROM THE DEPARTMENT DIRECTOR OR SENIOR MANAGEMENT, BE INTERVIEWED BY CHIEF NURSING OFFICER, MAINTAIN A 3.0 CUMULATIVE AVERAGE, SUBMIT TRANSCRIPTS OF GRADES

Part IV Supplemental Information

EVERY SCHOOL TERM, AND SERVE AS AN EMPLOYEE A MINIMUM OF ONE YEAR FROM EACH SCHOOL YEAR FOR WHICH SCHOLARSHIP MONIES ARE GRANTED. TRANSCRIPTS OF GRADES MUST BE RECEIVED BEFORE REIMBURSEMENT. SHOULD THE STUDENT NOT SEEK AND MAINTAIN EMPLOYMENT WITH URMC AFTER GRADUATION, FUNDS WILL BECOME DUE AND PAYABLE IN A PRORATE FASHION BASED ON EMPLOYMENT TERM. TUITION REIMBURSEMENT IS AWARDED FULL TIME AND REGULARLY SCHEDULED PART TIME EMPLOYEES. MONIES ARE GRANTED TO COVER TUITION, BOOKS AND LABORATORY FEE. EACH APPLICANT MUST BE ENROLLED IN AN ACCREDITED COLLEGE/UNIVERSITY WITHIN A PROGRAM DIRECTLY RELATED TO THE EMPLOYEE'S PRESENT POSITION OR A FIELD THAT WILL BE OF BENEFIT TO THE MEDICAL CENTER, SEEK APPROVAL FROM MANAGEMENT, FURNISH A TRANSCRIPT OF GRADES, MAINTAIN A "C" OR HIGHER AVERAGE TO BE REIMBURSED, AN EMPLOYEE MUST PRESENT A CERTIFIED COPY OF THE GRADE REPORT WITH AN AVERAGE OF "C" OR HIGHER.

SCHEDULE J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 23.**

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2017

Open to Public Inspection

Name of the organization

UPSON COUNTY HOSPITAL INC

Employer identification number

58-1734026

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
	☐ First-class or charter travel	☒ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax indemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (such as, maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	**1b**	X	
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked on line 1a?	**2**		X
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.			
	☐ Compensation committee	☐ Written employment contract		
	☐ Independent compensation consultant	☒ Compensation survey or study		
	☐ Form 990 of other organizations	☒ Approval by the board or compensation committee		
4	During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment?	**4a**		X
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**		X
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.			
5	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a	The organization?	**5a**		X
b	Any related organization?	**5b**		X
	If "Yes" on line 5a or 5b, describe in Part III.			
6	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a	The organization?	**6a**		X
b	Any related organization?	**6b**		X
	If "Yes" on line 6a or 6b, describe in Part III.			
7	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described on lines 5 and 6? If "Yes," describe in Part III	**7**		X
8	Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	**8**		X
9	If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	**9**		

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

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1) [redacted]	(i)	276,582.	0.	8,320.	5,300.	32,835.	323,037.	0.
CEO	(ii)	0.	0.	0.	0.	0.	0.	0.
(2)	(i)	224,786.	0.	0.	3,698.	9,971.	238,455.	0.
CFO	(ii)	0.	0.	0.	0.	0.	0.	0.
(3)	(i)	643,655.	397,348.	42,750.	5,300.	31,572.	1,120,625.	0.
ORTHOPEDIC SURGEON	(ii)	0.	0.	0.	0.	0.	0.	0.
(4)	(i)	489,904.	26,685.	33,600.	5,300.	30,951.	586,440.	0.
UROLOGY SURGEON	(ii)	0.	0.	0.	0.	0.	0.	0.
(5)	(i)	420,281.	133,942.	2,948.	2,227.	19,135.	578,533.	0.
ENT SURGEON	(ii)	0.	0.	0.	0.	0.	0.	0.
(6)	(i)	328,967.	183,239.	20,000.	5,300.	31,572.	569,078.	0.
SURGEON	(ii)	0.	0.	0.	0.	0.	0.	0.
(7)	(i)	318,224.	96,048.	0.	5,300.	29,046.	448,618.	0.
SURGEON	(ii)	0.	0.	0.	0.	0.	0.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
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	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

Part III Supplemental Information

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

PART I, LINE 1A:

THE INTERIM CHIEF NURSING OFFICER WAS PROVIDED TEMPORARY HOUSING AS PART OF THEIR CONTRACT TERMS OF EMPLOYMENT.

PART III

PHYSICIAN BONUSES ARE PAID BASED ON RELATIVE VALUE UNITS (RVUS) ACHIEVED DURING A SPECIFIED TIME PERIOD EACH PHYSICIAN'S EMPLOYMENT CONTRACT INCLUDES A RVU GOAL. THE PHYSICIAN IS PAID BONUSES BASED ON MEETING OR EXCEEDING THE GOAL AS DETERMINED BY THEIR CONTRACT.

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

Supplemental Information on Tax-Exempt Bonds

▶ Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.
▶ Attach to Form 990. ▶ Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047
2017
Open to Public Inspection

Name of the organization: UPSON COUNTY HOSPITAL INC

Employer identification number: 58-1734026

Part I Bond Issues SEE PART VI FOR COLUMN (F) CONTINUATIONS

	(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased Yes	(g) Defeased No	(h) On behalf of issuer Yes	(h) On behalf of issuer No	(i) Pooled financing Yes	(i) Pooled financing No
A	HOSPITAL AUTHORITY OF UPSON COUNTY	58-6002427	NONE	12/31/04	10000000.	RENOVATION & EXPANSION OF HOSP		X		X		X
B	HOSPITAL AUTHORITY OF UPSON COUNTY	58-6002427	NONE	01/20/05	6,000,000.	RENOVATION & EXPANSION OF HOSP		X		X		X
C												
D												

Part II Proceeds

		A	B	C	D
1	Amount of bonds retired	5,565,000.	3,335,000.		
2	Amount of bonds legally defeased				
3	Total proceeds of issue	10,000,000.	6,000,000.		
4	Gross proceeds in reserve funds				
5	Capitalized interest from proceeds				
6	Proceeds in refunding escrows				
7	Issuance costs from proceeds	124,175.	79,846.		
8	Credit enhancement from proceeds				
9	Working capital expenditures from proceeds				
10	Capital expenditures from proceeds	9,875,825.	5,920,154.		
11	Other spent proceeds				
12	Other unspent proceeds				
13	Year of substantial completion	2007	2007		

		A Yes	A No	B Yes	B No	C Yes	C No	D Yes	D No
14	Were the bonds issued as part of a current refunding issue?		X		X				
15	Were the bonds issued as part of an advance refunding issue?		X		X				
16	Has the final allocation of proceeds been made?	X		X					
17	Does the organization maintain adequate books and records to support the final allocation of proceeds?	X		X					

Part III Private Business Use

		A Yes	A No	B Yes	B No	C Yes	C No	D Yes	D No
1	Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds?		X		X				
2	Are there any lease arrangements that may result in private business use of bond-financed property?		X		X				

Part III Private Business Use *(Continued)*

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
3a Are there any management or service contracts that may result in private business use of bond-financed property?		X		X				
b If "Yes" to line 3a, does the organization routinely engage bond counsel or other outside counsel to review any management or service contracts relating to the financed property?								
c Are there any research agreements that may result in private business use of bond-financed property?		X		X				
d If "Yes" to line 3c, does the organization routinely engage bond counsel or other outside counsel to review any research agreements relating to the financed property?								
4 Enter the percentage of financed property used in a private business use by entities other than a section 501(c)(3) organization or a state or local government ▶	.00 %		.00 %		%		%	
5 Enter the percentage of financed property used in a private business use as a result of unrelated trade or business activity carried on by your organization, another section 501(c)(3) organization, or a state or local government ▶	.00 %		.00 %		%		%	
6 Total of lines 4 and 5	.00 %		.00 %		%		%	
7 Does the bond issue meet the private security or payment test?		X		X				
8a Has there been a sale or disposition of any of the bond-financed property to a non-governmental person other than a 501(c)(3) organization since the bonds were issued?		X		X				
b If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of	%		%		%		%	
c If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2?								
9 Has the organization established written procedures to ensure that all nonqualified bonds of the issue are remediated in accordance with the requirements under Regulations sections 1.141-12 and 1.145-2?	X		X					

Part IV Arbitrage

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
1 Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate?		X		X				
2 If "No" to line 1, did the following apply?								
a Rebate not due yet?		X		X				
b Exception to rebate?		X		X				
c No rebate due?	X		X					
If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed								
3 Is the bond issue a variable rate issue?		X		X				
4a Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue?		X		X				
b Name of provider								
c Term of hedge								
d Was the hedge superintegrated?								
e Was the hedge terminated?								

Part IV Arbitrage *(Continued)*

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
5a Were gross proceeds invested in a guaranteed investment contract (GIC)?		X		X				
b Name of provider								
c Term of GIC								
d Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
6 Were any gross proceeds invested beyond an available temporary period?		X		X				
7 Has the organization established written procedures to monitor the requirements of section 148?		X		X				

Part V Procedures To Undertake Corrective Action

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
Has the organization established written procedures to ensure that violations of federal tax requirements are timely identified and corrected through the voluntary closing agreement program if self-remediation isn't available under applicable regulations?		X		X				

Part VI Supplemental Information. Provide additional information for responses to questions on Schedule K. See instructions

SCHEDULE K, PART I, BOND ISSUES:
(A) ISSUER NAME: HOSPITAL AUTHORITY OF UPSON COUNTY
(F) DESCRIPTION OF PURPOSE: RENOVATION & EXPANSION OF HOSPITAL

(A) ISSUER NAME: HOSPITAL AUTHORITY OF UPSON COUNTY
(F) DESCRIPTION OF PURPOSE: RENOVATION & EXPANSION OF HOSPITAL

SCHEDULE K, PART IV, ARBITRAGE, LINE 2C:
(A) ISSUER NAME: HOSPITAL AUTHORITY OF UPSON COUNTY
DATE THE REBATE COMPUTATION WAS PERFORMED: 12/30/2009

(A) ISSUER NAME: HOSPITAL AUTHORITY OF UPSON COUNTY
DATE THE REBATE COMPUTATION WAS PERFORMED: 01/20/2010

SCHEDULE L (Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Transactions With Interested Persons

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

OMB No. 1545-0047

2017

Open To Public Inspection

Name of the organization
UPSON COUNTY HOSPITAL INC

Employer identification number
58-1734026

Part I Excess Benefit Transactions (section 501(c)(3), section 501(c)(4), and 501(c)(29) organizations only).

Complete if the organization answered "Yes" on Form 990, Part IV, line 25a or 25b, or Form 990-EZ, Part V, line 40b.

1 (a) Name of disqualified person	(b) Relationship between disqualified person and organization	(c) Description of transaction	(d) Corrected? Yes	(d) Corrected? No

2 Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 ▶ $

3 Enter the amount of tax, if any, on line 2, above, reimbursed by the organization ▶ $

Part II Loans to and/or From Interested Persons.

Complete if the organization answered "Yes" on Form 990-EZ, Part V, line 38a or Form 990, Part IV, line 26; or if the organization reported an amount on Form 990, Part X, line 5, 6, or 22.

(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the organization? To	(d) From	(e) Original principal amount	(f) Balance due	(g) In default? Yes	(g) No	(h) Approved by board or committee? Yes	(h) No	(i) Written agreement? Yes	(i) No
Total ▶ $												

Part III Grants or Assistance Benefiting Interested Persons.

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

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

Part IV Business Transactions Involving Interested Persons.

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

(a) Name of interested person	(b) Relationship between interested person and the organization	(c) Amount of transaction	(d) Description of transaction	(e) Sharing of organization's revenues?	
				Yes	No
STEPHANIE DAVIS	FAMILY MEMBER OF A	28,994.	COMPENSATED		X

Part V Supplemental Information

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

SCH L, PART IV, BUSINESS TRANSACTIONS INVOLVING INTERESTED PERSONS:

(A) NAME OF PERSON: STEPHANIE DAVIS

(B) RELATIONSHIP BETWEEN INTERESTED PERSON AND ORGANIZATION:

FAMILY MEMBER OF A BOARD MEMBER

(D) DESCRIPTION OF TRANSACTION: COMPENSATED AS EMPLOYEE

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

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

OMB No. 1545-0047

2017

Open to Public Inspection

Name of the organization
UPSON COUNTY HOSPITAL INC

Employer identification number
58-1734026

FORM 990, PART I, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

SURROUNDING AREA, REGARDLESS OF THE ABILITY TO PAY.

FORM 990, PART VI, SECTION B, LINE 11B:

EACH BOARD OF TRUSTEE WAS INFORMED VIA EMAIL THAT THE FORM 990 WAS AVAILABLE ON A BOARD PORTAL. EACH BOARD MEMBER WAS GIVEN TIME TO REVIEW THE FORM 990 PRIOR TO THE IRS FILING. FORM 990 REVIEW WAS PLACED ON THE BOARD AGENDA FOR DISCUSSIONS SHOULD ANY QUESTIONS OCCUR. THE 990 IS REVIEWED BY THE CFO IN DETAIL PRIOR TO FILING WITH THE IRS.

FORM 990, PART VI, SECTION B, LINE 12C:

THE POLICY COVERS ALL DIRECTORS, OFFICERS AND KEY EMPLOYEES OF THE ORGANIZATION. SHOULD A MATTER COME BEFORE THE BOARD OF DIRECTORS WHICH CONSTITUTES A CONFLICT OF INTEREST, THE INDIVIDUAL INVOLVED WILL MAKE KNOWN THE POTENTIAL CONFLICT AND WITHDRAW FROM THE MEETING SO LONG AS THE MATTER SHALL CONTINUE UNDER DISCUSSION AND SHALL NOT EITHER VOTE ON THE MATTER UNDER DISCUSSION OR ATTEMPT TO INFLUENCE A DECISION OF THE GOVERNING AUTHORITY WITH RESPECT TO SUCH MATTERS, UPON WHICH THERE COULD POSSIBLY BE A CONFLICT OF INTEREST.

FORM 990, PART VI, SECTION B, LINE 15:

IN DETERMINING COMPENSATION FOR TOP OFFICIALS, HUMAN RESOURCES OBTAINS THE COMPARABLE SALARY SURVEY AND PRESENTS IT TO THE BOARD OF DIRECTORS WHO MAKE A FINAL DECISION. THE CEO IS NOT PRESENT DURING THE DISCUSSION AND DECISION-MAKING PROCESS. DELIBERATIONS AND DECISIONS ARE DOCUMENTED IN THE MINUTES OF THE MEETING.

Name of the organization: UPSON COUNTY HOSPITAL INC

Employer identification number: 58-1734026

IN DETERMINING COMPENSATION FOR THE CFO, OTHER OFFICERS OR KEY EMPLOYEES, THE ORGANIZATION'S HUMAN RESOURCES DEPARTMENT OBTAINS COMPARABLE SALARY DATA AND PRESENTS IT TO THE GOVERNING BODY WHO MAKES THE FINAL DECISION. THE INDIVIDUAL IN THE CONSIDERATION PROCESS IS NOT PRESENT DURING THE DISCUSSION AND DECISION-MAKING PROCESS. DELIBERATIONS AND DECISIONS ARE DOCUMENTED IN THE MINUTES OF THE MEETING. ANNUAL MERIT ADJUSTMENT: SALARY ADJUSTMENT IS DETERMINED BY ORGANIZATIONAL PERFORMANCE AS REFLECTED IN THE SCORE OF THE ESTABLISHED PERFORMANCE MEASUREMENT INSTRUMENT. (LEM/LEADERSHIP EVALUATION MANAGEMENT). PERIODIC MARKET ADJUSTMENT: SALARY OF EACH OFFICER IS REVIEWED PERIODICALLY BY HUMAN RESOURCES AND APPROPRIATE OFFICER AND COMPARED TO SALARIES OF COMPARABLE ORGANIZATIONS TO ENSURE THAT THE CURRENT RATE IS COMPETITIVE.

FORM 990, PART VI, SECTION C, LINE 18:

THE FORM 900 AND 990T IS MADE AVAILABLE UPON REQUEST.

FORM 990, PART VI, SECTION C, LINE 19:

THE GOVERNING DOCUMENTS, CONFLICT OF INTEREST POLICY, AND FINANCIAL STATEMENTS ARE AVAILABLE FOR INSPECTION, WITH NOTICE, IN THE OFFICE OF THE ORGANIZATION.

FORM 990, PART IX, LINE 11G, OTHER FEES:

CONTRACT LABOR:

PROGRAM SERVICE EXPENSES	1,715,319.
MANAGEMENT AND GENERAL EXPENSES	1,310,371.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	3,025,690.

Name of the organization: UPSON COUNTY HOSPITAL INC

Employer identification number: 58-1734026

OTHER FEES:

PROGRAM SERVICE EXPENSES	2,330,679.
MANAGEMENT AND GENERAL EXPENSES	3,123,228.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	5,453,907.

PHYSICIAN FEES:

PROGRAM SERVICE EXPENSES	2,429,908.
MANAGEMENT AND GENERAL EXPENSES	0.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	2,429,908.

CONSULTING FEES:

PROGRAM SERVICE EXPENSES	1,377.
MANAGEMENT AND GENERAL EXPENSES	796,216.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	797,593.

COLLECTIONS AND BILLING:

PROGRAM SERVICE EXPENSES	0.
MANAGEMENT AND GENERAL EXPENSES	435,559.
FUNDRAISING EXPENSES	0.
TOTAL EXPENSES	435,559.
TOTAL OTHER FEES ON FORM 990, PART IX, LINE 11G, COL A	12,142,657.

FORM 990, PART XII, LINE 2C:

THIS PROCESS HAS NOT CHANGED FROM PRIOR YEAR.

Name of the organization
UPSON COUNTY HOSPITAL INC

Employer identification number
58-1734026

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

▶ Attach to Form 990.

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

OMB No. 1545-0047

2017

Open to Public Inspection

Name of the organization

UPSON COUNTY HOSPITAL INC

Employer identification number

58-1734026

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

(a) Name, address, and EIN (if applicable) of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
UPSON MEDICAL ASSOCIATES LLC - 55-0840991 801 WEST GORDON STREET THOMASTON, GA 30286	PHYS OFC	GEORGIA	-271,106.	199,356.	UPSON COUNTY HOSPITAL INC
UPSON REGIONAL WELLNESS CENTER LLC - 20-5095610, 801 WEST GORDON STREET, THOMASTON, GA 30286	WELLNESS CENTER	GEORGIA	-29,727.	200,630.	UPSON COUNTY HOSPITAL INC
UPSON WOMEN'S SERVICES LLC - 26-3227893 801 WEST GORDON STREET THOMASTON, GA 30286	PHYS OFC	GEORGIA	-803,348.	618,528.	UPSON COUNTY HOSPITAL INC
UPSON FAMILY PHYSICIANS LLC - 27-0192553 801 WEST GORDON STREET THOMASTON, GA 30286	PHYS OFC	GEORGIA	-776,975.	319,287.	UPSON COUNTY HOSPITAL INC

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) No
URMC HEALTH FOUNDATION - 83-0411781 PO BOX 1089 THOMASTON, GA 30286	FOUNDATION	GEORGIA	501(C)(3)	LINE 12A, I	UCH - UPSON COUNTY HOSPITAL INC	X	
HOSPITAL AUTHORITY OF UPSON COUNTY 801 WEST GEORGIA GORDON STREET THOMASTON, GA 30286-0027	MANAGEMENT	GEORGIA	GOVT		N/A		X

For Paperwork Reduction Act Notice, see the Instructions for Form 990. **Schedule R (Form 990) 2017**

732161 09-11-17 LHA

Part I **Continuation of Identification of Disregarded Entities**

(a) Name, address, and EIN of disregarded entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Total income	(e) End-of-year assets	(f) Direct controlling entity
UPSON SURGICAL ASSOCIATES LLC - 27-5252545 801 WEST GORDON STREET THOMASTON, GA 30286	PHYS OFC	GEORGIA	-2,062,798.	1,181,010.	UPSON COUNTY HOSPITAL INC
OTHOPEDICS SPORTS MEDICINE & SURGERY - 27-2123255, 801 WEST GORDON STREET, THOMASTON, GA 30286	PHYS OFC	GEORGIA	-855,626.	348,008.	UPSON COUNTY HOSPITAL INC
URMC MEDICAL OFFICE BUILDING LLC - 47-4279645, 801 WEST GORDON STREET, THOMASTON, GA 30286	MEDICAL OFFICE BUILDINGS	GEORGIA	-160,693.	4,910,440.	UPSON COUNTY HOSPITAL INC

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

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

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

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

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

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

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

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

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

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

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

Part VII Supplemental Information.

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

Form **990-T**

Exempt Organization Business Income Tax Return
(and proxy tax under section 6033(e))

For calendar year 2017 or other tax year beginning _____, and ending _____.

▶ **Go to www.irs.gov/Form990T for instructions and the latest information.**

▶ **Do not enter SSN numbers on this form as it may be made public if your organization is a 501(c)(3).**

OMB No. 1545-0687

2017

Open to Public Inspection for 501(c)(3) Organizations Only

Department of the Treasury
Internal Revenue Service

A ☐ Check box if address changed

B Exempt under section
☒ 501(c)(3)
☐ 408(e) ☐ 220(e)
☐ 408A ☐ 530(a)
☐ 529(a)

C Book value of all assets at end of year 185,781,308.

Print or Type

Name of organization (☐ Check box if name changed and see instructions.)
UPSON COUNTY HOSPITAL INC

D Employer identification number (Employees' trust, see instructions.)
58-1734026

Number, street, and room or suite no. If a P.O. box, see instructions.
801 WEST GORDON STREET

E Unrelated business activity codes (See instructions.)

City or town, state or province, country, and ZIP or foreign postal code
THOMASTON, GA 30286-0027

900099

F Group exemption number (See instructions.) ▶

G Check organization type ▶ ☒ 501(c) corporation ☐ 501(c) trust ☐ 401(a) trust ☐ Other trust

H Describe the organization's primary unrelated business activity. ▶ SEE STATEMENT 1

I During the tax year, was the corporation a subsidiary in an affiliated group or a parent-subsidiary controlled group? ▶ ☐ Yes ☒ No

If "Yes," enter the name and identifying number of the parent corporation. ▶

J The books are in care of ▶ JOHN WILLIAMS CFO Telephone number ▶ 706-647-8111

Part I Unrelated Trade or Business Income

			(A) Income	(B) Expenses	(C) Net
1a	Gross receipts or sales 569,527. b Less returns and allowances c Balance ▶	1c	569,527.		
2	Cost of goods sold (Schedule A, line 7)	2			
3	Gross profit. Subtract line 2 from line 1c	3	569,527.		569,527.
4a	Capital gain net income (attach Schedule D)	4a			
b	Net gain (loss) (Form 4797, Part II, line 17) (attach Form 4797)	4b			
c	Capital loss deduction for trusts	4c			
5	Income (loss) from partnerships and S corporations (attach statement)	5			
6	Rent income (Schedule C)	6			
7	Unrelated debt-financed income (Schedule E)	7			
8	Interest, annuities, royalties, and rents from controlled organizations (Sch. F)	8			
9	Investment income of a section 501(c)(7), (9), or (17) organization (Schedule G)	9			
10	Exploited exempt activity income (Schedule I)	10			
11	Advertising income (Schedule J)	11			
12	Other income (See instructions; attach schedule)	12			
13	**Total.** Combine lines 3 through 12	13	569,527.		569,527.

Part II Deductions Not Taken Elsewhere (See instructions for limitations on deductions.)

(Except for contributions, deductions must be directly connected with the unrelated business income.)

14	Compensation of officers, directors, and trustees (Schedule K)			14	
15	Salaries and wages			15	
16	Repairs and maintenance			16	7,380.
17	Bad debts			17	
18	Interest (attach schedule)			18	
19	Taxes and licenses			19	3,123.
20	Charitable contributions (See instructions for limitation rules)			20	
21	Depreciation (attach Form 4562)	21	33,328.		
22	Less depreciation claimed on Schedule A and elsewhere on return	22a		22b	33,328.
23	Depletion			23	
24	Contributions to deferred compensation plans			24	
25	Employee benefit programs			25	
26	Excess exempt expenses (Schedule I)			26	
27	Excess readership costs (Schedule J)			27	
28	Other deductions (attach schedule) SEE STATEMENT 2			28	544,877.
29	**Total deductions.** Add lines 14 through 28			29	588,708.
30	Unrelated business taxable income before net operating loss deduction. Subtract line 29 from line 13			30	-19,181.
31	Net operating loss deduction (limited to the amount on line 30) SEE STATEMENT 3			31	
32	Unrelated business taxable income before specific deduction. Subtract line 31 from line 30			32	-19,181.
33	Specific deduction (Generally $1,000, but see line 33 instructions for exceptions)			33	1,000.
34	**Unrelated business taxable income.** Subtract line 33 from line 32. If line 33 is greater than line 32, enter the smaller of zero or line 32			34	-19,181.

Part III Tax Computation

35	**Organizations Taxable as Corporations.** See instructions for tax computation. Controlled group members (sections 1561 and 1563) check here ▶ [X] **See instructions** and:		
a	Enter your share of the $50,000, $25,000, and $9,925,000 taxable income brackets (in that order): (1) $ (2) $ (3) $		
b	Enter organization's share of: **(1)** Additional 5% tax (not more than $11,750) $ **(2)** Additional 3% tax (not more than $100,000) $		
c	Income tax on the amount on line 34 ▶	35c	0.
36	**Trusts Taxable at Trust Rates.** See instructions for tax computation. Income tax on the amount on line 34 from: [ ] Tax rate schedule or [ ] Schedule D (Form 1041) ▶	36	
37	**Proxy tax.** See instructions ▶	37	
38	Alternative minimum tax	38	
39	**Tax on Non-Compliant Facility Income.** See instructions	39	
40	**Total.** Add lines 37, 38 and 39 to line 35c or 36, whichever applies	40	0.

Part IV Tax and Payments

41a	Foreign tax credit (corporations attach Form 1118; trusts attach Form 1116)	41a			
b	Other credits (see instructions)	41b			
c	General business credit. Attach Form 3800	41c			
d	Credit for prior year minimum tax (attach Form 8801 or 8827)	41d			
e	**Total credits.** Add lines 41a through 41d			41e	
42	Subtract line 41e from line 40			42	0.
43	Other taxes. Check if from: [ ] Form 4255 [ ] Form 8611 [ ] Form 8697 [ ] Form 8866 [ ] Other (attach schedule)			43	
44	**Total tax.** Add lines 42 and 43			44	0.
45 a	Payments: A 2016 overpayment credited to 2017	45a			
b	2017 estimated tax payments	45b			
c	Tax deposited with Form 8868	45c			
d	Foreign organizations: Tax paid or withheld at source (see instructions)	45d			
e	Backup withholding (see instructions)	45e			
f	Credit for small employer health insurance premiums (Attach Form 8941)	45f			
g	Other credits and payments: [ ] Form 2439 [ ] Form 4136 [ ] Other Total ▶	45g			
46	**Total payments.** Add lines 45a through 45g			46	
47	Estimated tax penalty (see instructions). Check if Form 2220 is attached ▶ [ ]			47	
48	**Tax due.** If line 46 is less than the total of lines 44 and 47, enter amount owed ▶			48	0.
49	**Overpayment.** If line 46 is larger than the total of lines 44 and 47, enter amount overpaid ▶			49	0.
50	Enter the amount of line 49 you want: **Credited to 2018 estimated tax** ▶ **Refunded** ▶			50	

Part V Statements Regarding Certain Activities and Other Information (see instructions)

		Yes	No
51	At any time during the 2017 calendar year, did the organization have an interest in or a signature or other authority over a financial account (bank, securities, or other) in a foreign country? If YES, the organization may have to file FinCEN Form 114, Report of Foreign Bank and Financial Accounts. If YES, enter the name of the foreign country here ▶ CAYMAN ISLANDS	X	
52	During the tax year, did the organization receive a distribution from, or was it the grantor of, or transferor to, a foreign trust? If YES, see instructions for other forms the organization may have to file.		X
53	Enter the amount of tax-exempt interest received or accrued during the tax year ▶ $		

Sign Here

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

▶ _____ Signature of officer _____ Date ▶ CFO Title

May the IRS discuss this return with the preparer shown below (see instructions)? [X] Yes [ ] No

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check [ ] if self-employed	PTIN
AMY BIBBY	AMY BIBBY			P00445891

Firm's name ▶ DIXON HUGHES GOODMAN LLP Firm's EIN ▶ 56-0747981

Firm's address ▶ 500 RIDGEFIELD COURT ASHEVILLE, NC 28806 Phone no. (828) 254-2254

Schedule A - Cost of Goods Sold. Enter method of inventory valuation ▶ N/A

1	Inventory at beginning of year	1		6	Inventory at end of year	6	
2	Purchases	2		7	**Cost of goods sold.** Subtract line 6 from line 5. Enter here and in Part I, line 2	7	
3	Cost of labor	3					
4a	Additional section 263A costs (attach schedule)	4a		8	Do the rules of section 263A (with respect to property produced or acquired for resale) apply to the organization?	Yes	No
b	Other costs (attach schedule)	4b					
5	**Total.** Add lines 1 through 4b	5					

Schedule C - Rent Income (From Real Property and Personal Property Leased With Real Property)

(see instructions)

1. Description of property

(1)
(2)
(3)
(4)

	2. Rent received or accrued		3(a) Deductions directly connected with the income in columns 2(a) and 2(b) (attach schedule)
	(a) From personal property (if the percentage of rent for personal property is more than 10% but not more than 50%)	(b) From real and personal property (if the percentage of rent for personal property exceeds 50% or if the rent is based on profit or income)	
(1)			
(2)			
(3)			
(4)			
Total	0.	0.	

(c) Total income. Add totals of columns 2(a) and 2(b). Enter here and on page 1, Part I, line 6, column (A) ▶ 0.

(b) Total deductions. Enter here and on page 1, Part I, line 6, column (B) ▶ 0.

Schedule E - Unrelated Debt-Financed Income (see instructions)

1. Description of debt-financed property	2. Gross income from or allocable to debt-financed property	3. Deductions directly connected with or allocable to debt-financed property	
		(a) Straight line depreciation (attach schedule)	(b) Other deductions (attach schedule)
(1)			
(2)			
(3)			
(4)			

	4. Amount of average acquisition debt on or allocable to debt-financed property (attach schedule)	5. Average adjusted basis of or allocable to debt-financed property (attach schedule)	6. Column 4 divided by column 5	7. Gross income reportable (column 2 x column 6)	8. Allocable deductions (column 6 x total of columns 3(a) and 3(b))
(1)			%		
(2)			%		
(3)			%		
(4)			%		
				Enter here and on page 1, Part I, line 7, column (A).	Enter here and on page 1, Part I, line 7, column (B).
Totals ▶				0.	0.
Total dividends-received deductions included in column 8 ▶					0.

Schedule F - Interest, Annuities, Royalties, and Rents From Controlled Organizations (see instructions)

1. Name of controlled organization	2. Employer identification number	Exempt Controlled Organizations: 3. Net unrelated income (loss) (see instructions)	4. Total of specified payments made	5. Part of column 4 that is included in the controlling organization's gross income	6. Deductions directly connected with income in column 5
(1)					
(2)					
(3)					
(4)					

Nonexempt Controlled Organizations

7. Taxable Income	8. Net unrelated income (loss) (see instructions)	9. Total of specified payments made	10. Part of column 9 that is included in the controlling organization's gross income	11. Deductions directly connected with income in column 10
(1)				
(2)				
(3)				
(4)				
			Add columns 5 and 10. Enter here and on page 1, Part I, line 8, column (A).	Add columns 6 and 11. Enter here and on page 1, Part I, line 8, column (B).
Totals ▶			0.	0.

Schedule G - Investment Income of a Section 501(c)(7), (9), or (17) Organization

(see instructions)

1. Description of income	2. Amount of income	3. Deductions directly connected (attach schedule)	4. Set-asides (attach schedule)	5. Total deductions and set-asides (col. 3 plus col. 4)
(1)				
(2)				
(3)				
(4)				
	Enter here and on page 1, Part I, line 9, column (A).			Enter here and on page 1, Part I, line 9, column (B).
Totals ▶	0.			0.

Schedule I - Exploited Exempt Activity Income, Other Than Advertising Income

(see instructions)

1. Description of exploited activity	2. Gross unrelated business income from trade or business	3. Expenses directly connected with production of unrelated business income	4. Net income (loss) from unrelated trade or business (column 2 minus column 3). If a gain, compute cols. 5 through 7.	5. Gross income from activity that is not unrelated business income	6. Expenses attributable to column 5	7. Excess exempt expenses (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
	Enter here and on page 1, Part I, line 10, col. (A).	Enter here and on page 1, Part I, line 10, col. (B).				Enter here and on page 1, Part II, line 26.
Totals ▶	0.	0.				0.

Schedule J - Advertising Income (see instructions)

Part I Income From Periodicals Reported on a Consolidated Basis

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals (carry to Part II, line (5)) ▶	0.	0.				0.

Part II **Income From Periodicals Reported on a Separate Basis** (For each periodical listed in Part II, fill in columns 2 through 7 on a line-by-line basis.)

1. Name of periodical	2. Gross advertising income	3. Direct advertising costs	4. Advertising gain or (loss) (col. 2 minus col. 3). If a gain, compute cols. 5 through 7.	5. Circulation income	6. Readership costs	7. Excess readership costs (column 6 minus column 5, but not more than column 4).
(1)						
(2)						
(3)						
(4)						
Totals from Part I ▶	0.	0.				0.
	Enter here and on page 1, Part I, line 11, col. (A).	Enter here and on page 1, Part I, line 11, col. (B).				Enter here and on page 1, Part II, line 27.
Totals, Part II (lines 1-5) ▶	0.	0.				0.

Schedule K - Compensation of Officers, Directors, and Trustees (see instructions)

1. Name	2. Title	3. Percent of time devoted to business	4. Compensation attributable to unrelated business
(1)		%	
(2)		%	
(3)		%	
(4)		%	
Total. Enter here and on page 1, Part II, line 14 ▶			0.

SCHEDULE O (Form 1120)
(Rev. December 2012)
Department of the Treasury
Internal Revenue Service

Consent Plan and Apportionment Schedule for a Controlled Group

▶ Attach to Form 1120, 1120-C, 1120-F, 1120-FSC, 1120-L, 1120-PC, 1120-REIT, or 1120-RIC.
▶ Information about Schedule O (Form 1120) and its instructions is available at www.irs.gov/form1120.

OMB No. 1545-0123

Name: UPSON COUNTY HOSPITAL INC

Employer identification number: 58-1734026

Part I Apportionment Plan Information

1 Type of controlled group:
- a [X] Parent-subsidiary group
- b [ ] Brother-sister group
- c [ ] Combined group
- d [ ] Life insurance companies only

2 This corporation has been a member of this group:
- a [X] For the entire year.
- b [ ] From _____ , until _____ .

3 This corporation consents and represents to:
- a [ ] Adopt an apportionment plan. All the other members of this group are adopting an apportionment plan effective for the current tax year which ends on _____ , and for all succeeding tax years.
- b [ ] Amend the current apportionment plan. All the other members of this group are currently amending a previously adopted plan, which was in effect for the tax year ending _____ , and for all succeeding tax years.
- c [ ] Terminate the current apportionment plan and not adopt a new plan. All the other members of this group are not adopting an apportionment plan.
- d [ ] Terminate the current apportionment plan and adopt a new plan. All the other members of this group are adopting an apportionment plan effective for the current tax year which ends on _____ , and for all succeeding tax years.

4 If you checked box 3c or 3d above, check the applicable box below to indicate if the termination of the current apportionment plan was:
- a [ ] Elected by the component members of the group.
- b [ ] Required for the component members of the group.

5 If you did not check a box on line 3 above, check the applicable box below concerning the status of the group's apportionment plan (see instructions).
- a [ ] No apportionment plan is in effect and none is being adopted.
- b [X] An apportionment plan is already in effect. It was adopted for the tax year ending DECEMBER 31, 2015 , and for all succeeding tax years.

6 If all the members of this group are adopting a plan or amending the current plan for a tax year after the due date (including extensions) of the tax return for this corporation, is there at least one year remaining on the statute of limitations from the date this corporation filed its amended return for such tax year for assessing any resulting deficiency? See instructions. N/A .
- a [ ] Yes.
  - (i) [ ] The statute of limitations for this year will expire on _____ .
  - (ii) [ ] On _____ , this corporation entered into an agreement with the Internal Revenue Service to extend the statute of limitations for purposes of assessment until _____ .
- b [ ] No. The members may not adopt or amend an apportionment plan.

7 Required information and elections for component members. Check the applicable box(es) (see instructions).
- a [ ] The corporation will determine its tax liability by applying the maximum tax rate imposed by section 11 to the entire amount of its taxable income.
- b [ ] The corporation and the other members of the group elect the FIFO method (rather than defaulting to the proportionate method) for allocating the additional taxes for the group imposed by section 11(b)(1).
- c [ ] The corporation has a short tax year that does not include December 31.

Part II **Taxable Income Apportionment** (See instructions)

Caution: Each total in Part II, column (g) for each component member must equal taxable income from Form 1120, page 1, line 30 or the comparable line of such member's tax return.

	(a) Group member's name and employer identification number		(b) Tax year end (Yr-Mo)	Taxable Income Amount Allocated to Each Bracket (c) 15%	(d) 25%	(e) 34%	(f) 35%	(g) **Total** (add columns (c) through (f))
1	UPSON COUNTY HOSPITAL INC	58-1734026	17-12					0.
2	URMC HEALTH FOUNDATION INC	TAX EXEMPT	17-12					0.
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
Total								

Part III **Income Tax Apportionment** (See instructions)

(a) Group member's name	Income Tax Apportionment (b) 15%	(c) 25%	(d) 34%	(e) 35%	(f) 5%	(g) 3%	(h) Total income tax (combine lines (b) through (g))
1 UPSON COUNTY HOSPITAL INC							
2 URMC HEALTH FOUNDATION INC							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
Total							

Part IV **Other Apportionments** (See instructions)

(a) Group member's name	Other Apportionments (b) Accumulated earnings credit	(c) AMT exemption amount	(d) Phaseout of AMT exemption amount	(e) Penalty for failure to pay estimated tax	(f) Other
1 UPSON COUNTY HOSPITAL INC					
2 URMC HEALTH FOUNDATION INC					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
Total					

FORM 990-T DESCRIPTION OF ORGANIZATION'S PRIMARY UNRELATED BUSINESS ACTIVITY STATEMENT 1

WELLNESS AND FITNESS CENTER AND CATERING SERVICES

TO FORM 990-T, PAGE 1

FORM 990-T OTHER DEDUCTIONS STATEMENT 2

DESCRIPTION	AMOUNT
FOOD COSTS FOR CAFETERIA	5,865.
OTHER CAFETERIA COSTS	697.
MANAGEMENT FEES	35,088.
CONTRACTED SERVICES	267,623.
OTHER PROFESSIONAL FEES	8,166.
ADVERTISING	5,691.
OFFICE EXPENSE	6,318.
TRAVEL	4,285.
SUPPLIES	8,299.
MINOR EQUIPMENT	1,977.
OTHER EXPENSES	27,374.
RENTAL EXPENSE	169,784.
FOOD EXPENSE	3,710.
TOTAL TO FORM 990-T, PAGE 1, LINE 28	544,877.

FORM 990-T NET OPERATING LOSS DEDUCTION STATEMENT 3

TAX YEAR	LOSS SUSTAINED	LOSS PREVIOUSLY APPLIED	LOSS REMAINING	AVAILABLE THIS YEAR
12/31/08	781,702.	0.	781,702.	781,702.
12/31/09	685,303.	0.	685,303.	685,303.
12/31/10	547,527.	0.	547,527.	547,527.
12/31/11	594,706.	0.	594,706.	594,706.
12/31/12	417,384.	0.	417,384.	417,384.
12/31/13	374,259.	0.	374,259.	374,259.
12/31/14	399,631.	0.	399,631.	399,631.
12/31/15	21,687.	0.	21,687.	21,687.
12/31/16	25,166.	0.	25,166.	25,166.
NOL CARRYOVER AVAILABLE THIS YEAR			3,847,365.	3,847,365.

** PUBLIC DISCLOSURE COPY **

Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

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

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

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

OMB No. 1545-0047

2017

Open to Public Inspection

A For the 2017 calendar year, or tax year beginning **and ending**

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

C Name of organization
URMC HEALTH FOUNDATION INC

Doing business as

Number and street (or P.O. box if mail is not delivered to street address) Room/suite
PO BOX 1059

City or town, state or province, country, and ZIP or foreign postal code
THOMASTON, GA 30286-0027

F Name and address of principal officer: JOHN WILLIAMS
SAME AS C ABOVE

D Employer identification number
83-0411781

E Telephone number
706-647-8111

G Gross receipts $ 227,428.

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

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

H(c) Group exemption number ▶

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

J Website: ▶ N/A

K Form of organization: ☒ Corporation ☐ Trust ☐ Association ☐ Other ▶

L Year of formation: 2004 **M** State of legal domicile: GA

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities: EXISTS TO AID, ASSIST AND SUPPORT THE MEDICAL, CHARITABLE AND EDUCATIONAL SERVICES OF UPSON

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

3	Number of voting members of the governing body (Part VI, line 1a)	3	19
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	18
5	Total number of individuals employed in calendar year 2017 (Part V, line 2a)	5	0
6	Total number of volunteers (estimate if necessary)	6	24
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	0.
b	Net unrelated business taxable income from Form 990-T, line 34	7b	0.

Revenue

		Prior Year	Current Year
8	Contributions and grants (Part VIII, line 1h)	37,008.	66,664.
9	Program service revenue (Part VIII, line 2g)	0.	0.
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	108,304.	160,764.
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	0.	0.
12	Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	145,312.	227,428.

Expenses

13	Grants and similar amounts paid (Part IX, column (A), lines 1-3)	67,580.	407.
14	Benefits paid to or for members (Part IX, column (A), line 4)	0.	0.
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	0.	0.
16a	Professional fundraising fees (Part IX, column (A), line 11e)	0.	0.
b	Total fundraising expenses (Part IX, column (D), line 25) ▶ 0.		
17	Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	11.	10.
18	Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	67,591.	417.
19	Revenue less expenses. Subtract line 18 from line 12	77,721.	227,011.

Net Assets or Fund Balances

		Beginning of Current Year	End of Year
20	Total assets (Part X, line 16)	3,626,412.	4,237,871.
21	Total liabilities (Part X, line 26)	0.	0.
22	Net assets or fund balances. Subtract line 21 from line 20	3,626,412.	4,237,871.

Part II Signature Block

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

Sign Here

▶ Signature of officer Date

▶ JOHN WILLIAMS, CFO
Type or print name and title

Paid Preparer Use Only

Print/Type preparer's name	Preparer's signature	Date	Check if self-employed	PTIN
AMY BIBBY	AMY BIBBY		☐	P00445891

Firm's name ▶ DIXON HUGHES GOODMAN LLP Firm's EIN ▶ 56-0747981

Firm's address ▶ 500 RIDGEFIELD COURT
ASHEVILLE, NC 28806 Phone no. (828) 254-2254

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

SEE SCHEDULE O FOR ORGANIZATION MISSION STATEMENT CONTINUATION

Part III Statement of Program Service Accomplishments

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

1 Briefly describe the organization's mission:
EXISTS TO AID, ASSIST AND SUPPORT THE MEDICAL, CHARITABLE AND EDUCATIONAL SERVICES OF UPSON COUNTY HOSPTAL, INC.

2 Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? ☐ Yes ☒ No
If "Yes," describe these new services on Schedule O.

3 Did the organization cease conducting, or make significant changes in how it conducts, any program services? ☐ Yes ☒ No
If "Yes," describe these changes on Schedule O.

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

4a (Code:) (Expenses $ 417. including grants of $ 407.) (Revenue $ 0.)
THE FOUNDATION WILL CONDUCT FUNDRAISING FOR UPSON COUNTY HOSPITAL, INC., 501(C)(3)ORGANIZATION AND THE SUPPORTED ORGANIZATION. THE FOUNDATION WILL SOLICIT DONATIONS FROM AREA INDIVIDUALS AND BUSINESSES AND RAISE FUNDS THROUGH ANNUAL FUNDRAISERS.

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

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

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

4e Total program service expenses ▶ 417.

Part IV Checklist of Required Schedules

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

Part IV Checklist of Required Schedules *(continued)*

			Yes	No
20a	Did the organization operate one or more hospital facilities? *If "Yes," complete Schedule H*	20a		X
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	20b		
21	Did the organization report more than $5,000 of grants or other assistance to any domestic organization or domestic government on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21		X
22	Did the organization report more than $5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22		X
23	Did the organization answer "Yes" to Part VII, Section A, line 3, 4, or 5 about compensation of the organization's current and former officers, directors, trustees, key employees, and highest compensated employees? *If "Yes," complete Schedule J*	23	X	
24a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer lines 24b through 24d and complete Schedule K. If "No", go to line 25a*	24a		X
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		
25a	**Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.** Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	25a		X
b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? *If "Yes," complete Schedule L, Part I*	25b		X
26	Did the organization report any amount on Part X, line 5, 6, or 22 for receivables from or payables to any current or former officers, directors, trustees, key employees, highest compensated employees, or disqualified persons? *If "Yes," complete Schedule L, Part II*	26		X
27	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity or family member of any of these persons? *If "Yes," complete Schedule L, Part III*	27		X
28	Was the organization a party to a business transaction with one of the following parties (see Schedule L, Part IV instructions for applicable filing thresholds, conditions, and exceptions):			
a	A current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28a		X
b	A family member of a current or former officer, director, trustee, or key employee? *If "Yes," complete Schedule L, Part IV*	28b		X
c	An entity of which a current or former officer, director, trustee, or key employee (or a family member thereof) was an officer, director, trustee, or direct or indirect owner? *If "Yes," complete Schedule L, Part IV*	28c		X
29	Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29		X
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		X
33	Did the organization own 100% of an entity disregarded as separate from the organization under Regulations sections 301.7701-2 and 301.7701-3? *If "Yes," complete Schedule R, Part I*	33		X
34	Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1*	34	X	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?	35a		X
b	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	35b		
36	**Section 501(c)(3) organizations.** Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		X
37	Did the organization conduct more than 5% of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	37		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? **Note.** All Form 990 filers are required to complete Schedule O	38	X	

Part V Statements Regarding Other IRS Filings and Tax Compliance

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

				Yes	No
1a	Enter the number reported in Box 3 of Form 1096. Enter -0- if not applicable	1a	0		
b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?	1c			
2a	Enter the number of employees reported on Form W-3, Transmittal of Wage and Tax Statements, filed for the calendar year ending with or within the year covered by this return	2a	0		
b	If at least one is reported on line 2a, did the organization file all required federal employment tax returns?	2b			
	Note. If the sum of lines 1a and 2a is greater than 250, you may be required to *e-file* (see instructions)				
3a	Did the organization have unrelated business gross income of $1,000 or more during the year?	3a			X
b	If "Yes," has it filed a Form 990-T for this year? *If "No," to line 3b, provide an explanation in Schedule O*	3b			
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?	4a			X
b	If "Yes," enter the name of the foreign country: ▶ _____ See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?	5a			X
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?	5b			X
c	If "Yes," to line 5a or 5b, did the organization file Form 8886-T?	5c			
6a	Does the organization have annual gross receipts that are normally greater than $100,000, and did the organization solicit any contributions that were not tax deductible as charitable contributions?	6a			X
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?	6b			
7	**Organizations that may receive deductible contributions under section 170(c).**				
a	Did the organization receive a payment in excess of $75 made partly as a contribution and partly for goods and services provided to the payor?	7a			X
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?	7b			
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?	7c			X
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?	7e			X
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?	7f			X
g	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?	7g			
h	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?	7h			
8	**Sponsoring organizations maintaining donor advised funds.** Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?	8			
9	**Sponsoring organizations maintaining donor advised funds.**				
a	Did the sponsoring organization make any taxable distributions under section 4966?	9a			
b	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?	9b			
10	**Section 501(c)(7) organizations.** Enter:				
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	**Section 501(c)(12) organizations.** Enter:				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.)	11b			
12a	**Section 4947(a)(1) non-exempt charitable trusts.** Is the organization filing Form 990 in lieu of Form 1041?	12a			
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			
13	**Section 501(c)(29) qualified nonprofit health insurance issuers.**				
a	Is the organization licensed to issue qualified health plans in more than one state?	13a			
	Note. See the instructions for additional information the organization must report on Schedule O.				
b	Enter the amount of reserves the organization is required to maintain by the states in which the organization is licensed to issue qualified health plans	13b			
c	Enter the amount of reserves on hand	13c			
14a	Did the organization receive any payments for indoor tanning services during the tax year?	14a			X
b	If "Yes," has it filed a Form 720 to report these payments? *If "No," provide an explanation in Schedule O*	14b			

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

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

Section A. Governing Body and Management

				Yes	No
1a	Enter the number of voting members of the governing body at the end of the tax year	1a	19		
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.				
b	Enter the number of voting members included in line 1a, above, who are independent	1b	18		
2	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2			X
3	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors, or trustees, or key employees to a management company or other person?	3			X
4	Did the organization make any significant changes to its governing documents since the prior Form 990 was filed?	4			X
5	Did the organization become aware during the year of a significant diversion of the organization's assets?	5			X
6	Did the organization have members or stockholders?	6		X	
7a	Did the organization have members, stockholders, or other persons who had the power to elect or appoint one or more members of the governing body?	7a		X	
b	Are any governance decisions of the organization reserved to (or subject to approval by) members, stockholders, or persons other than the governing body?	7b			X
8	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following:				
a	The governing body?	8a		X	
b	Each committee with authority to act on behalf of the governing body?	8b		X	
9	Is there any officer, director, trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? *If "Yes," provide the names and addresses in Schedule O*	9			X

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

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

Section C. Disclosure

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

18 Section 6104 requires an organization to make its Forms 1023 (or 1024 if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.

☐ Own website ☐ Another's website ☒ Upon request ☐ Other *(explain in Schedule O)*

19 Describe in Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.

20 State the name, address, and telephone number of the person who possesses the organization's books and records: ▶

JOHN WILLIAMS - 706-647-8111
801 WEST GORDON STREET, THOMASTON, GA 32086

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

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

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

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

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

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

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

(A) Name and Title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) RUTH HATCHETT	0.15									
PRESIDENT		X		X				0.	0.	0.
(2) [illegible]	0.15									
VICE PRESIDENT	39.85	X		X				0.	77,841.	21,541.
(3) DEANN WHEELER ELLINGTON	0.15									
SECRETARY (THRU 6/30/17)		X		X				0.	0.	0.
(4) KAY SEARCY	0.15									
BOARD MEMBER	0.75	X						0.	0.	0.
(5) SCOTT BLACKSTOCK	0.15									
BOARD MEMBER	0.75	X						0.	0.	0.
(6) JONATHAN BUSBEE, MD	0.15									
BOARD MEMBER	0.75	X						0.	0.	0.
(7) KYLE FLETCHER	0.15									
BOARD MEMBER (THRU 6/30/17)		X						0.	0.	0.
(8) PETER BANKS	0.15									
BOARD MEMBER		X						0.	0.	0.
(9) ROSA DRAKE	0.15									
BOARD MEMBER (THRU 6/30/17)		X						0.	0.	0.
(10) WILLIAM DALLAS, MD	0.15									
BOARD MEMBER (ROTATED OFF)		X						0.	0.	0.
(11) HARVEL ESTES	0.15									
BOARD MEMBER		X						0.	0.	0.
(12) NEIL HIGHTOWER	0.15									
BOARD MEMBER		X						0.	0.	0.
(13) MABLE WORTHY	0.15									
BOARD MEMBER (THRU 6/30/17)		X						0.	0.	0.
(14) WILLIAM OXFORD, MD	0.15									
BOARD MEMBER		X						0.	0.	0.
(15) CHARLES D. TATE	0.15									
BOARD MEMBER		X						0.	0.	0.
(16) RYAN TUCKER	0.15									
BOARD MEMBER		X						0.	0.	0.
(17) CARSON GLEATON	0.15									
BOARD MEMBER (THRU 6/30/17)		X						0.	0.	0.

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(18) ANN MCDANIEL	0.15									
BOARD MEMBER		X						0.	0.	0.
(19) BARNEY HANCOCK	0.15									
BOARD MEMBER	0.75	X						0.	0.	0.
(20) JIM EDWARDS	0.15									
BOARD MEMBER	0.75	X						0.	0.	0.
(21) WILLIAM HIGHTOWER IV	0.15									
BOARD MEMBER	0.75	X						0.	0.	0.
(22) KAY ROBINSON	0.15									
BOARD MEMBER	0.75	X						0.	0.	0.
(23) RALPH WARNOCK, MD	0.15									
BOARD MEMBER	0.75	X						0.	0.	0.
(24) STEVE KEADLE	0.15									
BOARD MEMBER	0.75	X						0.	0.	0.
(25)	8.00									
EXECUTIVE DIRECTOR, ASSIST TREASURER		X						0.	91,142.	1,112.
(26)	1.00									
HOSPITAL CEO	40.00			X				0.	284,902.	38,135.
1b Sub-total ▶								0.	453,885.	60,788.
c Total from continuation sheets to Part VII, Section A ▶								0.	224,786.	13,669.
d Total (add lines 1b and 1c) ▶								0.	678,671.	74,457.

2 Total number of individuals (including but not limited to those listed above) who received more than $100,000 of reportable compensation from the organization ▶ 0

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

Section B. Independent Contractors

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

(A) Name and business address	(B) Description of services	(C) Compensation
NONE		

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶ 0

SEE PART VII, SECTION A CONTINUATION SHEETS

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

(A) Name and title	(B) Average hours per week (list any hours for related organizations below line)	(C) Position (check all that apply): Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former	(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
(27) [illegible] HOSPITAL CFO	1.00 40.00			X				0.	224,786.	13,669.
Total to Part VII, Section A, line 1c									224,786.	13,669.

732201
04-01-17

Part VIII Statement of Revenue

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512 - 514
Contributions, Gifts, Grants and Other Similar Amounts	1a Federated campaigns	1a				
	b Membership dues	1b				
	c Fundraising events	1c				
	d Related organizations	1d				
	e Government grants (contributions)	1e				
	f All other contributions, gifts, grants, and similar amounts not included above	1f	66,664.			
	g Noncash contributions included in lines 1a-1f: $					
	h **Total.** Add lines 1a-1f ▶		66,664.			
Program Service Revenue		**Business Code**				
	2a					
	b					
	c					
	d					
	e					
	f All other program service revenue					
	g **Total.** Add lines 2a-2f ▶					
Other Revenue	3 Investment income (including dividends, interest, and other similar amounts) ▶		90,477.			90,477.
	4 Income from investment of tax-exempt bond proceeds ▶					
	5 Royalties ▶					
		(i) Real / (ii) Personal				
	6a Gross rents					
	b Less: rental expenses					
	c Rental income or (loss)					
	d Net rental income or (loss) ▶					
		(i) Securities / (ii) Other				
	7a Gross amount from sales of assets other than inventory	70,287.				
	b Less: cost or other basis and sales expenses	0.				
	c Gain or (loss)	70,287.				
	d Net gain or (loss) ▶		70,287.			70,287.
	8a Gross income from fundraising events (not including $ _____ of contributions reported on line 1c). See Part IV, line 18	a				
	b Less: direct expenses	b				
	c Net income or (loss) from fundraising events ▶					
	9a Gross income from gaming activities. See Part IV, line 19	a				
	b Less: direct expenses	b				
	c Net income or (loss) from gaming activities ▶					
	10a Gross sales of inventory, less returns and allowances	a				
	b Less: cost of goods sold	b				
	c Net income or (loss) from sales of inventory ▶					
	Miscellaneous Revenue	**Business Code**				
	11a					
	b					
	c					
	d All other revenue					
	e **Total.** Add lines 11a-11d ▶					
	12 **Total revenue.** See instructions. ▶		227,428.	0.	0.	160,764.

Part IX Statement of Functional Expenses

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
1 Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21	407.	407.		
2 Grants and other assistance to domestic individuals. See Part IV, line 22				
3 Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
4 Benefits paid to or for members				
5 Compensation of current officers, directors, trustees, and key employees				
6 Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
7 Other salaries and wages				
8 Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)				
9 Other employee benefits				
10 Payroll taxes				
11 Fees for services (non-employees):				
a Management				
b Legal				
c Accounting				
d Lobbying				
e Professional fundraising services. See Part IV, line 17				
f Investment management fees				
g Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Sch O.)				
12 Advertising and promotion				
13 Office expenses				
14 Information technology				
15 Royalties				
16 Occupancy				
17 Travel				
18 Payments of travel or entertainment expenses for any federal, state, or local public officials				
19 Conferences, conventions, and meetings				
20 Interest				
21 Payments to affiliates				
22 Depreciation, depletion, and amortization				
23 Insurance				
24 Other expenses. Itemize expenses not covered above. (List miscellaneous expenses in line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
a MISCELLANEOUS	10.	10.		
b				
c				
d				
e All other expenses				
25 **Total functional expenses.** Add lines 1 through 24e	417.	417.	0.	0.
26 **Joint costs.** Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here ▶ ☐ if following SOP 98-2 (ASC 958-720)				

Part X Balance Sheet

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

			(A) Beginning of year		(B) End of year
Assets	1	Cash - non-interest-bearing		1	
	2	Savings and temporary cash investments	6,999.	2	11,283.
	3	Pledges and grants receivable, net		3	
	4	Accounts receivable, net		4	
	5	Loans and other receivables from current and former officers, directors, trustees, key employees, and highest compensated employees. Complete Part II of Schedule L		5	
	6	Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), persons described in section 4958(c)(3)(B), and contributing employers and sponsoring organizations of section 501(c)(9) voluntary employees' beneficiary organizations (see instr). Complete Part II of Sch L		6	
	7	Notes and loans receivable, net		7	
	8	Inventories for sale or use		8	
	9	Prepaid expenses and deferred charges		9	
	10a	Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D — 10a			
	b	Less: accumulated depreciation — 10b		10c	
	11	Investments - publicly traded securities	3,619,413.	11	4,226,588.
	12	Investments - other securities. See Part IV, line 11		12	
	13	Investments - program-related. See Part IV, line 11		13	
	14	Intangible assets		14	
	15	Other assets. See Part IV, line 11		15	
	16	**Total assets.** Add lines 1 through 15 (must equal line 34)	3,626,412.	16	4,237,871.
Liabilities	17	Accounts payable and accrued expenses		17	
	18	Grants payable		18	
	19	Deferred revenue		19	
	20	Tax-exempt bond liabilities		20	
	21	Escrow or custodial account liability. Complete Part IV of Schedule D		21	
	22	Loans and other payables to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons. Complete Part II of Schedule L		22	
	23	Secured mortgages and notes payable to unrelated third parties		23	
	24	Unsecured notes and loans payable to unrelated third parties		24	
	25	Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D		25	
	26	**Total liabilities.** Add lines 17 through 25	0.	26	0.
Net Assets or Fund Balances		**Organizations that follow SFAS 117 (ASC 958), check here ▶ ☒ and complete lines 27 through 29, and lines 33 and 34.**			
	27	Unrestricted net assets	3,626,412.	27	4,237,871.
	28	Temporarily restricted net assets		28	
	29	Permanently restricted net assets		29	
		Organizations that do not follow SFAS 117 (ASC 958), check here ▶ ☐ and complete lines 30 through 34.			
	30	Capital stock or trust principal, or current funds		30	
	31	Paid-in or capital surplus, or land, building, or equipment fund		31	
	32	Retained earnings, endowment, accumulated income, or other funds		32	
	33	Total net assets or fund balances	3,626,412.	33	4,237,871.
	34	Total liabilities and net assets/fund balances	3,626,412.	34	4,237,871.

Part XI Reconciliation of Net Assets

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

1	Total revenue (must equal Part VIII, column (A), line 12)	1	227,428.
2	Total expenses (must equal Part IX, column (A), line 25)	2	417.
3	Revenue less expenses. Subtract line 2 from line 1	3	227,011.
4	Net assets or fund balances at beginning of year (must equal Part X, line 33, column (A))	4	3,626,412.
5	Net unrealized gains (losses) on investments	5	384,448.
6	Donated services and use of facilities	6	
7	Investment expenses	7	
8	Prior period adjustments	8	
9	Other changes in net assets or fund balances (explain in Schedule O)	9	0.
10	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 33, column (B))	10	4,237,871.

Part XII Financial Statements and Reporting

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

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

SCHEDULE A
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Public Charity Status and Public Support

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

OMB No. 1545-0047

2017

Open to Public Inspection

Name of the organization
URMC HEALTH FOUNDATION INC

Employer identification number
83-0411781

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

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

1 ☐ A church, convention of churches, or association of churches described in **section 170(b)(1)(A)(i).**
2 ☐ A school described in **section 170(b)(1)(A)(ii).** (Attach Schedule E (Form 990 or 990-EZ).)
3 ☐ A hospital or a cooperative hospital service organization described in **section 170(b)(1)(A)(iii).**
4 ☐ A medical research organization operated in conjunction with a hospital described in **section 170(b)(1)(A)(iii).** Enter the hospital's name, city, and state: _____
5 ☐ An organization operated for the benefit of a college or university owned or operated by a governmental unit described in **section 170(b)(1)(A)(iv).** (Complete Part II.)
6 ☐ A federal, state, or local government or governmental unit described in **section 170(b)(1)(A)(v).**
7 ☐ An organization that normally receives a substantial part of its support from a governmental unit or from the general public described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
8 ☐ A community trust described in **section 170(b)(1)(A)(vi).** (Complete Part II.)
9 ☐ An agricultural research organization described in **section 170(b)(1)(A)(ix)** operated in conjunction with a land-grant college or university or a non-land-grant college of agriculture (see instructions). Enter the name, city, and state of the college or university: _____
10 ☐ An organization that normally receives: (1) more than 33 1/3% of its support from contributions, membership fees, and gross receipts from activities related to its exempt functions - subject to certain exceptions, and (2) no more than 33 1/3% of its support from gross investment income and unrelated business taxable income (less section 511 tax) from businesses acquired by the organization after June 30, 1975. See **section 509(a)(2).** (Complete Part III.)
11 ☐ An organization organized and operated exclusively to test for public safety. See **section 509(a)(4).**
12 ☒ An organization organized and operated exclusively for the benefit of, to perform the functions of, or to carry out the purposes of one or more publicly supported organizations described in **section 509(a)(1)** or **section 509(a)(2)**. See **section 509(a)(3).** Check the box in lines 12a through 12d that describes the type of supporting organization and complete lines 12e, 12f, and 12g.

a ☒ **Type I.** A supporting organization operated, supervised, or controlled by its supported organization(s), typically by giving the supported organization(s) the power to regularly appoint or elect a majority of the directors or trustees of the supporting organization. **You must complete Part IV, Sections A and B.**
b ☐ **Type II.** A supporting organization supervised or controlled in connection with its supported organization(s), by having control or management of the supporting organization vested in the same persons that control or manage the supported organization(s). **You must complete Part IV, Sections A and C.**
c ☐ **Type III functionally integrated.** A supporting organization operated in connection with, and functionally integrated with, its supported organization(s) (see instructions). **You must complete Part IV, Sections A, D, and E.**
d ☐ **Type III non-functionally integrated.** A supporting organization operated in connection with its supported organization(s) that is not functionally integrated. The organization generally must satisfy a distribution requirement and an attentiveness requirement (see instructions). **You must complete Part IV, Sections A and D, and Part V.**
e ☐ Check this box if the organization received a written determination from the IRS that it is a Type I, Type II, Type III functionally integrated, or Type III non-functionally integrated supporting organization.
f Enter the number of supported organizations 1
g Provide the following information about the supported organization(s).

(i) Name of supported organization	(ii) EIN	(iii) Type of organization (described on lines 1-10 above (see instructions))	(iv) Is the organization listed in your governing document? Yes	(iv) No	(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
UPSON COUNTY HOSPITAL INC DBA UP	58-1734026	3	X		407.	0.
Total					407.	0.

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
3 The value of services or facilities furnished by a governmental unit to the organization without charge						
4 **Total.** Add lines 1 through 3						
5 The portion of total contributions by each person (other than a governmental unit or publicly supported organization) included on line 1 that exceeds 2% of the amount shown on line 11, column (f)						
6 **Public support.** Subtract line 5 from line 4.						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
7 Amounts from line 4						
8 Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
9 Net income from unrelated business activities, whether or not the business is regularly carried on						
10 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
11 **Total support.** Add lines 7 through 10						

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

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

Section C. Computation of Public Support Percentage

14 Public support percentage for 2017 (line 6, column (f) divided by line 11, column (f)) 14 %

15 Public support percentage from 2016 Schedule A, Part II, line 14 15 %

16a **33 1/3% support test - 2017.** If the organization did not check the box on line 13, and line 14 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support test - 2016.** If the organization did not check a box on line 13 or 16a, and line 15 is 33 1/3% or more, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

17a **10% -facts-and-circumstances test - 2017.** If the organization did not check a box on line 13, 16a, or 16b, and line 14 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐

b **10% -facts-and-circumstances test - 2016.** If the organization did not check a box on line 13, 16a, 16b, or 17a, and line 15 is 10% or more, and if the organization meets the "facts-and-circumstances" test, check this box and **stop here.** Explain in Part VI how the organization meets the "facts-and-circumstances" test. The organization qualifies as a publicly supported organization ▶ ☐

18 **Private foundation.** If the organization did not check a box on line 13, 16a, 16b, 17a, or 17b, check this box and see instructions ▶ ☐

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

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

Section A. Public Support

Calendar year (or fiscal year beginning in) ▶	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
1 Gifts, grants, contributions, and membership fees received. (Do not include any "unusual grants.")						
2 Gross receipts from admissions, merchandise sold or services performed, or facilities furnished in any activity that is related to the organization's tax-exempt purpose						
3 Gross receipts from activities that are not an unrelated trade or business under section 513						
4 Tax revenues levied for the organization's benefit and either paid to or expended on its behalf						
5 The value of services or facilities furnished by a governmental unit to the organization without charge						
6 **Total.** Add lines 1 through 5						
7a Amounts included on lines 1, 2, and 3 received from disqualified persons						
b Amounts included on lines 2 and 3 received from other than disqualified persons that exceed the greater of $5,000 or 1% of the amount on line 13 for the year						
c Add lines 7a and 7b						
8 **Public support.** (Subtract line 7c from line 6.)						

Section B. Total Support

Calendar year (or fiscal year beginning in) ▶	(a) 2013	(b) 2014	(c) 2015	(d) 2016	(e) 2017	(f) Total
9 Amounts from line 6						
10a Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources						
b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975						
c Add lines 10a and 10b						
11 Net income from unrelated business activities not included in line 10b, whether or not the business is regularly carried on						
12 Other income. Do not include gain or loss from the sale of capital assets (Explain in Part VI.)						
13 **Total support.** (Add lines 9, 10c, 11, and 12.)						

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

Section C. Computation of Public Support Percentage

15 Public support percentage for 2017 (line 8, column (f) divided by line 13, column (f))	15	%
16 Public support percentage from 2016 Schedule A, Part III, line 15	16	%

Section D. Computation of Investment Income Percentage

17 Investment income percentage for **2017** (line 10c, column (f) divided by line 13, column (f))	17	%
18 Investment income percentage from **2016** Schedule A, Part III, line 17	18	%

19a **33 1/3% support tests - 2017.** If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

b **33 1/3% support tests - 2016.** If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and **stop here.** The organization qualifies as a publicly supported organization ▶ ☐

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

Part IV Supporting Organizations

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

Section A. All Supporting Organizations

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

Part IV Supporting Organizations *(continued)*

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

Section B. Type I Supporting Organizations

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

Section C. Type II Supporting Organizations

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

Section D. All Type III Supporting Organizations

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

Section E. Type III Functionally Integrated Supporting Organizations

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

a ☐ The organization satisfied the Activities Test. *Complete* **line 2** *below.*

b ☐ The organization is the parent of each of its supported organizations. *Complete* **line 3** *below.*

c ☐ The organization supported a governmental entity. *Describe in* **Part VI** *how you supported a government entity (see instructions).*

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

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

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

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

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

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

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

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

Section D - Distributions		Current Year
1	Amounts paid to supported organizations to accomplish exempt purposes	
2	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity	
3	Administrative expenses paid to accomplish exempt purposes of supported organizations	
4	Amounts paid to acquire exempt-use assets	
5	Qualified set-aside amounts (prior IRS approval required)	
6	Other distributions (describe in **Part VI**). See instructions.	
7	**Total annual distributions.** Add lines 1 through 6.	
8	Distributions to attentive supported organizations to which the organization is responsive (provide details in **Part VI**). See instructions.	
9	Distributable amount for 2017 from Section C, line 6	
10	Line 8 amount divided by line 9 amount	

Section E - Distribution Allocations (see instructions)		(i) Excess Distributions	(ii) Underdistributions Pre-2017	(iii) Distributable Amount for 2017
1	Distributable amount for 2017 from Section C, line 6			
2	Underdistributions, if any, for years prior to 2017 (reasonable cause required- explain in **Part VI**). See instructions.			
3	Excess distributions carryover, if any, to 2017			
a				
b	From 2013			
c	From 2014			
d	From 2015			
e	From 2016			
f	**Total** of lines 3a through e			
g	Applied to underdistributions of prior years			
h	Applied to 2017 distributable amount			
i	Carryover from 2012 not applied (see instructions)			
j	Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
4	Distributions for 2017 from Section D, line 7: $			
a	Applied to underdistributions of prior years			
b	Applied to 2017 distributable amount			
c	Remainder. Subtract lines 4a and 4b from 4.			
5	Remaining underdistributions for years prior to 2017, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, explain in **Part VI.** See instructions.			
6	Remaining underdistributions for 2017. Subtract lines 3h and 4b from line 1. For result greater than zero, explain in **Part VI**. See instructions.			
7	**Excess distributions carryover to 2018.** Add lines 3j and 4c.			
8	Breakdown of line 7:			
a	Excess from 2013			
b	Excess from 2014			
c	Excess from 2015			
d	Excess from 2016			
e	Excess from 2017			

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

SCHEDULE A, PART I

THE PURPOSE OF THE ORGANIZATION IS TO SERVE AND PROMOTE THE PUBLIC HEALTH OF THE GENERAL POPULATION AND, PARTICULARLY, TO SERVE AS A FUNDRAISING ORGANIZATION TO HELP SUPPORT UPSON COUNTY HOSPITAL, INC., THE SUPPORTED ORGANIZATION, AND OTHER SPECIAL COMMUNITY HEALTH CARE NEEDS, AND IN FURTHERANCE THEREOF TO CONDUCT THE FOLLOWING (1) TO RAISE PUBLIC AWARENESS OF COMMUNITY HEALTH CARE NEEDS, (2) TO SOLICIT AND ACCEPT DONATIONS AND CONTRIBUTIONS, IN CASH OR IN KIND, AND TO USE SUCH DONATIONS AND CONTRIBUTIONS TO PROMOTE THE DELIVERY OF HEALTH CARE TO THE GENERAL PUBLIC BY PROVIDING RESOURCES FOR UPSON COUNTRY HOSPITAL, INC. AND OTHER SPECIAL COMMUNITY HEALTH CARE NEEDS, AND (3) TO PERFORM ALL OTHER ACTS NECESSARY, USEFUL, ADVISABLE, OR CONDUCTIVE, DIRECTLY OR INDIRECTLY, AS SET FORTH IN THE ORGANIZATION'S GOVERNING DOCUMENTS.

Schedule B
(Form 990, 990-EZ, or 990-PF)
Department of the Treasury
Internal Revenue Service

Schedule of Contributors

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

OMB No. 1545-0047

2017

Name of the organization	**Employer identification number**
URMC HEALTH FOUNDATION INC	83-0411781

Organization type (check one):

Filers of:	**Section:**
Form 990 or 990-EZ	☒ 501(c)(3) (enter number) organization
	☐ 4947(a)(1) nonexempt charitable trust **not** treated as a private foundation
	☐ 527 political organization
Form 990-PF	☐ 501(c)(3) exempt private foundation
	☐ 4947(a)(1) nonexempt charitable trust treated as a private foundation
	☐ 501(c)(3) taxable private foundation

Check if your organization is covered by the **General Rule** or a **Special Rule.**
Note: Only a section 501(c)(7), (8), or (10) organization can check boxes for both the General Rule and a Special Rule. See instructions.

General Rule

☒ For an organization filing Form 990, 990-EZ, or 990-PF that received, during the year, contributions totaling $5,000 or more (in money or property) from any one contributor. Complete Parts I and II. See instructions for determining a contributor's total contributions.

Special Rules

☐ For an organization described in section 501(c)(3) filing Form 990 or 990-EZ that met the 33 1/3% support test of the regulations under sections 509(a)(1) and 170(b)(1)(A)(vi), that checked Schedule A (Form 990 or 990-EZ), Part II, line 13, 16a, or 16b, and that received from any one contributor, during the year, total contributions of the greater of **(1)** $5,000; or **(2)** 2% of the amount on (i) Form 990, Part VIII, line 1h; or (ii) Form 990-EZ, line 1. Complete Parts I and II.

☐ For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, total contributions of more than $1,000 *exclusively* for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals. Complete Parts I, II, and III.

☐ For an organization described in section 501(c)(7), (8), or (10) filing Form 990 or 990-EZ that received from any one contributor, during the year, contributions *exclusively* for religious, charitable, etc., purposes, but no such contributions totaled more than $1,000. If this box is checked, enter here the total contributions that were received during the year for an *exclusively* religious, charitable, etc., purpose. Don't complete any of the parts unless the **General Rule** applies to this organization because it received *nonexclusively* religious, charitable, etc., contributions totaling $5,000 or more during the year ..... ▶ $ _____

Caution: An organization that isn't covered by the General Rule and/or the Special Rules doesn't file Schedule B (Form 990, 990-EZ, or 990-PF), but it **must** answer "No" on Part IV, line 2, of its Form 990; or check the box on line H of its Form 990-EZ or on its Form 990-PF, Part I, line 2, to certify that it doesn't meet the filing requirements of Schedule B (Form 990, 990-EZ, or 990-PF).

Name of organization: URMC HEALTH FOUNDATION INC

Employer identification number: 83-0411781

Part I **Contributors** (see instructions). Use duplicate copies of Part I if additional space is needed.

(a) No.	(b) Name, address, and ZIP + 4	(c) Total contributions	(d) Type of contribution
1		$ 36,984.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
2		$ 25,000.	Person [X] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)
		$	Person [ ] Payroll [ ] Noncash [ ] (Complete Part II for noncash contributions.)

Name of organization	Employer identification number
URMC HEALTH FOUNDATION INC	83-0411781

Part II **Noncash Property** (see instructions). Use duplicate copies of Part II if additional space is needed.

(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
		$	
(a) No. from Part I	(b) Description of noncash property given	(c) FMV (or estimate) (See instructions.)	(d) Date received
		$	

Name of organization: URMC HEALTH FOUNDATION INC

Employer identification number: 83-0411781

Part III *Exclusively* religious, charitable, etc., contributions to organizations described in section 501(c)(7), (8), or (10) that total more than $1,000 for the year from any one contributor. Complete columns (a) through (e) and the following line entry. For organizations completing Part III, enter the total of exclusively religious, charitable, etc., contributions of $1,000 or less for the year. (Enter this info. once.) ▶ $

Use duplicate copies of Part III if additional space is needed.

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

(a) No. from Part I	(b) Purpose of gift	(c) Use of gift	(d) Description of how gift is held

(e) Transfer of gift

Transferee's name, address, and ZIP + 4	Relationship of transferor to transferee

SCHEDULE D (Form 990)

Department of the Treasury
Internal Revenue Service

Supplemental Financial Statements

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

OMB No. 1545-0047

2017

Open to Public Inspection

Name of the organization
URMC HEALTH FOUNDATION INC

Employer identification number
83-0411781

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

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

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

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

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

Part II Conservation Easements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:

a Board designated or quasi-endowment ▶ _____%
b Permanent endowment ▶ _____%
c Temporarily restricted endowment ▶ _____%

The percentages on lines 2a, 2b, and 2c should equal 100%.

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by:

		Yes	No
(i) unrelated organizations	3a(i)		
(ii) related organizations	3a(ii)		
b If "Yes" on line 3a(ii), are the related organizations listed as required on Schedule R?	3b		

4 Describe in Part XIII the intended uses of the organization's endowment funds.

Part VI Land, Buildings, and Equipment.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11a. See Form 990, Part X, line 10.

Description of property	(a) Cost or other basis (investment)	(b) Cost or other basis (other)	(c) Accumulated depreciation	(d) Book value
1a Land				
b Buildings				
c Leasehold improvements				
d Equipment				
e Other				
Total. Add lines 1a through 1e. *(Column (d) must equal Form 990, Part X, column (B), line 10c.)* ▶				0.

Part VII Investments - Other Securities.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11b. See Form 990, Part X, line 12.

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

Part VIII Investments - Program Related.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11c. See Form 990, Part X, line 13.

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

Part IX Other Assets.

Complete if the organization answered "Yes" on Form 990, Part IV, line 11d. See Form 990, Part X, line 15.

(a) Description	(b) Book value
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 15.)* ▶	

Part X Other Liabilities.

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

1. (a) Description of liability	(b) Book value
(1) Federal income taxes	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
Total. *(Column (b) must equal Form 990, Part X, col. (B) line 25.)* ▶	

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

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

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

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

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

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

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

Part XIII Supplemental Information.

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

PART X, LINE 2:

THE HOSPITAL AND FOUNDATION ARE NOT-FOR-PROFIT CORPORATIONS AND ARE TAX-EXEMPT PURSUANT TO SECTION 501(C)(3) OF THE INTERNAL REVENUE CODE. THE SEGREGATED PORTFOLIO INTENDS TO CONDUCT ITS AFFAIRS IN A MANNER IN WHICH IT WILL NOT BE SUBJECT TO U.S. FEDERAL INCOME TAX OR GEORGIA INCOME TAX. THE REMAINING WHOLLY OWNED SUBSIDIARIES ARE CONSIDERED DISREGARDED ENTITIES AND ARE INCLUDED IN THE HOSPITAL'S TAX FILINGS. THEREFORE, NO PROVISION FOR FEDERAL INCOME TAXES HAS BEEN MADE IN THE ACCOMPANYING FINANCIAL STATEMENTS.

THE HOSPITAL AND FOUNDATION APPLY ACCOUNTING POLICIES THAT PRESCRIBE WHEN TO RECOGNIZE AND HOW TO MEASURE THE FINANCIAL STATEMENT EFFECTS OF INCOME

Part XIII Supplemental Information *(continued)*

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 AND FOUNDATION ONLY RECOGNIZE 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 DECEMBER 31, 2017 AND 2016 OR FOR THE YEARS THEN ENDED. THE HOSPITAL AND FOUNDATION'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.

SCHEDULE J (Form 990)

Department of the Treasury
Internal Revenue Service

Compensation Information

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

▶ **Complete if the organization answered "Yes" on Form 990, Part IV, line 23.**

▶ **Attach to Form 990.**

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

OMB No. 1545-0047

2017

Open to Public Inspection

Name of the organization

URMC HEALTH FOUNDATION INC

Employer identification number

83-0411781

Part I Questions Regarding Compensation

			Yes	No
1a	Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.			
	☐ First-class or charter travel	☐ Housing allowance or residence for personal use		
	☐ Travel for companions	☐ Payments for business use of personal residence		
	☐ Tax indemnification and gross-up payments	☐ Health or social club dues or initiation fees		
	☐ Discretionary spending account	☐ Personal services (such as, maid, chauffeur, chef)		
b	If any of the boxes on line 1a are checked, did the organization follow a written policy regarding payment or reimbursement or provision of all of the expenses described above? If "No," complete Part III to explain	**1b**		
2	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all directors, trustees, and officers, including the CEO/Executive Director, regarding the items checked on line 1a?	**2**		
3	Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. Do not check any boxes for methods used by a related organization to establish compensation of the CEO/Executive Director, but explain in Part III.			
	☐ Compensation committee	☐ Written employment contract		
	☐ Independent compensation consultant	☐ Compensation survey or study		
	☐ Form 990 of other organizations	☐ Approval by the board or compensation committee		
4	During the year, did any person listed on Form 990, Part VII, Section A, line 1a, with respect to the filing organization or a related organization:			
a	Receive a severance payment or change-of-control payment?	**4a**		X
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	**4b**		X
c	Participate in, or receive payment from, an equity-based compensation arrangement?	**4c**		X
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III.			
	Only section 501(c)(3), 501(c)(4), and 501(c)(29) organizations must complete lines 5-9.			
5	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of:			
a	The organization?	**5a**		X
b	Any related organization?	**5b**		X
	If "Yes" on line 5a or 5b, describe in Part III.			
6	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of:			
a	The organization?	**6a**		X
b	Any related organization?	**6b**		X
	If "Yes" on line 6a or 6b, describe in Part III.			
7	For persons listed on Form 990, Part VII, Section A, line 1a, did the organization provide any nonfixed payments not described on lines 5 and 6? If "Yes," describe in Part III	**7**		X
8	Were any amounts reported on Form 990, Part VII, paid or accrued pursuant to a contract that was subject to the initial contract exception described in Regulations section 53.4958-4(a)(3)? If "Yes," describe in Part III	**8**		X
9	If "Yes" on line 8, did the organization also follow the rebuttable presumption procedure described in Regulations section 53.4958-6(c)?	**9**		

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

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

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

(A) Name and Title		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Retirement and other deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation in column (B) reported as deferred on prior Form 990
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other reportable compensation				
(1)	(i)	0.	0.	0.	0.	0.	0.	0.
HOSPITAL CEO	(ii)	276,582.	0.	8,320.	5,300.	32,835.	323,037.	0.
(2)	(i)	0.	0.	0.	0.	0.	0.	0.
HOSPITAL CFO	(ii)	224,786.	0.	0.	3,698.	9,971.	238,455.	0.
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
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	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

Part III Supplemental Information

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

SCHEDULE J, PAGE 1, PART 1, LINE 3

NONE OF THE INDIVIDUAL BOARD MEMBERS OR OFFICERS ARE COMPENSATED BY THE FILING ORGANIZATION. THE FILING ORGANIZATION, INSTEAD, RELIES ON THE METHODS USED BY THE SUPPORTED ORGANIZATION, UPSON COUNTY HOSPITAL, INC. DBA UPSON REGIONAL MEDICAL CENTER ("URMC"), TO ESTABLISH COMPENSATION OF THE CEO AND EXECUTIVE OFFICERS. COMPENSATION DETERMINATION BY URMC INCLUDES COMPENSATION SURVEYS AND BOARD APPROVAL. THESE METHODS ARE WELL DOCUMENTED.

THE FOUNDATION'S EXECUTIVE DIRECTOR IS AN EMPLOYEE HIRED BY URMC FOR PHYSICIAN RECRUITMENT AND FUNDRAISING SERVICES FOR THE FOUNDATION. HE SPENDS APPROXIMATELY 80% OF HIS TIME RECRUITING FOR THE HOSPITAL.

SCHEDULE O
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information to Form 990 or 990-EZ

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

OMB No. 1545-0047

2017

Open to Public Inspection

Name of the organization
URMC HEALTH FOUNDATION INC

Employer identification number
83-0411781

FORM 990, PART I, LINE 1, DESCRIPTION OF ORGANIZATION MISSION:

COUNTY HOSPTAL, INC.

FORM 990, PART VI, SECTION A, LINE 6:

THE BOARD OF DIRECTORS OF URMC, THE SUPPORTED ORGANIZATION, HAS THE POWER TO ELECT AND REMOVE THE BOARD MEMBERS OF THE ENTITY.

FORM 990, PART VI, SECTION A, LINE 7A:

THE BOARD OF DIRECTORS SHALL BE ELECTED BY THE BOARD OF DIRECTORS OF URMC, THE SUPPORTED ORGANIZATION. URMC BOARD MEMBERS ALSO HAVE THE RIGHT TO REMOVE FOUNDATION DIRECTORS.

FORM 990, PART VI, SECTION B, LINE 11B:

JOHN WILLIAMS, THE CFO OF THE ORGANIZATION, WILL REVIEW THE FORM 990 FOR CONSISTENCY.

FORM 990, PART VI, SECTION B, LINE 12C:

THE CONFLICT OF INTEREST POLICY COVERS ALL DIRECTORS, OFFICERS AND KEY EMPLOYEES OF THE ORGANIZATION. SHOULD A MATTER COME BEFORE THE BOARD OF DIRECTORS WHICH CONSTITUTES A CONFLICT OF INTEREST, THE INDIVIDUAL INVOLVED WILL MAKE KNOWN THE POTENTIAL CONFLICT AND WITHDRAW FROM THE MEETING SO LONG AS THE MATTER SHALL CONTINUE UNDER DISCUSSION AND SHALL NOT EITHER VOTE ON THE MATTER UNDER DISCUSSION OR ATTEMPT TO INFLUENCE A DECISION OF THE GOVERNING AUTHORITY WITH RESPECT TO SUCH MATTERS, UPON WHICH THERE COULD POSSIBLY BE A CONFLICT OF INTEREST.

Name of the organization: URMC HEALTH FOUNDATION INC

Employer identification number: 83-0411781

FORM 990, PART VI, SECTION C, LINE 18:

THE FORM 990 IS AVAILABLE FOR INSPECTION AT THE OFFICE OF THE ORGANIZATION, WITH NOTICE.

FORM 990, PART VI, SECTION C, LINE 19:

THE GOVERNING DOCUMENTS, FINANCIAL STATEMENTS, CONFLICT OF INTEREST POLICY ARE AVAILABLE FOR INSPECTION AT THE OFFICE OF THE ORGANIZATION, WITH NOTICE.

FORM 990, PART XII, LINE 2C:

THIS PROCESS HAS NOT CHANGED FROM PRIOR YEAR.

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

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

▶ Attach to Form 990.

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

OMB No. 1545-0047

2017

Open to Public Inspection

Name of the organization

URMC HEALTH FOUNDATION INC

Employer identification number

83-0411781

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

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

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity? Yes	(g) Section 512(b)(13) controlled entity? No
UPSON COUNTY HOSPITAL INC DBA URMC - 58-1734026, 801 WEST GORDON STREET, THOMASTON, GA 30286	HOSPITAL	GEORGIA	501(C)(3)	LINE 3	N/A		X

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

Schedule R (Form 990) 2017

732161 09-11-17 LHA

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

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

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

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

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

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

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

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

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

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

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

Part VII Supplemental Information.

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

[redacted]tal Questionnaire

Part A : General Information

1. Identification

UID:HOSP523

Facility Name: Upson Regional Medical Center

County: Upson

Street Address: 801 West Gordon Street

City: Thomaston

Zip: 30286

Mailing Address: PO Drawer 1059

Mailing City: Thomaston

Mailing Zip: 30286-0013

Medicaid Provider Number: 000001988A

Medicare Provider Number: 110002

2. Report Period

Report Data for the full twelve month period- January 1, 2018 through December 31, 2018.
Do not use a different report period.

Check the box to the right if your facility was **not** operational for the entire year. ☐
If your facility was **not** operational for the entire year, provide the dates the facility was operational.

Part B : Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey.

Contact Name: Suzanne Streetman

Contact Title: Chief Regulatory Affairs Officer

Phone: 706-647-8111

Fax: 706-646-3153

E-mail: suzanne.streetman@urmc.org

Part C : Ownership, Operation and Management

1. Ownership, Operation and Management

As of the last day of the report period, indicate the operation/management status of the facility and provide the effective date. Using the drop-down menus, select the organization type. If the category is not applicable, the form requires you only to enter Not Applicable in the legal name field. You must enter something for each category.

A. Facility Owner

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Hospital Authority of Upson County, Georgia	Hospital Authority	4/23/1946

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A	Not Applicable	

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Upson Regional Medical Center	Not for Profit	12/31/1987

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A	Not Applicable	

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Health Tech Management Service	For Profit	2/24/2002

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A	Not Applicable	

2. Changes in Ownership, Operation or Management

Check the box to the right if there were any changes in the ownership, operation, or management of the facility during the report period or since the last day of the Report Period. ☐
If checked, please explain in the box below and include effective dates.

3. Check the box to the right if your facility is part of a health care system ☐
Name:
City: **State:**

4. Check the box to the right if your hospital is a division or subsidiary of a holding company. ☐
Name:
City: **State:**

5. Check the box to the right if the hospital itself operates subsidiary corporations ☑
Name: Upson County Health Resources
City: Thomaston **State:** Ga

6. Check the box to the right if your hospital is a member of an alliance. ☐
Name:
City: **State:**

7. Check the box to the right if your hospital is a participant in a health care network ☑
Name: Secure Health
City: Macon **State:** Ga

8. Check the box to the right if the hospital has a policy or policies and a peer review process related to medical errors. ☑

9. Check the box to the right if the hospital owns or operates a primary care physician group practice. ☑

10a. Managed Care Information: Formal Written Contract
Does the hospital have a formal written contract that specifies the obligations of each party with each of the following? (check the appropriate boxes)

1. Health Maintenance Organization(HMO) ☑

2. Preferred Provider Organization(PPO) ☑

3. Physician Hospital Organization(PH0) ☐

4. Provider Service Organization(PSO) ☐

5. Other Managed Care or Prepaid Plan ☐

10b. Managed Care Information: Insurance Products
Check the appropriate boxes to indicate if any of the following insurance products have been developed by the hospital, health care system, network, or as a joint venture with an insurer:

Type of Insurance Product	Hospital	Health Care System	Network	Joint Venture with Insurer
Health Maintenance Organization	☐	☐	☐	☐
Preferred Provider Organization	☐	☐	☐	☐
Indemnity Fee-for-Service Plan	☐	☐	☐	☐
Another Insurance Product Not Listed Above	☐	☐	☐	☐

11. Owner or Owner Parent Based in Another State
If the owner or owner parent at Part C, Question 1(A&B) is an entity based in another state please report the location in which the entity is based. (City and State)

Part D : Inpatient Services

1. Utilization of Beds as Set Up and Staffed(SUS):

Please indicate the following information. Dod not include newborn and neonatal services. Do not include long-term care untits, such as Skilled Nursing Facility beds, if not licensed as hospital beds. If your facility is approved for LTCH beds report them below.

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
Obstetrics (no GYN, include LDRP)	7	350	984	350	984
Pediatrics (Non ICU)	5	463	1,859	463	1,859
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	7	81	151	81	151
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	28	1,477	5,833	1,477	5,833
Intensive Care	8	143	788	143	788
Psychiatry	12	189	0	189	0
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	0	0	0	0	0
Pediatric Physical Rehabilitation (0-17)	0	0	0	0	0
Burn Care	0	0	0	0	0
Swing Bed (Include All Utilization)	0	0	0	0	0
Long Term Care Hospital (LTCH)	0	0	0	0	0
SCU	20	712	2,926	712	2,926
	0	0	0	0	0
	0	0	0	0	0
Total	**87**	**3,415**	**12,541**	**3,415**	**12,541**

2. Race/Ethnicity

Please report admissions and inpatient days for the hospital by the following race and ethnicity categories. Exclude newborn and neonatal.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	1	3
Asian	2	6
Black/African American	953	3,502
Hispanic/Latino	10	25
Pacific Islander/Hawaiian	2	4
White	2,395	8,819
Multi-Racial	52	182
Total	**3,415**	**12,541**

3. Gender

Please report admissions and inpatient days by gender. Exclude newborn and neonatal.

Gender	Admissions	Inpatient Days
Male	1,408	7,645
Female	2,007	4,896
Total	**3,415**	**12,541**

4. Payment Source

Please report admissions and inpatient days by primary payment source. Exclude newborn and neonatal.

Primary Payment Source	Admissions	Inpatient Days
Medicare	1,950	7,469
Medicaid	687	2,541
Peachare	0	0
Third-Party	501	1,626
Self-Pay	277	905
Other	0	0

5. Discharges to Death

Report the total number of inpatient admissions discharged during the reporting period due to death.

113

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2018 (to the nearest whole dollar).

Service	Charge
Private Room Rate	1,122
Semi-Private Room Rate	1,122
Operating Room: Average Charge for the First Hour	10,333
Average Total Charge for an Inpatient Day	3,203

Part E : Emergency Department and Outpatient Services

1. Emergency Visits
Please report the number of emergency visits only.

27,145

2. Inpatient Admissions from ER
Please report inpatient admssions to the Hospital from the ER for emergency cases ONLY.

2,417

3. Beds Available
Please report the number of beds available in ER as of the last day of the report period.

21

4. Utilization by Specific type of ER bed or room for the report period.

Type of ER Bed or Room	Beds	Visits
Beds dedicated for Trauma	0	0
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	0	0
General Beds	21	27,145
	0	0
	0	0
	0	0
	0	0

5. Transfers
Please provide the number of Transfers to another institution from the Emergency Department.

437

6. Non-Emergency Visits
Please provide the number of Outpatient/Clinic/All Other Non-Emergency visits to the hospital.

27,145

7. Observation Visits/Cases
Please provide the total number of Observation visits/cases for the entire report period.

1,285

8. Diverted Cases
Please provide the number of cases your ED diverted while on Ambulance Diversion for the entire report period.

0

9. Ambulance Diversion Hours
Please provide the total number of Ambulance Diversion hours for your ED for the entire report period

0

10. Untreated Cases

Please provide the number of patients who sought care in your ED but who left without or before being treated. Do not include patients who were transferred or cases that were diverted.

755

Part F : Services and Facilities

1a. Services and Facilities

Please report services offered onsite for in-house and contract services as requested. Please reflect the status of the service during the report period. *(Use the blank lines to specify other services.)*

Site Codes
1 = In-House - Provided by the Hospital
2 = Contract - Provided by a contractor but onsite
3 = Not Applicable

Status Codes
1 = On-Going
2 = Newly Initiated
3 = Discontinued
4 = Not Applicable

Service/Facilities	Site Code	Service Status
Podatric Services	3	4
Renal Dialysis	2	1
ESWL	2	1
Billiary Lithotropter	3	4
Kidney Transplants	3	4
Heart Transplants	3	4
Other-Organ/Tissues Transplants	3	4
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnositic	1	1
Positron Emission Tomography (PET)	1	1
Radioisotope, Therapeutic	3	4
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	1	1
Respiratory Therapy	1	1
Occupational Therapy	2	1
Physical Therapy	2	1
Speech Pathology Therapy	2	1
Gamma Ray Knife	3	4
Audiology Services	3	4
HIV/AIDS Diagnostic Treatment/Services	3	4
Ambulance Services	3	4
Hospice	3	4
Respite Care Services	3	4
Ultrasound/Medical Sonography	1	1
	0	0
	0	0
	0	0

1b. Report Period Workload Totals

Please report the workload totals for in-house and contract services as requested. The number of units should equal the number of machines.

Category	Total
Number of Podiatric Patients	0
Number of Dialysis Treatments	94
Number of ESWL Patients	87
Number of ESWL Procedures	87
Number of ESWL Units	1
Number of Biliary Lithotripter Procedures	0
Number of Biliary Lithotripter Units	1
Number of Kidney Transplants	0
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	0
Number of Diagnostic X-Ray Procedures	20,866
Number of CTS Units (machines)	2
Number of CTS Procedures	10,403
Number of Diagnostic Radioisotope Procedures	1,019
Number of PET Units (machines)	1
Number of PET Procedures	36
Number of Therapeautic Radioisotope Procedures	0
Number of Number of MRI Units	1
Number of Number of MRI Procedures	1,513
Number of Chemotherapy Treatments	80
Number of Respiratory Therapy Treatments	55,228
Number of Occupational Therapy Treatments	0
Number of Physical Therapy Treatments	49,372
Number of Speech Pathology Patients	274
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	0
Number of HIV/AIDS Diagnostic Procedures	0
Number of HIV/AIDS Patients	0
Number of Ambulance Trips	0
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	2
Number of Ultrasound/Medical Sonography Procedures	4,069
Number of Treatments, Procedures, or Patients (Other 1)	0
Number of Treatments, Procedures, or Patients (Other 2)	0
Number of Treatments, Procedures, or Patients (Other 3)	0

2. Medical Ventilators

Provide the number of computerized/mechanical Ventilator Machines that were in use or available

for immediate use as of the last day of the report period (12/31).

21

3. Robotic Surgery System

Please report the number of units, number of procedures, and type of unit(s).

# Units	# Procedures	Type of Unit(s)
0	0	0

Part G : Facility Workforce Information

1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2018. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2018.

Profession	Profession	Profession	Profession
Licensed Physicians	0.00	0.00	0.00
Physician Assistants Only (not including Licensed Physicians)	0.00	0.00	0.00
Registered Nurses (RNs-Advanced Practice*)	217.00	15.00	0.00
Licensed Practical Nurses (LPNs)	41.00	4.00	0.00
Pharmacists	6.00	0.00	0.00
Other Health Services Professionals*	164.00	14.00	0.00
Administration and Support	23.00	1.00	0.00
All Other Hospital Personnel (not included above)	268.00	13.00	0.00

2. Filling Vacancies

Using the drop-down menus, please select the average time needed during the past six months to fill each type of vacant position.

Type of Vacancy	Average Time Needed to Fill Vacancies
Physician's Assistants	61-90 Days
Registered Nurses (RNs-Advance Practice)	31-60 Days
Licensed Practical Nurses (LPNs)	30 Days or Less
Pharmacists	Not Applicable
Other Health Services Professionals	30 Days or Less
All Other Hospital Personnel (not included above)	30 Days or Less

3. Race/Ethnicity of Physicians

Please report the number of physicians with admitting privileges by race.

Race/Ethnicity	Number of Physicians
American Indian/Alaska Native	6
Asian	2
Black/African American	10
Hispanic/Latino	0
Pacific Islander/Hawaiian	1
White	24
Multi-Racial	0

4. Medical Staff

Please report the number of active and associate/provisional medical staff for the following specialty categories. Keep in mind that physicians may be counted in more than one specialty. Please

indicate whether the specialty group(s) is hospital-based. Also, indicate how many of each medical specialty are enrolled as providers in Georgia Medicaid/PeachCare for Kids and/or the Public Employee Health Benefit Plans (PEHB-State Health Benefit Plant and/or Board of Regents Benefit Plan).

Medical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
General and Family Practice	7	☑	0	0
General Internal Medicine	12	☑	0	0
Pediatricians	6	☑	0	0
Other Medical Specialties	2	☑	0	0

Surgical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
Obstetrics	9	☑	0	0
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	10	☑	0	0
Ophthalmology Surgery	1	☐	0	0
Orthopedic Surgery	1	☑	0	0
Plastic Surgery	0	☐	0	0
General Surgery	3	☑	0	0
Thoracic Surgery	0	☐	0	0
Other Surgical Specialties	2	☐	0	0

Other Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
Anesthesiology	3	☑	0	0
Dermatology	0	☐	0	0
Emergency Medicine	1	☑	0	0
Nuclear Medicine	0	☐	0	0
Pathology	1	☑	0	0
Psychiatry	2	☑	0	0
Radiology	3	☑	0	0
	0	☐	0	0
	0	☐	0	0
	0	☐	0	0

5a. Non-Physicians

Please report the number of professionals for the categories below. Exclude any hospital-based staff reported in Part G, Questions 1,2,3 and 4 above.

Profession	Number
Dentists (include oral surgeions) with Admitting Privleges	0
Podiatrists	0
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	21

5b. Name of Other Professions

Please provide the names of professions classified as "Other Staff Affiliates with Clinical Privileges" above.

Nurse Practioners, Physician Assistants, CRNA's

Comments and Suggestions:

Part H : Physician Name and License Number

1. Physicians on Staff

Please report the full name and license number of each physician on staff. **(Due to the large number of entries, this section has been moved to a separate PDF file.)**

Part I : Patient Origin Table

1. Patient Origin

Please report the county of origin for the inpatient admissions or discharges excluding newborns (except surgical services should include outpatients only).

Inpat=Inpatient Services
Surg=Outpatient Surgical
OB=Obstetric
P18+=Acute psychiatric adult 18 and over
P13-17=Acute psychiatric adolescent 13-17
P0-12=Acute psychiatric children 12 and under
Rehab=Inpatient Rehabilitation
S18+=Substance abuse adult 18 and over
S13-17=Substance abuse adolescent 13-17
E18+=Extended care adult 18 and over
E13-17=Extended care adolescent 13-17
E0-12=Extended care children 0-12
LTCH=Long Term Care Hospital

County	Inpat	Surg	OB	P18+	P13-17	P0-12	S18+	S13-17	E18+	E13-17	E0-12	LTCH	Rehab
Berrien	1	0	0	0	0	0	0	0	0	0	0	0	0
Bibb	14	14	1	3	0	0	0	0	0	0	0	0	0
Bleckley	1	0	0	0	0	0	0	0	0	0	0	0	0
Butts	14	17	2	4	0	0	0	0	0	0	0	0	0
Carroll	7	0	1	6	0	0	0	0	0	0	0	0	0
Chatham	1	0	0	0	0	0	0	0	0	0	0	0	0
Chattooga	2	0	0	1	0	0	0	0	0	0	0	0	0
Cherokee	2	0	0	1	0	0	0	0	0	0	0	0	0
Clayton	1	4	0	0	0	0	0	0	0	0	0	0	0
Cobb	2	1	0	1	0	0	0	0	0	0	0	0	0
Columbia	2	0	0	1	0	0	0	0	0	0	0	0	0
Coweta	0	4	0	0	0	0	0	0	0	0	0	0	0
Crawford	25	9	1	3	0	0	0	0	0	0	0	0	0
Crisp	4	0	0	2	0	0	0	0	0	0	0	0	0
Dawson	1	0	0	0	0	0	0	0	0	0	0	0	0
Decatur	7	0	0	0	0	0	0	0	0	0	0	0	0
DeKalb	7	0	0	2	0	0	0	0	0	0	0	0	0
Dooly	2	0	0	1	0	0	0	0	0	0	0	0	0
Fayette	4	1	0	3	0	0	0	0	0	0	0	0	0
Floyd	2	0	0	2	0	0	0	0	0	0	0	0	0
Fulton	11	1	1	2	0	0	0	0	0	0	0	0	0
Glynn	2	0	0	1	0	0	0	0	0	0	0	0	0
Gordon	1	0	0	1	0	0	0	0	0	0	0	0	0
Gwinnett	7	0	0	3	0	0	0	0	0	0	0	0	0
Haralson	4	0	0	2	0	0	0	0	0	0	0	0	0
Harris	13	15	2	3	0	0	0	0	0	0	0	0	0
Heard	2	2	0	1	0	0	0	0	0	0	0	0	0

Henry	12	15	1	0	0	0	0	0	0	0	0	0	0
Houston	6	2	1	3	0	0	0	0	0	0	0	0	0
Jasper	1	3	0	0	0	0	0	0	0	0	0	0	0
Jones	0	1	0	0	0	0	0	0	0	0	0	0	0
Lamar	362	328	56	7	0	0	0	0	0	0	0	0	0
Laurens	1	0	0	0	0	0	0	0	0	0	0	0	0
Macon	3	0	0	1	0	0	0	0	0	0	0	0	0
Marion	7	4	0	0	0	0	0	0	0	0	0	0	0
Meriwether	241	104	38	18	0	0	0	0	0	0	0	0	0
Monroe	57	63	6	2	0	0	0	0	0	0	0	0	0
Muscogee	15	2	1	12	0	0	0	0	0	0	0	0	0
Newton	0	1	0	0	0	0	0	0	0	0	0	0	0
Oconee	0	2	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	28	7	5	3	0	0	0	0	0	0	0	0	0
Paulding	1	0	0	0	0	0	0	0	0	0	0	0	0
Peach	6	1	1	3	0	0	0	0	0	0	0	0	0
Pike	388	323	31	20	0	0	0	0	0	0	0	0	0
Polk	2	0	0	1	0	0	0	0	0	0	0	0	0
Pulaski	1	0	0	0	0	0	0	0	0	0	0	0	0
Rabun	2	1	0	1	0	0	0	0	0	0	0	0	0
Randolph	0	1	0	0	0	0	0	0	0	0	0	0	0
Richmond	2	1	0	1	0	0	0	0	0	0	0	0	0
Rockdale	1	1	0	0	0	0	0	0	0	0	0	0	0
Schley	2	1	0	1	0	0	0	0	0	0	0	0	0
Spalding	64	157	15	12	0	0	0	0	0	0	0	0	0
Sumter	0	2	0	0	0	0	0	0	0	0	0	0	0
Talbot	53	33	6	3	0	0	0	0	0	0	0	0	0
Taylor	99	53	12	1	0	0	0	0	0	0	0	0	0
Treutlen	0	1	0	0	0	0	0	0	0	0	0	0	0
Troup	7	3	2	1	0	0	0	0	0	0	0	0	0
Upson	1,913	1,279	164	55	0	0	0	0	0	0	0	0	0
Whitfield	2	0	0	1	0	0	0	0	0	0	0	0	0
Total	**3,415**	**2,457**	**347**	**189**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Surgical Services Addendum

Part A : Surgical Services Utilization

1. Surgery Rooms in the OR Suite

Please report the Number of Surgery Rooms, (as of the end of the report period). Report only the rooms in CON-Approved Operating Room Suites pursuant to Rule 111-2-2-.40 and 111-8-48-.28.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Rooms
General Operating	0	0	4
Cystoscopy (OR Suite)	0	0	1
Endoscopy (OR Suite)	0	0	0
	0	0	0
Total	**0**	**0**	**5**

2. Procedures by Type of Room

Please report the number of procedures by type of room.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Inpatient Rooms	Shared Outpatient Rooms
General Operating	0	0	1,149	4,478
Cystoscopy	0	0	54	191
Endoscopy	0	0	209	636
	0	0	0	0
Total	**0**	**0**	**1,412**	**5,305**

3. Patients by Type of Room

Please report the number of patients by type of room.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Inpatient Rooms	Shared Outpatient Rooms
General Operating	0	0	1,149	4,478
Cystoscopy	0	0	54	191
Endoscopy	0	0	209	636
	0	0	0	0
Total	**0**	**0**	**1,412**	**5,305**

Part B : Ambulatory Patient Race/Ethnicity, Age, Gender and Payment Source

1. Race/Ethnicity of Ambulatory Patients

Please report the total number of ambulatory patients for both dedicated outpatient and shared room environment.

Race/Ethnicity	Number of Ambulatory Patients
American Indian/Alaska Native	4
Asian	4
Black/African American	614
Hispanic/Latino	8
Pacific Islander/Hawaiian	1
White	1,786
Multi-Racial	40
Total	**2,457**

2. Age Grouping

Please report the total number of ambulatory patients by age grouping.

Age of Patient	Number of Ambulatory Patients
Ages 0-14	404
Ages 15-64	1,548
Ages 65-74	346
Ages 75-85	147
Ages 85 and Up	12
Total	**2,457**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	1,081
Female	1,376
Total	**2,457**

4. Payment Source

Please report the total number of ambulatory patients by payment source.

Primary Payment Source	Number of Patients
Medicare	562
Medicaid	682
Third-Party	1,074
Self-Pay	139

Perinatal Services Addendum

Part A : Obstetrical Services Utilization

Please report the following obstetrical services information for the report period. Include all deliveries and births in any unit of th hospital or anywhere on its grounds.

1. Number of Delivery Rooms: 0

2. Number of Birthing Rooms: 0

3. Number of LDR Rooms: 0

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 146

6. Total Live Births: 347

7. Total Births (Live and Late Fetal Deaths): 350

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 350

Part B : Newborn and Neonatal Nursery Services

1. Nursery Services

Please Report the following newborn and neonatal nursery information for the report period.

Type of Nursery	Set-Up and Staffed Beds/Station	Neonatal Admissions	Inpatient Days	Transfers within Hospital
Normal Newborn (Basic)	0	325	831	0
Specialty Care (Intermediate Neonatal Care)	0	22	87	0
Subspecialty Care (Intensive Neonatal Care)	0	0	0	0

Part C : Obstetrical Charges and Utilization by Mother's Race/Ethnicity and Age

1. Race/Ethnicity

Please provide the number of admissions and inpatient days for mothers by the mother's race using race/ethnicity classifications.

Race/Ethnicity	Admissions by Mother's Race	Inpatient Days
American Indian/Alaska Native	1	3
Asian	0	0
Black/African American	138	358
Hispanic/Latino	5	14
Pacific Islander/Hawaiian	0	0
White	190	531
Multi-Racial	13	12
Total	**347**	**918**

2. Age Grouping
Please provide the number of admissions by the following age groupings.

Age of Patient	Number of Admissions	Inpatient Days
Ages 0-14	1	2
Ages 15-44	346	916
Ages 45 and Up	0	0
Total	**347**	**918**

3. Average Charge for an Uncomplicated Delivery
Please report the average hospital charge for an uncomplicated delivery(CPT 59400)

$8,159.00

4. Average Charge for a Premature Delivery
Please report the average hospital charge for a premature delivery.

$16,164.00

LTCH Addendum

Part A : General Information

1a. Accreditation Check the box to the right if your Long Term Care Hospital is accredited. ☐
If you checked the box for yes, please specify the agency that accredits your facility in the space below.

1b. Level/Status of Accreditation
Please provide your organization's level/status of accreditation.

2. Number of Licensed LTCH Beds: 0

3. Permit Effective Date:

4. Permit Designation:

5. Number of CON Beds: 0

6. Number of SUS Beds: 0

7. Total Patient Days: 0

8. Total Discharges: 0

9. Total LTCH Admissions: 0

Part B : Utilization by Race, Age, Gender and Payment Source

1. Race/Ethnicity
Please provide the number of admissions and inpatient days using the following race/ethnicity classifications.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0
Total	**0**	**0**

2. Age of LTCH Patient

Please provide the number of admissions and inpatient days by the following age groupings.

Age of Patient	Admissions	Inpatient Days
Ages 0-64	0	0
Ages 65-74	0	0
Ages 75-84	0	0
Ages 85 and Up	0	0
Total	**0**	**0**

3. Gender

Please provide the number of admissions and inpatient days by the following gender classifications.

Gender of Patient	Admissions	Inpatient Days
Male	0	0
Female	0	0
Total	**0**	**0**

4. Payment Source

Please indicate the number of patients by the payment source. Please note that individuals may have multiple payment sources.

Primary Payment Source	Number of Patients	Inpatient Days
Medicare	0	0
Third-Party	0	0
Self-Pay	0	0
Other	0	0

Psychiatric/Substance Abuse Services Addendum

Part A : Psychiatric and Substance Abuse Data by Program

1. Beds

Please report the number of beds as of the last day of the report period. Report beds only for officially recognized programs. Use the blank row to report combined beds. For combined bed programs, please report each of the combined bed programs and the number of combined beds. Indicate the combined programs using letters A through H, for example,"AB"

Patient Type	Distribution of CON-Authorized Beds	Set-Up and Staffed Beds
A- General Acute Psychiatric Adults 18 and over	18	18
B- General Acute Psychiatric Adolescents 13-17	0	0
C- General Acute Psychiatric Children 12 and under	0	0
D- Acute Substance Abuse Adults 18 and over	0	0
E- Acute Substance Abuse Adolescents 13-17	0	0
F-Extended Care Adults 18 and over	0	0
G- Extended Care Adolescents 13-17	0	0
H- Extended Care Adolescents 0-12	0	0
	0	0

2. Admissions, Days, Discharges, Accreditation

Please report the following utilization for the report period. Report only for officially recognized programs.

Program Type	Admissions	Inpatient Days	Discharges	Discharge Days	Average Charge Per Patient Day	Check if the Program is JCAHO Accredited
General Acute Psychiatric Adults 18 and over	189	2,384	189	2,384	31,459	☑
General Acute Psychiatric Adolescents 13-17	0	0	0	0	0	☐
General Acute Psychiatric Children 12 and Under	0	0	0	0	0	☐
Acute Substance Abuse Adults 18 and over	0	0	0	0	0	☐
Acute Substance Abuse Adolescents 13-17	0	0	0	0	0	☐
Extended Care Adults 18 and over	0	0	0	0	0	☐
Extended Care Adolescents 13-17	0	0	0	0	0	☐
Extended Care Adolescents 0-12	0	0	0	0	0	☐

Part B : Psych/SA Utilization by Race/Ethnicity, Gender, and Payment Source

1. Race/Ethnicity

Please provide the number of admissions and inpatient days using the following race/ethnicity classifications.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	44	687
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	130	1,497
Multi-Racial	15	200
Total	**189**	**2,384**

2. Gender

Please provide the number of admissions and inpatient days by the following gender classifications.

Gender of Patient	Admissions	Inpatient Days
Male	82	920
Female	107	1,464
Total	**189**	**2,384**

3. Payment Source

Please indicate the number of patients by the following payment sources. Please note that individuals may have multiple payment sources.

Primary Payment Source	Number of Patients	Inpatient Days
Medicare	152	1,929
Medicaid	24	320
Third Party	9	108
Self-Pay	4	27
PeachCare	0	0

Georgia Minority Health Advisory Council Addendum

Because of Georgia's racial and ethnic diversity, and a dramatic increase in segments of the population with Limited English Proficiency, the Georgia Minority Health Advisory Council is working with the Department of Community Health to assess our health systems' ability to provide Culturally and Linguistically Appropriate Services (CLAS) to all segments of our population. We appreciate your willingness to provide information on the following questions:

1. Do you have paid medical interpreters on staff? *(Check the box, if yes.)* ☐
If you checked yes, how many? (FTE's)
What languages do they interpret?

2. When a paid medical interpreter is not available for a limited-English proficiency patient, what alternative mechanisms do you use to assure the provision of Linguistically Appropriate Services? *(Check all that apply)*

Bilingual Hospital Staff Member ☐	Bilingual Member of Patient's Family ☐
Community Volunteer Intrepreter ☐	Telephone Interpreter Service ☑
Refer Patient to Outside Agency ☑	Other (please describe): ☐

3. Please complete the following grid to show the proportion of patients you serve who prefer speaking various languages (name the 3 most common non-English languages spoken.)

Top 3 most common non-English languages spoken by your patients	Percent of patients for whom this is their preferred language	# of physicians on staff who speak this language	# of nurses on staff who speak this language	# of other employed staff who speak this language
English	99.5	27	121	0
Spanish	0.5	1	1	0
		0	0	0

4. What **training** have you provided to your staff to assure cultural competency and the provision of **Culturally and Linguistically Appropriate Services (CLAS)** to your patients?

5. What is the most urgent tool or resource you need in order to increase your ability to provide **Culturally and Linguistically Appropriate Services (CLAS)** to your patients?

6. In what languages are the signs written that direct patients within your facility?

1. English
2.
3.
4.

7. If an uninsured patient visits your emergency department, is there a community health center, federally-qualified health center, free clinic, or other reduced-fee safety net clinic nearby to which you could refer that patient in order to provide him or her an affordable primary care medical home regardless of ability to pay? *(Check the box, if yes)* ☑
If you checked yes, what is the name and location of that health care center or clinic?

South West Georgia Healthcare, Inc. operates:
Thomaston Convenient Care (Thomaston) & Butler Medical Center (Butler)
Your Town Health operates Community Health Centers in Meriwether Pike and Lamar.

Comprehensive Inpatient Physical Rehabilitation Addendum

Part A : Rehab Utilization by Race/Ethnicity, Gender, and Payment Source

1. Admissions and Days of Care by Race

Please report the number of inpatient physical rehabilitation admissions and inpatient days for the hospital by the following race and ethnicity categories.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0

2. Admissions and Days of care by Gender

Please report the number of inpatient physical rehabilitation admissions and inpatient days by gender.

Gender	Admissions	Inpatient Days
Male	0	0
Female	0	0

3. Admissions and Days of Care by Age Cohort

Please report the number of inpatient physical rehabilitation admissions and inpatient days by age cohort.

Gender	Admissions	Inpatient Days
0-17	0	0
18-64	0	0
65-84	0	0
85 Up	0	0

Part B : Referral Source

1. Referral Source

Please report the number of inpatient physical rehabilitation admissions during the report period from each of the following sources.

Referral Source	Admissions
Acute Care Hospital/General Hospital	0
Long Term Care Hospital	0
Skilled Nursing Facility	0
Traumatic Brain Injury Facility	0

	0

1. Payers

Please report the number of inpatient physical rehabilitation admissions by each of the following payer categories.

Primary Payment Source	Admissions
Medicare	0
Third Party/Commercial	0
Self Pay	0
Other	0

2. Uncompensated Indigent and Charity Care

Please report the number of inpatietn physical rehabilitation patients qualifying as uncompensated indigent or charity care

0

Part D : Admissions by Diagnosis Code

1. Admissions by Diagnosis Code

Please report the number of inpatient physical rehabilitation admissions by the "CMS 13" diagnosis of the patient listed below.

Diagnosis	Admissions
1. Stroke	0
2. Brain Injury	0
3. Amputation	0
4. Spinal Cord	0
5. Fracture of the femur	0
6. Neurological disorders	0
7. Multiple Trauma	0
8. Congenital deformity	0
9. Burns	0
10. Osteoarthritis	0
11. Rheumatoid arthritis	0
12. Systemic vasculidities	0
13. Joint replacement	0
All Other	0

Electronic Signature

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Executive Officer or Executive Director (principal officer) of the facility. The signature can be completed only AFTER all survey data has been finalized. By law, the signatory is attesting under penalty of law that the information is accurate and complete.

I state, certify and attest that to the best of my knowledge upon conducting due diligence to assure the accuracy and

completeness of all data, and based upon my affirmative review of the entire completed survey, this completed survey contains no untrue statement, or incaccurate data, nor omits requested material information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I further understand that inaccurate, incomplete or omitted data could lead to sanctions against me or my facility. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Authorized Signature: Suzanne Streetman

Date: 3/15/2019

Title: Chief Regulatory Affairs Officer

Comments:

The number of SUS Beds was entered. Please let me know if there is anything else missing.

State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2017

DSH Version 5.20 11/1/2017

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2016	06/30/2017

2. Select Your Facility from the Drop-Down Menu Provided: UPSON REGIONAL MEDICAL CENTER

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	01/01/2017	12/31/2017
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES

	Data
6. Medicaid Provider Number:	000001988A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110002

B. DSH OB Qualifying Information

Questions 1-3, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the DSH Examination Year:

	DSH Examination Year (07/01/16 - 06/30/17)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	4/1/1951

Questions 4-6, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the Interim DSH Payment Year:

	DSH Payment Year (07/01/18 - 06/30/19)
4. Does the hospital have at least two obstetricians who have staff privileges at the hospital who have agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes

List the Names of the two Obstetricians (or case of rural hospital, Physicians) who have agreed to perform OB services:

Dr. Nicolas Psomiadis
Dr. L. Joy Baker

5. Is the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
6. Is the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for DSH Year 07/01/2016 - 06/30/2017**
   (Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

$ 841,142

Certification:

	Answer
1. **Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year? Matching the federal share with an IGT/CPE is not a basis for answering this question "no". If your hospital was not allowed to retain 100% of its DSH payments, please explain what circumstances were present that prevented the hospital from retaining its payments.**	Yes

Explanation for "No" answers:

The following certification is to be completed by the hospital's CEO or CFO:

I hereby certify that the information in Sections A, B, C, D, E, F, G, H, I, J, K and L of the DSH Survey files are true and accurate to the best of our ability, and supported by the financial and other records of the hospital. All Medicaid eligible patients, including those who have private insurance coverage, have been reported on the DSH survey regardless of whether the hospital received payment on the claim. I understand that this information will be used to determine the Medicaid program's compliance with federal Disproportionate Share Hospital (DSH) eligibility and payments provisions. Detailed support exists for all amounts reported in the survey. These records will be retained for a period of not less than 5 years following the due date of the survey, and will be made available for inspection when requested.

Hospital CEO or CFO Signature	Title	Date
	CFO	11/20/2018

Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail
John Williams	706-647-8111	jhwilliams@urmc.org

Contact Information for individuals authorized to respond to inquiries related to this survey:

Hospital Contact:	
Name	John Williams
Title	CFO
Telephone Number	706-647-8111
E-Mail Address	jhwilliams@urmc.org
Mailing Street Address	801 West Gordon St.
Mailing City, State, Zip	Thomaston, GA 30286

Outside Preparer:	
Name	Jeff Askey, CPA
Title:	Partner
Firm Name:	Draffin & Tucker, LLP
Telephone Number	229-883-7878
E-Mail Address	jcreamer@draffin-tucker.com

DSH Version 7.25 5/3/2018

D. General Cost Report Year Information 1/1/2017 - 12/31/2017

The following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and select "Yes" or "No" to either agree or disagree with the accuracy of the information. If you disagree with one of these items, please provide the correct information along with supporting documentation when you submit your survey.

1. Select Your Facility from the Drop-Down Menu Provided: UPSON REGIONAL MEDICAL CENTER

	1/1/2017 through 12/31/2017		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		

3. Status of Cost Report Used for this Survey (Should be audited if available): 1 - As Submitted

3a. Date CMS processed the HCRIS file into the HCRIS database: 6/29/2018

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	UPSON REGIONAL MEDICAL CENTER	Yes	
5. Medicaid Provider Number:	000001988A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110002	Yes	
8a. Owner/Operator (Private, State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
8b. DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Non-Small Rural	Yes	

Out-of-State Medicaid Provider Number. List all states where you had a Medicaid provider agreement during the cost report year:

	State Name	Provider No.
9. State Name & Number		
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (01/01/2017 - 12/31/2017)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ -
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -
4. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**	$-
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ -
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -
7. **Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**	$-
8. **Out-of-State DSH Payments (See Note 2)**	$ -

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 37,099	$ 459,658	$496,757
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 382,805	$ 2,914,726	$3,297,531
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)	$419,904	$3,374,384	$3,794,288
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	8.84%	13.62%	13.09%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** No

Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services	$ -
15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services	$ -
16. Total Medicaid managed care non-claims payments (see question 13 above) received	$-

Note 1: Subtitle B - Miscellaneous Provision, Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 provides federal reimbursement for emergency health services furnished to undocumented aliens. If your hospital received these funds during any cost report year covered by the survey, they must be reported here. If you can document that a portion of the payment received is related to non-hospital services (physician or ambulance services), report that amount in the section titled "Section 1011 Payments Related to Non-Hospital Services." Otherwise report 100 percent of the funds you received in the section related to hospital services.

Note 2: Report any DSH payments your hospital received from a state Medicaid program (other than your home state). In-state DSH payments will be reported directly from the Medicaid program and should not be included in this section of the survey.

F. MIUR / LIUR Qualifying Data from the Cost Report (01/01/2017 - 12/31/2017)

F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	10,908 (See Note in Section F-3, below)

F-2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (Used in Low-Income Utilization Ratio (LIUR) Calculation):

2.	Inpatient Hospital Subsidies	-
3.	Outpatient Hospital Subsidies	-
4.	Unspecified I/P and O/P Hospital Subsidies	-
5.	Non-Hospital Subsidies	-
6.	Total Hospital Subsidies	$ -
7.	Inpatient Hospital Charity Care Charges	4,816,656
8.	Outpatient Hospital Charity Care Charges	9,164,290
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 13,980,946

F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (W/S G-2 and G-3 of Cost Report)

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

		Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$16,835,456.00			$ 12,488,052	$ -	$ -	$ 4,347,404
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$0.00			$ -	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$68,683,271.00	$183,714,254.00		$ 50,947,253	$ 136,273,891	$ -	$ 65,176,381
20.	Outpatient Services		$0.00			$ -	$ -	$ -
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$0.00			$ -	
26.	Other	$906,604.00	$16,007,402.00	$0.00	$ 672,492	$ 11,873,825	$ -	$ 4,367,688
27.	Total	$ 86,425,331	$ 199,721,656	$ -	$ 64,107,797	$ 148,147,717	$ -	$ 73,891,473
28.	Total Hospital and Non Hospital		Total from Above	$ 286,146,987		Total from Above	$ 212,255,514	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	286,146,987	Total Contractual Adj. (G-3 Line 2)	212,255,514
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
35.	Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"			-	
35.	Adjusted Contractual Adjustments				212,255,514

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2017-12/31/2017) | UPSON REGIONAL MEDICAL CENTER

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 9,114,664	$ -	$ -	$0.00	$ 9,114,664	7,393	$7,840,283.00		$ 1,232.88
2	03100 INTENSIVE CARE UNIT	$ 4,199,638	$ -	$ -		$ 4,199,638	3,749	$7,992,586.00		$ 1,120.20
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 955,430	$ -	$ -		$ 955,430	1,053	$1,002,587.00		$ 907.34
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 14,269,732	$ -	$ -	$ -	$ 14,269,732	12,195	$ 16,835,456		
19	Weighted Average									$ 1,170.13

Line #			*Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8*	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*	*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Observation Data (Non-Distinct)									
20	09200	Observation (Non-Distinct)	1,287	-	-	$ 1,586,717	$165,307.00	$1,765,659.00	$ 1,930,966	0.821722

Line #			*Cost Report Worksheet B, Part I, Col. 26*	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):										
21	5000	OPERATING ROOM	$6,301,092.00	$ -	$0.00		$ 6,301,092	$18,570,803.00	$24,108,414.00	$ 42,679,217	0.147638
22	5100	RECOVERY ROOM	$2,038,977.00	$ -	$0.00		$ 2,038,977	$2,504,723.00	$6,172,678.00	$ 8,677,401	0.234976
23	5200	DELIVERY ROOM & LABOR ROOM	$2,057,485.00	$ -	$0.00		$ 2,057,485	$1,719,759.00	$504,414.00	$ 2,224,173	0.925056
24	5300	ANESTHESIOLOGY	$186,432.00	$ -	$0.00		$ 186,432	$724,071.00	$1,644,747.00	$ 2,368,818	0.078703
25	5400	RADIOLOGY-DIAGNOSTIC	$4,784,357.00	$ -	$0.00		$ 4,784,357	$5,881,745.00	$51,617,161.00	$ 57,498,906	0.083208
26	5600	RADIOISOTOPE	$600,356.00	$ -	$0.00		$ 600,356	$230,149.00	$2,976,919.00	$ 3,207,068	0.187198
27	5900	CARDIAC CATHETERIZATION	$558,534.00	$ -	$0.00		$ 558,534	$902,844.00	$2,714,667.00	$ 3,617,511	0.154397
28	6000	LABORATORY	$4,977,407.00	$ -	$0.00		$ 4,977,407	$6,205,134.00	$20,576,814.00	$ 26,781,948	0.185849
29	6200	WHOLE BLOOD & PACKED RED BLOOD CELL	$279,355.00	$ -	$0.00		$ 279,355	$1,201,527.00	$737,530.00	$ 1,939,057	0.144067

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2017-12/31/2017) UPSON REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
30	6500 RESPIRATORY THERAPY	$2,235,632.00	$ -	$3,257.00		$ 2,238,889	$6,793,115.00	$4,894,318.00	$ 11,687,433	0.191564
31	6600 PHYSICAL THERAPY	$2,574,983.00	$ -	$0.00		$ 2,574,983	$2,117,720.00	$7,008,432.00	$ 9,126,152	0.282154
32	6900 ELECTROCARDIOLOGY	$1,103,921.00	$ -	$0.00		$ 1,103,921	$1,348,916.00	$5,956,981.00	$ 7,305,897	0.151100
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$3,346,089.00	$ -	$0.00		$ 3,346,089	$4,112,854.00	$5,215,823.00	$ 9,328,677	0.358688
34	7200 IMPL. DEV. CHARGED TO PATIENTS	$1,703,406.00	$ -	$0.00		$ 1,703,406	$3,325,622.00	$4,358,333.00	$ 7,683,955	0.221683
35	7300 DRUGS CHARGED TO PATIENTS	$3,771,452.00	$ -	$0.00		$ 3,771,452	$9,341,797.00	$14,679,391.00	$ 24,021,188	0.157005
36	7400 RENAL DIALYSIS	$212,023.00	$ -	$0.00		$ 212,023	$551,246.00	$27,489.00	$ 578,735	0.366356
37	9100 EMERGENCY	$6,306,066.00	$ -	$0.00		$ 6,306,066	$2,985,939.00	$28,754,484.00	$ 31,740,423	0.198676
38		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
39		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
40		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
41		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
42		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
43		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
44		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
45		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
46		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
47		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
48		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
49		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
50		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
51		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
52		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
53		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
54		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
55		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
56		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
57		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
58		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
59		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
60		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
61		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
62		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
63		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
64		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
65		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
66		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
67		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
68		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
69		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
70		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
71		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
72		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
73		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
74		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
75		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
76		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
77		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
78		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
79		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
80		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
81		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
82		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
83		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
84		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
85		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
86		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
87		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
88		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
89		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2017-12/31/2017) UPSON REGIONAL MEDICAL CENTER

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
90			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
91			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
92			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
93			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
94			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
95			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
96			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
97			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
98			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
99			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
100			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
101			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
102			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
103			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
104			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
105			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
106			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
107			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
108			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
109			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
110			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
111			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
112			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
113			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
114			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
115			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
116			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
117			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
118			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
119			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
120			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
121			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
122			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
123			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
124			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
125			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
126		**Total Ancillary**	$ 43,037,567	$ -	$ 3,257		$ 43,040,824	$ 68,683,271	$ 183,714,254	$ 252,397,525	
127		**Weighted Average**									0.176814
128		**Sub Totals**	$ 57,307,299	$ -	$ 3,257		$ 57,310,556	$ 85,518,727	$ 183,714,254	$ 269,232,981	
129		NF, SNF, and Swing Bed Cost for Medicaid *(Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)*					$0.00				
130		NF, SNF, and Swing Bed Cost for Medicare *(Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)*					$0.00				
131		NF, SNF, and Swing Bed Cost for Other Payors *(Hospital must calculate. Submit support for calculation of cost.)*									
131.01		Other Cost Adjustments (support must be submitted)									
132		**Grand Total**					$ 57,310,556				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.00%				

* Note A - Final cost-to-charge ratios should include teaching cost. Only enter Intern & Resident costs if it was removed in Column 25 of Worksheet B, Pt. I of the cost report you are using.

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data

Cost Report Year (01/01/2017-12/31/2017 | UPSON REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Routine Cost Centers (from Section G):			Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	$ 1,232.88		598		905		642		62		424		2,207		43.15%
2	03100 INTENSIVE CARE UNIT	$ 1,120.20		553		95		404		77		246		1,129		36.73%
3	03200 CORONARY CARE UNIT	$ -												-		
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -												-		
6	03500 OTHER SPECIAL CARE UNIT	$ -												-		
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 907.34		37		804				3		7		844		81.01%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			Total Days	1,188		1,804		1,046		142		677		4,180		39.89%
19	Total Days per PS&R or Exhibit Detail			1,188		1,804		1,046		142		677				
20	Unreconciled Days (Explain Variance			-		-		-		-		-				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 1,900,499		$ 1,917,973		$ 1,852,409		$ 251,878		$ 993,209		$ 5,922,759		41.15%
21.01	Calculated Routine Charge Per Dien			$ 1,599.75		$ 1,063.18		$ 1,770.95		$ 1,773.79		$ 1,467.07		$ 1,416.93		
	Ancillary Cost Centers (from W/S C) (from Section G):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	
22	09200 Observation (Non-Distinct		0.821722	22,309	324,288	17,800	306,709	30,801	503,694	1,380	5,632	18,748	375,970	$ 72,290	$ 1,140,323	83.34%
23	5000 OPERATING ROOM		0.147638	1,529,992	2,283,240	2,375,550	6,242,993	1,574,938	3,268,851	111,511	85,807	1,193,320	1,742,588	$ 5,591,991	$ 11,880,891	47.85%
24	5100 RECOVERY ROOM		0.234976	251,408	404,532	-	-	-	-	-	-	-	-	$ 251,408	$ 404,532	7.56%
25	5200 DELIVERY ROOM & LABOR ROOM		0.925056	51,288	4,860	1,223,112	339,084	14,991	3,624	8,115	-	10,692	4,962	$ 1,297,506	$ 347,568	74.85%
26	5300 ANESTHESIOLOGY		0.078703	81,336	124,792	104,312	270,207	83,443	146,588	5,127	5,399	60,822	84,120	$ 274,218	$ 546,986	40.83%
27	5400 RADIOLOGY-DIAGNOSTIC		0.083208	1,005,195	3,144,808	454,251	4,639,421	1,103,094	5,284,030	135,101	308,393	955,024	7,392,020	$ 2,697,641	$ 13,376,652	42.60%
28	5600 RADIOISOTOPE		0.187198	24,042	117,509	1,813	74,702	34,933	328,291	-	2,762	18,312	151,449	$ 60,788	$ 523,264	23.68%
29	5900 CARDIAC CATHETERIZATION		0.154397	-	-	-	25,488	26,778	60,556	-	-	56,463	38,938	$ 26,778	$ 86,044	5.98%
30	6000 LABORATORY		0.185849	1,015,317	1,868,179	1,052,602	2,855,028	934,828	2,222,210	133,791	147,075	677,904	3,232,873	$ 3,136,537	$ 7,092,491	52.94%
31	6200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.144067	114,681	60,791	82,439	24,417	49,917	68,645	10,441	3,152	34,034	38,769	$ 257,478	$ 157,005	25.15%
32	6500 RESPIRATORY THERAPY		0.191564	1,018,809	44,178	229,340	48,331	1,004,278	112,168	219,068	9,581	395,022	34,525	$ 2,471,495	$ 214,258	26.67%
33	6600 PHYSICAL THERAPY		0.282154	175,283	78,898	30,104	641,835	283,414	650,030	20,931	84,957	75,192	133,855	$ 509,731	$ 1,455,721	23.83%
34	6900 ELECTROCARDIOLOGY		0.151100	224,673	450,168	56,189	447,449	241,250	855,380	26,188	35,059	117,959	609,794	$ 548,300	$ 1,788,056	42.07%
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.358688	469,765	359,633	396,844	611,562	559,224	450,572	46,218	8,798	289,265	375,839	$ 1,472,051	$ 1,430,565	38.29%
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.221683	470,677	223,860	175,314	252,010	546,687	338,848	29,063	2,080	129,882	177,302	$ 1,221,741	$ 816,798	30.56%
37	7300 DRUGS CHARGED TO PATIENTS		0.157005	1,382,163	978,245	880,070	1,778,925	1,259,996	1,387,411	177,403	42,078	802,943	1,946,018	$ 3,699,632	$ 4,186,660	44.38%
38	7400 RENAL DIALYSIS		0.366356	102,250	-	-	-	83,845	10,225	18,405	-	4,090	-	$ 204,500	$ 10,225	38.16%
39	9100 EMERGENCY		0.198676	460,204	2,795,797	140,238	5,313,647	392,999	2,886,008	41,947	124,636	328,210	6,339,521	$ 1,035,388	$ 11,120,088	59.47%
40			-											$ -	$ -	
41			-											$ -	$ -	
42			-											$ -	$ -	
43			-											$ -	$ -	
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
47			-											$ -	$ -	
48			-											$ -	$ -	
49			-											$ -	$ -	
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83			-											$ -	$ -	
84			-											$ -	$ -	
85			-											$ -	$ -	

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data

Cost Report Year (01/01/2017-12/31/2017 | UPSON REGIONAL MEDICAL CENTER

				In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
86			-											$ -	$ -	
87			-											$ -	$ -	
88			-											$ -	$ -	
89			-											$ -	$ -	
90			-											$ -	$ -	
91			-											$ -	$ -	
92			-											$ -	$ -	
93			-											$ -	$ -	
94			-											$ -	$ -	
95			-											$ -	$ -	
96			-											$ -	$ -	
97			-											$ -	$ -	
98			-											$ -	$ -	
99			-											$ -	$ -	
100			-											$ -	$ -	
101			-											$ -	$ -	
102			-											$ -	$ -	
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111			-											$ -	$ -	
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121			-											$ -	$ -	
122			-											$ -	$ -	
123			-											$ -	$ -	
124			-											$ -	$ -	
125			-											$ -	$ -	
126			-											$ -	$ -	
127			-											$ -	$ -	
				$ 8,399,391	$ 13,263,780	$ 7,219,978	$ 23,871,807	$ 8,225,416	$ 18,577,131	$ 984,689	$ 865,408	$ 5,167,883	$ 22,678,543			
	Totals / Payments															
128	**Total Charges** ***(includes organ acquisition from Section J)***			$ 10,299,890	$ 13,263,780	$ 9,137,951	$ 23,871,807	$ 10,077,825	$ 18,577,131	$ 1,236,567	$ 865,408	$ 6,161,092 (Agrees to Exhibit A)	$ 22,678,543 (Agrees to Exhibit A)	$ 30,752,232	$ 56,578,127	43.24%
129	Total Charges per PS&R or Exhibit Detail			$ 10,299,890	$ 13,263,780	$ 9,137,951	$ 23,871,807	$ 10,077,825	$ 18,577,131	$ 1,236,567	$ 865,408	$ 6,161,092	$ 22,678,543			
130	Unreconciled Charges (Explain Variance			-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**			$ 2,938,110	$ 2,338,982	$ 4,110,482	$ 4,314,933	$ 2,742,927	$ 3,210,589	$ 346,313	$ 137,776	$ 1,673,458	$ 3,708,956	$ 10,137,832	$ 10,002,280	44.62%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 3,055,882	$ 1,927,130		$ 189	$ 242,701	$ 226,812	$ 13,852	$ 12,133			$ 3,312,435	$ 2,166,264	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)					$ 2,385,174	$ 3,503,418				$ 205			$ 2,385,174	$ 3,503,623	
134	Private Insurance (including primary and third party liability)			$ 28,482	$ 536			$ 25	$ 3,952	$ 290,587	$ 136,752			$ 319,094	$ 141,240	
135	Self-Pay (including Co-Pay and Spend-Down)				$ 4,933	$ 10	$ 8,067			$ 1,316	$ 3,914			$ 1,326	$ 16,914	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 3,084,364	$ 1,932,599	$ 2,385,184	$ 3,511,674									
137	Medicaid Cost Settlement Payments (See Note B)				$ 48,427									$ -	$ 48,427	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)													$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)							$ 2,502,949	$ 2,153,213	$ 162,288	$ 24,508			$ 2,665,237	$ 2,177,721	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									$ 50,219	$ 25,398			$ 50,219	$ 25,398	
141	Medicare Cross-Over Bad Debt Payments							$ 38,549	$ 96,796					$ 38,549	$ 96,796	
142	Other Medicare Cross-Over Payments (See Note D)											(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 37,099	$ 459,658			
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)											$ -	$ -			
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**			$ (146,254)	$ 357,956	$ 1,725,298	$ 803,259	$ (41,297)	$ 729,816	$ (171,949)	$ (65,134)	$ 1,636,359	$ 3,249,298	$ 1,365,798	$ 1,825,897	
146	**Calculated Payments as a Percentage of Cost**			105%	85%	58%	81%	102%	77%	150%	147%	2%	12%	87%	82%	
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)**							5,576								
148	**Percent of cross-over days to total Medicare days from the cost report**							19%								

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with s
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education pay
Note E - Medicaid Managed Care payments should include*all* Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payn

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2017-12/31/2017) UPSON REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)		
	Routine Cost Centers (list below):			Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	$ 1,232.88		4								4	
2	03100 INTENSIVE CARE UNIT	$ 1,120.20		2								2	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ -										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 907.34		2								2	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			Total Days	8		-		-		-		8	
19	Total Days per PS&R or Exhibit Detail			8		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges			$ 11,096								$ 11,096	
21.01	Calculated Routine Charge Per Diem			$ 1,387.00		$ -		$ -		$ -		$ 1,387.00	
	Ancillary Cost Centers (from W/S C) (list below):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	09200 Observation (Non-Distinct)		0.821722	-	1,920						-	$ -	$ 1,920
23	5000 OPERATING ROOM		0.147638	12,932	-						-	$ 12,932	$ -
24	5100 RECOVERY ROOM		0.234976	-	-						-	$ -	$ -
25	5200 DELIVERY ROOM & LABOR ROOM		0.925056	3,399	762						-	$ 3,399	$ 762
26	5300 ANESTHESIOLOGY		0.078703	1,023	-						-	$ 1,023	$ -
27	5400 RADIOLOGY-DIAGNOSTIC		0.083208	21,783	48,367						4,449	$ 21,783	$ 52,816
28	5600 RADIOISOTOPE		0.187198	-	5,675						-	$ -	$ 5,675
29	5900 CARDIAC CATHETERIZATION		0.154397	-	8,066						-	$ -	$ 8,066
30	6000 LABORATORY		0.185849	8,829	25,301						4,320	$ 8,829	$ 29,621
31	6200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.144067	232	143						-	$ 232	$ 143
32	6500 RESPIRATORY THERAPY		0.191564	624	1,696						-	$ 624	$ 1,696
33	6600 PHYSICAL THERAPY		0.282154	-	-						-	$ -	$ -
34	6900 ELECTROCARDIOLOGY		0.151100	446	7,798						892	$ 446	$ 8,690
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.358688	2,286	1,539						58	$ 2,286	$ 1,596
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.221683	1,354	1,378						-	$ 1,354	$ 1,378
37	7300 DRUGS CHARGED TO PATIENTS		0.157005	7,734	14,755						1,886	$ 7,734	$ 16,641
38	7400 RENAL DIALYSIS		0.366356	2,045	-						-	$ 2,045	$ -
39	9100 EMERGENCY		0.198676	1,689	40,821						10,102	$ 1,689	$ 50,923
40			-									$ -	$ -
41			-									$ -	$ -
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
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75			-									$ -	$ -
76			-									$ -	$ -
77			-									$ -	$ -
78			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2017-12/31/2017) UPSON REGIONAL MEDICAL CENTER

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
79			-									$ -	$ -
80			-									$ -	$ -
81			-									$ -	$ -
82			-									$ -	$ -
83			-									$ -	$ -
84			-									$ -	$ -
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124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 64,377	$ 158,221	$ -	$ -	$ -	$ -	$ -	$ 21,706		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ 75,473	$ 158,221	$ -	$ -	$ -	$ -	$ -	$ 21,706	$ 75,473	$ 179,927
129	Total Charges per PS&R or Exhibit Detail	$ 75,473	$ 158,221	$ -	$ -	$ -	$ -	$ -	$ 21,706		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 21,214	$ 26,125	$ -	$ -	$ -	$ -	$ -	$ 3,632	$ 21,214	$ 29,757
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 4,425	$ 5,366						$ 616	$ 4,425	$ 5,982
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)		$ 298							$ -	$ 298
134	Private Insurance (including primary and third party liability)		$ 2,831						$ 645	$ -	$ 3,476
135	Self-Pay (including Co-Pay and Spend-Down)									$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 4,425	$ 8,495	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)									$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)									$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)									$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									$ -	$ -
141	Medicare Cross-Over Bad Debt Payments									$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)									$ -	$ -
143	**Calculated Payment Shortfall / (Longfall)**	$ 16,789	$ 17,630	$ -	$ -	$ -	$ -	$ -	$ 2,371	$ 16,789	$ 20,001
144	**Calculated Payments as a Percentage of Cost**	21%	33%	0%	0%	0%	0%	0%	35%	21%	33%

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

J. Transplant Facilities Only: Organ Acquisition Cost In-State Medicaid and Uninsured

Cost Report Year (01/01/2017-12/31/2017) UPSON REGIONAL MEDICAL CENTER

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquistion Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Organ Acquisition Cost Centers (list below):															
1	Lung Acquisition	$0.00	$ -	$ -		0										
2	Kidney Acquisition	$0.00	$ -	$ -		0										
3	Liver Acquisition	$0.00	$ -	$ -		0										
4	Heart Acquisition	$0.00	$ -	$ -		0										
5	Pancreas Acquisition	$0.00	$ -	$ -		0										
6	Intestinal Acquisition	$0.00	$ -	$ -		0										
7	Islet Acquisition	$0.00	$ -	$ -		0										
8		$0.00	$ -	$ -		0										
9	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
10	**Total Cost**							-		-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).
Note B: Enter Organ Acquisition Payments in Section H as part of your In-State Medicaid total payments.
Note C: Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

K. Transplant Facilities Only: Organ Acquisition Cost Out-of-State Medicaid

Cost Report Year (01/01/2017-12/31/2017) UPSON REGIONAL MEDICAL CENTER

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquistion Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	$ -	$ -	$ -	$ -	0								
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0								
13	Liver Acquisition	$ -	$ -	$ -	$ -	0								
14	Heart Acquisition	$ -	$ -	$ -	$ -	0								
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17	Islet Acquisition	$ -	$ -	$ -	$ -	0								
18		$ -	$ -	$ -	$ -	0								
19	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20	**Total Cost**							-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey
Note B: Enter Organ Acquisition Payments in Section I as part of your Out-of-State Medicaid total payments.

L. Provider Tax Assessment Reconciliation / Adjustment

An adjustment is necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals. The Medicaid and uninsured share of the provider tax assessment collected is an allowable cost in determining hospital-specific DSH limits and, therefore, can be included in the DSH examination survey. However, depending on how your hospital reports it on the Medicare cost report, an adjustment may be necessary to ensure the cost is properly reflected in determining your hospital-specific DSH limit. For instance, if your hospital removed part or all of the provider tax assessment on the Medicare cost report, the full amount of the provider tax assessment would not have been apportioned to the various payers through the step down allocation process, resulting in the Medicaid and uninsured share being understated in determining the hospital-specific DSH limit. If your hospital needs to make an adjustment for the Medicaid and uninsured share of the provider tax assessment, please fill out the reconciliation below, and submit the supporting general ledger entries and other supporting documentation to Myers and Stauffer, LC along with your hospital's DSH examination surveys.

Cost Report Year (01/01/2017-12/31/2017) UPSON REGIONAL MEDICAL CENTER

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 875,530		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense	01.9500.9305	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 875,530		*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)		$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*				*(Reclassified to / (from))*
5	*Reclassification Code*				*(Reclassified to / (from))*
6	*Reclassification Code*				*(Reclassified to / (from))*
7	*Reclassification Code*				*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*	Elimination for Medicare Cost Report - A-8 Ln# 45	$ (875,530)	5.00	*(Adjusted to / (from))*
9	*Reason for adjustment*				*(Adjusted to / (from))*
10	*Reason for adjustment*				*(Adjusted to / (from))*
11	*Reason for adjustment*				*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*				
13	*Reason for adjustment*				
14	*Reason for adjustment*				
15	*Reason for adjustment*				
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ -		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report	$ 875,530

** Assessment must exclude any non-hospital assessment such as Nursing Facility.*

Real Property Holdings Owned by the Hospital Authority of Upson County and Upson County Hospital, Inc. (HB 321)								
Location[1]	**Tax Parcel ID Number**	**Estimated Size**	**Purchase Price**[2]	**Current HealthCare Purpose?**[3]		**Improvements?**[4]		**Notes** (Optional)
				Yes	No	Yes	No	
URMC Main Campus 801 West Gordon St. Thomaston, GA	T13 033, T13 032	18.17 Acres	Donated	X		X		Hospital Main Campus
URMC Storage Thurston Avenue, Thomaston, GA	T23 012	6.82 Acres	Donated	X		X		Hospital Offsite Storage
EMS Services Hugo Starling Dr Thomaston, GA	T38 016B	6.52 Acres	$108,825	X		X		Ambulance Service Building
Vacant Land West Gordon St Thomaston, GA	045 037	40.96 Acres	$266,300		X		X	Land for Future Growth
Residency Housing 214 Cherokee Rd Thomaston, GA	T13 035	0.66 Acres	$460,000	X		X		Vacant Medical Office with 2nd Floor Residency Housing
Tyler Medical Building 612 W Gordon St Thomaston, GA	T22 019, T22 020, T22 021, T22 022, T22 023, T22 024, T22 025	3.26 Acres	$400,500	X		X		Medical Office

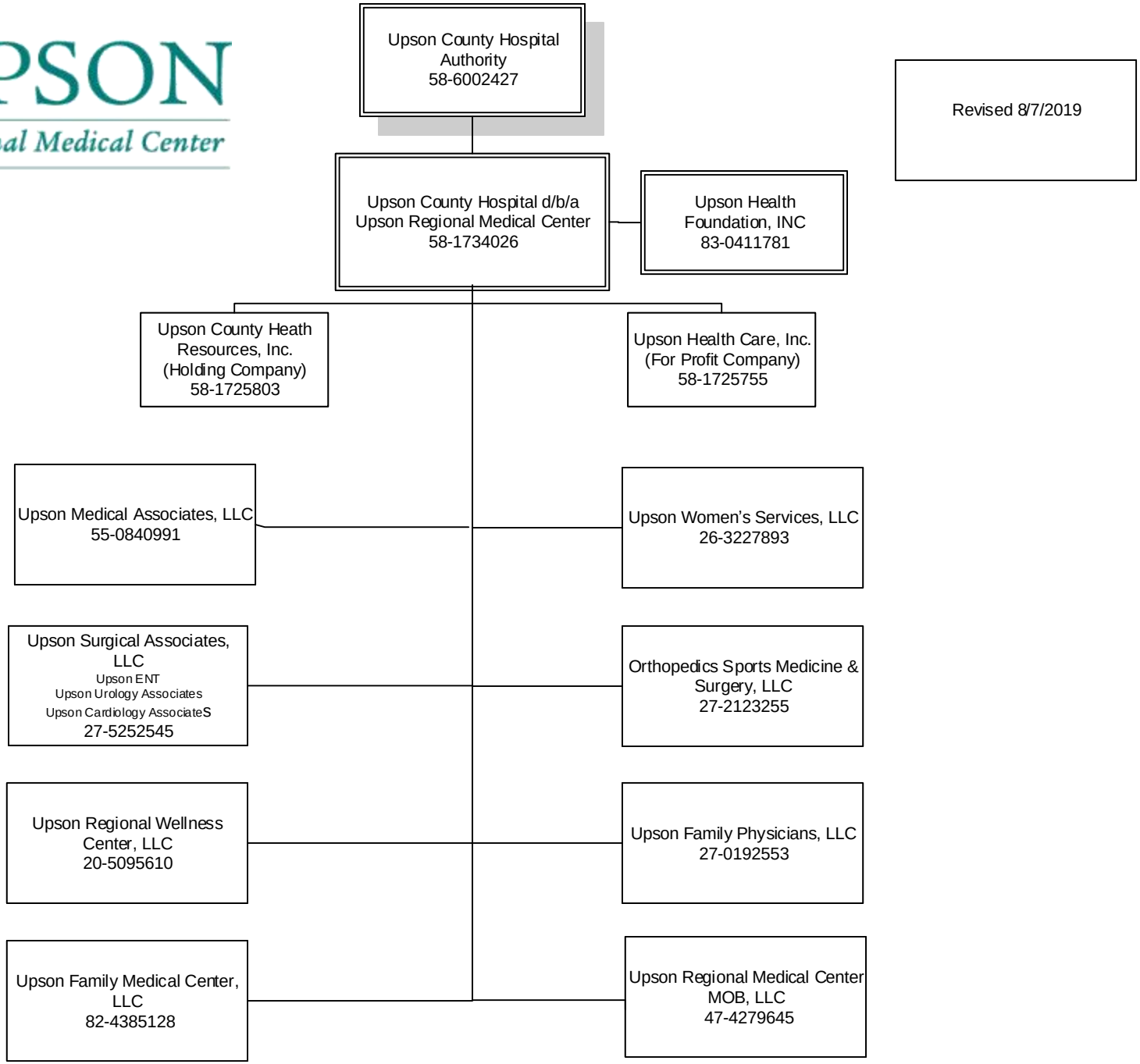
[1] Location may be the county, address, or site identification/description.
[2] Purchase price to be listed as of the date of acquisition of the property by the hospital, if known. If unknown, state "UNK".
[3] Health care purpose includes the provision of patient care; the provision or delivery of healthcare services, including supportive administrative services; the training and education of physicians, nurses, and other healthcare personnel; and community education and outreach relating to health care or wellness.
[4] Improvement means the permanent addition or construction of a building or structure.

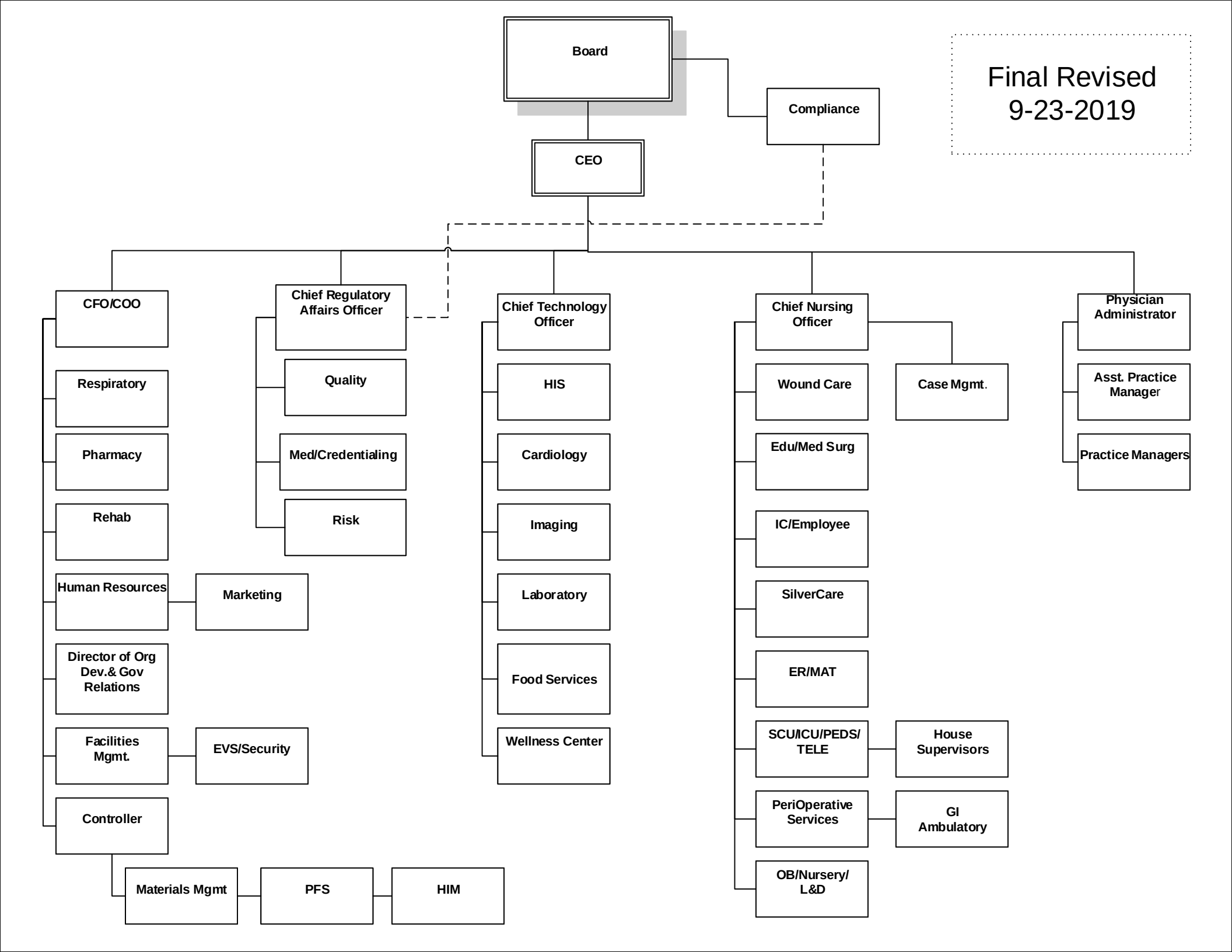
Location[1]	Tax Parcel ID Number	Estimated Size	Purchase Price[2]	Current HealthCare Purpose?[3]		Improvements?[4]		Notes (Optional)
				Yes	No	Yes	No	
URMC Medical Office Bldg 915 and 917 W Gordon St Thomaston, GA	T12 004, T12 005	8.11 Acres	$500,000	X		X		Medical Office
Zebulon Medical Office Bldg 7171 US Hwy 19 N Zebulon, GA	068 009 O	1.68 Acres	$35,000	X		X		Medical Office
Barnesville Medical Office Bldg 100 Hwy 18 W Barnesville, GA	B10 015	3.01 Acres	$475,000	X		X		Medical Office
Butler Medical Office Bldg 91 W Main St Butler, GA	B03 018	2.63 Acres	$200,000	X		X		Medical Office
Woodbury Medial Office Bldg 17438 Main St Woodbury, GA	152 032	.76 Acres	$135,000		X	X		Currently Listed for Sale
Date: 09/20/2019 Revised:								

[1] Location may be the county, address, or site identification/description.
[1] Purchase price to be listed as of the date of acquisition of the property by the hospital, if known. If unknown, state "UNK".
[1] Health care purpose includes the provision of patient care; the provision or delivery of healthcare services, including supportive administrative services; th e training and education of physicians, nurses, and other healthcare personnel; and community education and outreach relating to he alth care or wellness.
[1] Improvement means the permanent addition or construction of a building or structure.

UPSON
Regional Medical Center

Revised 8/7/2019




Board
Compliance
CEO
Final Revised
9-23-2019
CFO/COO
Respiratory
Pharmacy
Rehab
Human Resources
Marketing
Director of Org Dev.& Gov Relations
Facilities Mgmt.
EVS/Security
Controller
Materials Mgmt
PFS
HIM
Chief Regulatory Affairs Officer
Quality
Med/Credentialing
Risk
Chief Technology Officer
HIS
Cardiology
Imaging
Laboratory
Food Services
Wellness Center
Chief Nursing Officer
Wound Care
Case Mgmt.
Edu/Med Surg
IC/Employee
SilverCare
ER/MAT
SCU/ICU/PEDS/ TELE
House Supervisors
PeriOperative Services
GI Ambulatory
OB/Nursery/ L&D
Physician Administrator
Asst. Practice Manager
Practice Managers

DNV·GL

CERTIFICATE OF ACCREDITATION

Certificate No.:	Initial date:	Valid until:
217289-2017-AHC-USA-NIAHO	4/21/2017	4/21/2020

This is to certify that:

Upson Regional Medical Center

801 West Gordon Street, P.O. Box 1059, Thomaston, GA 30286

has been found to comply with the requirements of the:

NIAHO® Hospital Accreditation Program

Pursuant to the authority granted to DNV GL Healthcare USA, Inc. by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, this organization is deemed in compliance with the Medicare Conditions of Participation for Hospitals (42 C.F.R. §482).

This certificate is valid for a period of three (3) years from the Effective Date of Accreditation.

For the Accreditation Body:
DNV GL - Healthcare
Katy, TX

Patrick Horine
Chief Executive Officer

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

UPSON REGIONAL MEDICAL CENTER

TITLE/DESCRIPTION:	Financial Assistance Policy
FILING NUMBER	4834
EFFECTIVE DATE:	02/01/2019
DATE OF LAST REVIEW:	09/23/2019
DATE OF LAST REVISION:	09/23/2019
APPROVED BY:	CFO/COO, Controller

Principles/Guidelines

Upson Regional Medical Center ("URMC") seeks to treat all patients equitably, with dignity, respect and compassion. URMC recognizes that some patients are unable to pay their hospital bills due to financial considerations. URMC will assist those individuals who cannot pay for all or part of their care by extending Financial Assistance to qualifying patients. The purpose of this Policy is to describe the financial assistance policy guidelines and application process.

URMC will provide free care and discounted financial assistance in keeping with the Policy described below. In order for URMC to apply this Policy fairly and consistently, patients and their families have a duty to provide appropriate and timely information that will help URMC determine the appropriate level or type of financial assistance given specific individual circumstances.
As further described below, this Financial Assistance Policy (FAP):

- Includes eligibility criteria for receiving financial assistance.
- Describes the basis for calculating amounts charged to patients eligible for financial assistance under this Policy.
- Limits the amount that URMC will charge for emergency or other medically necessary care provided to individuals eligible for financial assistance to no more than the amount generally billed to insured patients by URMC as defined in this Policy.
- Describes the method by which patients may apply for financial assistance.
- Describes the URMC collection Policy.

URMC remains committed to serving the emergency needs of all patients, regardless of ability to pay.

Definitions: As used in this Policy, the following terms have the meanings as set forth below:

1. **Financial Assistance**: Free or discounted health services provided to individuals who meet URMC's criteria for financial assistance and are unable to pay for all or a portion of the medically necessary services provided by the facility. Financial assistance includes:

    - **Free Care** – Free care is available when the household incomes of a patient and/or Guarantor are either equal to or less than 125 percent of the current Federal Poverty Guidelines.

    - **Discounted Financial Assistance** – Financial Assistance discounts are available when the household income of a patient and/or Guarantor is in excess of 125 percent and equal to or less than 300 percent of the current Federal Poverty Guidelines.

2. **Gross Charges** – The total charges at the organization's established rates for the provision of patient care services before deductions from revenue are applied.

3. **Federal Poverty Guidelines (FPG) -** The poverty guidelines issued by the U. S. Department of Health and Human Services at the beginning of each calendar year that are used to determine eligibility for certain assistance programs.

4. **Emergency Medical Conditions** – Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

5. **Medically Necessary** – Health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
    a. in accordance with the generally accepted standards of medical practice;
    b. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means:
    a. standards that are based on credible scientific evidence published in peer-reviewed, medical literature generally recognized by the relevant medical community;
    b. Physician Specialty Society recommendations;
    c. the views of Physicians practicing in the relevant clinical area; and
    d. any other relevant factors.

6. **Eligible Services** – Services eligible under this Policy include: (1) emergency medical services provided in an emergency room setting, (2) non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and, (3) other medically necessary services. Eligible services do not include elective, cosmetic or non-medically necessary services.

7. **Family Unit** – The family unit consists of the applicant, spouse and all legal dependents as allowed by the Internal Revenue Service. If the applicant is a minor or legal dependent for income tax purposes, the family unit will include parent(s), legal guardian(s) and/or the taxpayer claiming the patient as a dependent for income tax purposes.

8. **Family Unit Income** – The combined annual gross income of all members within the family unit (as previously defined) which includes the patient or Guarantor. Combined gross income will be calculated by annualizing documented income over the preceding three months. For the purposes of determining financial eligibility for financial assistance, income includes all gross funds or amounts received before taxes or other withholdings from all sources, including, but not limited to any type of employment or self-employment, alimony, sick leave, disability compensation, any pensions or retirement plans including military retirement pay, veteran's payments , rental income, royalty payments, Social Security payments, child support payments, unemployment compensation, regular insurance or annuity payments, interest or dividend income, and workers compensation benefits. The Hospital will require supporting documentation to be submitted with the paper Application to verify income. Income does not include need based assistance from non-profit organizations, disaster relief assistance, gifts, loans or similar items.

9. **Co-Payments, Coinsurance and Deductibles** – The amount determined by the patient's insurance policy as being due from the patient and/or any Guarantor. This amount is normally a required payment due from the patient or Guarantor by contract.

10. **Guarantor** – Individual other than the patient who is responsible for payment of the patient's bill.

11. **Patient Liability** – Patient Liability is the amount owed by the individual patient and/or Guarantor after first applying any insurance benefits and then applying any financial assistance discounts.

12. **Amounts Generally Billed Percentage** – The percentage determined by dividing the total of claims allowed by Medicare and all private health insurers (including all copayments and deductibles owed by the patient) during the 12 month look-back measurement period by total gross charges for these claims. The measurement period for the AGB percentage will be calculated at the end of each calendar year using the allowed claims from the preceding twelve (12) month period. This AGB percentages calculated will be updated February 1 each year and remain in effect until January 31 of the following calendar year. The AGB percentages for the period January 1, 2019 through January 31. 2020 is twenty seven percent (27%).

13. **Amounts Generally Billed** – The maximum amount for which all patients meeting the eligibility criteria under this Policy are individually responsible for paying. Amounts Generally Billed (AGB) will be calculated by multiplying gross charges for any eligible service by the appropriate AGB percentage as defined above.

14. **Extraordinary Collections Actions (ECAs)** – Actions that may be taken related to obtaining payment for services rendered include the following:

    a. Selling an individual's debt to another party unless the purchaser is prohibited from engaging in any ECAs to obtain payment, prohibited from charging interest in excess under IRC section 6621(a)(2) at the time the debt is sold, the debt is recallable upon determination the individual is eligible for financial assistance, and the individual does not pay or has no obligation to pay the purchaser and URMC together more than they are personally responsible for paying under this Financial Assistance Policy.
    b. Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.
    c. Deferring or denying, or requiring payment before providing medically necessary care because of nonpayment of one or more bills for previously provided care.
    d. Actions that require a legal or judicial process, including but not limited to:
        i. Placing a lien on an individual's property except for any lien URMC is entitled to assert under state law on the proceeds of a judgment, settlement, or compromise owed to an individual as a result of personal injuries for which care was provided;
        ii. Foreclosing on an individual's real property;
        iii. Attaching or seizing an individual's bank account or any other personal property;
        iv. Commencing a civil action against an individual;
        v. Causing an individual's arrest;
        vi. Causing arrest or body attachment; and
        vii. Garnishing an individual's wages.

15. Financial Assistance Application - The document made available to the patients of URMC which must be completed with certain required documentation for the hospital representative to make a determination of eligibility for financial assistance.

Eligibility Criteria for Financial Assistance

Free care and discounted financial assistance applies only to eligible services as defined in this Policy. A patient that qualifies for financial assistance under this Policy is eligible for discounts to co-payments, coinsurance and deductibles. Financial assistance discounts do not apply to any amounts received or receivable from an insurance company for eligible services. The maximum amount an FAP-eligible patient will pay is the AGB as defined in this Policy.

Approved financial assistance will be applicable only to the charges of URMC. In addition to URMC, providers that may become involved in your care at URMC that participate in our Financial Assistance Policy are as follows:

1. Upson Medical Associates - Anesthesiologist Professional fees
2. Wound Healing - Professional fees
3. URMC Cardiology services - Professional fees
4. URMC Pediatric services - Professional fees
5. Rural Health Services

URMC cannot make any financial arrangements for the charges of any private physician practice, including the following physician practices offering services at URMC:

1. Guardian Medical (CRNA)
2. South Ga. Radiologist
3. Schumacher (ED and Hospitalist)
4. Community Ambulance
5. Any attending physician

Patients seeking assistance will need to make payment arrangements directly with these physician practices.

URMC will assist the patient in qualifying for any State of Georgia Medicaid or Social Security (SSI) benefits. URMC utilizes the services of outside vendors to assist patients in obtaining these benefits. Amounts billed to patients approved for Financial Assistance pursuant to this Policy shall be based on AGB, as defined in this Policy. Patients shall not be expected to pay Gross Charges. Once a patient has been determined by URMC to be eligible for financial assistance, the patient shall not receive any future bills based on undiscounted Gross Charges for the episode of care in which an Application for Financial Assistance was submitted and any excess collections will be refunded to the patient and/or Guarantor. Any prior billings will be reissued at the proper discounted rate and the patient will be notified of correct amounts due.

A patient may qualify for Financial Assistance under this Policy if he or she meets one of the following criteria:

Household Income	**Maximum Amount Individual is Responsible for Paying**
Less than or equal to 125% of Federal Poverty Guidelines	0% of Gross Charges
In excess of 125% but less than or equal to 300% of Federal Poverty Guidelines	AGB

Qualification for financial assistance based on income will be determined using the following methods:

1. Completion of URMC's Financial Assistance Application as described below. Anyone approved for financial assistance after completion of URMC's Financial Assistance Application will remain approved for any eligible services for subsequent episodes of care rendered within 180 days of the date the application is approved.

2. Bankruptcies, deceased with no estate, Medicaid eligible in states URMC does not participate, and any State or Federal programs where funding has been exhausted accounts will be FAP approved without an application with a 100% discount

Financial Assistance Application Guidelines:

All requests for Financial Assistance must be submitted using URMC's Financial Assistance Application. The Application must be completed in its entirety and all required supporting documentation must be attached to the Application.

1. URMC makes information readily available to patients in regards to its financial assistance program by:
    a) Posting information in the main lobby, Emergency room lobby and cashier area of the hospital. (English & Spanish) NOTE –Offering a plain language summary of the FAP to every patient registering for services in the Registration Department, or presenting to the Emergency Department, to Physical Therapy or to the Wound Healing Center.
    b) Making a copy of the FAP and an application for financial assistance is available upon request at the Registration Department, the Business Office and on the hospital website at www.urmc.org. The Policy, plain language summary and the financial assistance application are available in a printable format without requiring additional software or a cost. Paper copies are also available at all primary entrance areas of the hospital.
    c) Including a conspicuous written notice on billing statements that notifies and informs recipients about the availability of financial assistance and provides telephone numbers where they may receive more information.

2. URMC makes reasonable efforts to determine whether an individual is FAP eligible prior to engaging in any ECAs. Our collection policies (as approved by the governing board), hold URMC Patient Financial Services Department responsible for this process. ECAs will not be initiated during the 120 day period beginning with the issuance of the first post-discharge billing statement to the patient. If, by the end of this 120 day period the patient has not submitted a Financial Assistance Application, URMC may begin collection actions against the patient, providing the patient has been notified in writing of the specific ECA(s) to be initiated at least 30 days prior to such actions. The application period during which URMC will accept and process a Financial Assistance Application ends on the 240th day after URMC issues the first post-discharge billing statement to the patient.

3. Applicant shall submit the following supporting documentation, if applicable, with a completed Application:
    a. Proof of income – IRS Form W-2, the most recent federal income tax return, pay stubs covering the last 90 consecutive days as of the date of application, proof of Social Security, unemployment receipts, investment income, alimony, worker's compensation, rental/royalty income, retirement income and any other documentation that supports household income as defined in the Financial Assistance Policy.
    b. Checking and savings account statements for the most recent 3 months. The statements are required to verify an applicant's income.
    c. If the annualized family unit income has decreased since the most recent federal income tax return, the applicant must submit written documentation verifying the decreased amount.
    d. Unemployment denial letter.
    e. Any additional documentation the applicant deems necessary to support their application for Financial Assistance.

4. Falsifying information on the Application will be grounds for denying or revoking financial assistance. Falsifying an Application includes, but is not limited to, failure to disclose all income.

5. Applicant shall identify all known third party payment sources for services rendered. Applicant shall cooperate with URMC in filing of claims and collection of reimbursement from all third party payment sources. Failure to cooperate will be grounds for denying financial assistance.

6. Applicant shall cooperate in the application for financial assistance from other sources, such as Medicaid and other programs. Failure to cooperate will be grounds for denying financial assistance.

Financial Assistance Procedures:

1. At the time of registration, which includes registration for Physical Therapy, Upson Clinic and Wound Healing Treatment, each patient will be offered a free written copy of the plain language summary of the Policy. A patient may begin the process for consideration for financial assistance by completing the financial assistance application and providing the necessary documentation to support their income. Granting of financial assistance shall be based on the individualized determination of income, and shall not take into consideration age, gender, race, or immigration status, sexual orientation or religious affiliation.

2. Applicants must fully cooperate and comply with verification of income to the best of their ability.

3. A Financial Assistance Representative (FAR) is available to discuss the Financial Assistance program offered by URMC with the patient or the patient's designated representative. A free written copy of the Financial Assistance Policy and Financial Assistance Application may be obtained from the Financial Assistance Representative. At the request of the patient or the patient's designated representative, the Financial Assistance Representative will assist the patient with initiation of the Financial Assistance Application. A Financial Assistance Representative is available in the Business Office Monday through Friday; from 8:30 a.m. until 4:30 p.m. Applications may also be mailed to URMC for processing to Upson Regional Medical Center 801 West Gordon Street Thomaston, Ga. 30286.

4. URMC will assist, as requested, patients in becoming covered under available state, local, federal or community based assistance programs.

5. When an Application is received, the Financial Assistance Representative will review the Application for completeness, which shall include all supporting documentation. If it is determined that the Application is incomplete, URMC will take the following actions:
    a. Suspend any collection actions against the patient/Guarantor.
    b. Provide the patient with a written notice that describes the additional information or documentation the patient must submit to complete his or her Application.
    c. Provide the patient with at least one written notice that informs the patient/Guarantor about the extraordinary collection actions that the hospital intends to initiate or resumed if the Application is not completed or if the amount due is not paid within 30 days from the date of the notice.
    d. If all supporting documentation is not submitted or the amount due is not paid within 30 days of the written notice as described in the preceding paragraph, the request for Financial Assistance will be denied and the account will remain in the billing cycle. A new Application may be submitted if the date of the Application is within 240 days after URMC issues the first post-discharge billing statement to the patient.

6. Once a completed Application has been received and reviewed, the Financial Assistance Representative will make a recommendation for approval or denial on the Application. URMC will render a decision in no more than five (5) working days from the receipt of a completed Financial Assistance Application.

7. Approval authority for Financial Assistance is as follows: All accounts involved resulting in a financial write off will be routed to the Director of Patient Financial Services, or her designee, for approval.

8. The patient will be notified in writing of URMC's decision to provide or deny Financial Assistance.

Collection Practices and Policies

In the event of non-payment by the patient for their portion of their account, statements indicating the process for applying for financial assistance will be mailed to the patient every 21 days.
If the account is not paid after 150 days from the first post discharged bill date, the hospital will refer the account to its primary collection agency for future collection efforts. The collection agency will provide the same disclosure on its statements as the hospital does to advise the individual of the Financial Assistance Policy and how to obtain a copy of the Policy, the plain language summary and application to apply for assistance.

The collection agencies must notify the patient in writing at least 30 days prior to initiating any ECAs and provide a copy of URMC's plain language summary of the FAP with the 30 day written notice. ECAs will not be initiated by either URMC or any of its agents (including any collection agencies) until at least 120 days from the date the first post-discharge bill was issued. In addition, either URMC or the collection agency will make reasonable attempts to notify all patients orally about the hospital's FAP and how they can apply

URMC has the right to provide notification simultaneously for multiple episodes of care; however ECAs cannot begin until 120 days after the first post-discharge billing for the most recent episode of care.

If an individual submits an application after the ECAs have begun, the hospital will suspend all ECAs, notify the individual in writing of the determination and take all reasonable measures to reverse any ECA actions taken; such as report to the credit bureau to delete, cancel a judgment and/or cancel any garnishment action, etc.

Appeal Process for Financial Assistance Denials:
An applicant may appeal a denial of financial assistance determination. An appeal may be submitted in writing, either by letter or email, and sent to the Financial Assistance Representative at Upson Regional Medical Center. The FAR will respond to the appeal within 10 business days. Written appeals should be sent to:

Upson Regional Medical Center
Attention: Financial Assistance Representative
P.O. Box 1059
Thomaston, Ga. 30286
Email appeals should be sent to wwilson@urmc.org

Individuals may present to the Business Office Monday through Friday, 8:30 a.m. through 4:30 p.m. to appeal the decision in person.

URMC operates under an Emergency Care Policy which is available upon request through the Compliance Department at the hospital. Calls may be directed to 706-647-8111 Ext. 1240.

For more information contact:

Director, Patient Financial Services	706-647-8111 Ext. 1560
Asst. Director, Patient Financial Services	706-647-8111 Ext. 1330
Financial Assistance Representative	706-647-8111 Ext. 1473

Information may also be obtained on the hospital website at www.urmc.org.

[redacted] nancial Survey

Part A : General Information

1. Identification

UID:HOSP523

Facility Name: Upson Regional Medical Center

County: Upson

Street Address: 801 West Gordon Street

City: Thomaston

Zip: 30286

Mailing Address: PO Drawer 1059

Mailing City: Thomaston

Mailing Zip: 30286-0013

2. Report Period

Please report data for the hospital fiscal year ending during calender year 2018 only.
Do not use a different report period.

Please indicate your hospital fiscal year.
From: 1/1/2018 To:12/31/2018

Please indicate your cost report year.
From: 01/01/2018 To:12/31/2018

Check the box to the right if your facility was **not** operational for the entire year. ☐
If your facility was **not** operational for the entire year, provide the dates the facility was operational.

3. Trauma Center Designation Change During the Report Period

Check the box to the right if your facility experienced a change in trauma center designation during the report period.
If your facility's trauma center designation changed, provide the date and type of change. ☐

Part B : Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey.

Contact Name: John H. Williams
Contact Title: Chief Financial Officer
Phone: 706-647-8111
Fax: 706-646-3310
E-mail: jhwilliams@urmc.org

Part C : Financial Data and Indigent and Charity Care

1. Financial Table

Please report the following data elements. Data reported here must balance in other parts of the HFS.

Revenue or Expense	Amount
Inpatient Gross Patient Revenue	96,311,495
Total Inpatient Admissions accounting for Inpatient Revenue	3,790
Outpatient Gross Patient Revenue	202,746,257
Total Outpatient Visits accounting for Outpatient Revenue	75,268
Medicare Contractual Adjustments	105,625,726
Medicaid Contractual Adjustments	52,354,116
Other Contractual Adjustments:	31,323,108
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	18,507,405
Gross Indigent Care:	14,884,355
Gross Charity Care:	2,707,313
Uncompensated Indigent Care (net):	14,884,355
Uncompensated Charity Care (net):	2,707,313
Other Free Care:	1,311,378
Other Revenue/Gains:	10,195,508
Total Expenses:	75,294,939

2. Types of Other Free Care

Please enter the amount for each type of other free care. The amounts entered here must equal the total "Other Free Care" reported in Part C. Question 1. Use the blank line to indicate the type description and amount for other free care that is not included in the types listed.

Other Free Care Type	Other Free Care Amount
Self-Pay/Uninsured Discounts	1,013,012
Admin Discounts	205,971
Employee Discounts	92,396
	0
Total	**1,311,379**

Part D : Indigent/Charity Care Policies and Agreements

1. Formal Written Policy

Did the hospital have a formal written policy or written policies concerning the provision of indigent and/or charity care during 2018? (Check box if yes.) ☑

2. Effective Date

What was the effective date of the policy or policies in effect during 2018?

09/01/2015

3. Person Responsible

Please indicate the title or position held by the person most responsible for adherence to or interpretation of the policy or policies you will provide the department.?

Diane Oglesee, Patient Financial Services Director

4. Charity Care Provisions

Did the policy or policies include provisions for the care that is defined as charity pursuant to HFMA guidelines and the definitions contained in the Glossary that accompanies this survey (i.e., a sliding fee scale or the accomodation to provide care without the expectation of compensation for patients whose individual or family income exceeds 125% of federal poverty level guidelines)? (Check box if yes.) ☑

5. Maximum Income Level

If you had a provision for charity care in your policy, as reflected by responding yes to item 4, what was the maximum income level, expressed as a percentage of the federal poverty guidelines, for a patient to be considered for charity care (e.g., 185%, 200%, 235%, etc.)?

300%

6. Agreements Concerning the Receipt of Government Funds

Did the hospital have an agreement or agreements with any city or county concerning the receipt of government funds for indigent and/or charity care during 2018? (Check box if yes.) ☐

Part E : Indigent And Charity Care

1. Gross Indigent and Charity Care Charges

Please indicate the totals for indigent and charity care for the categories provided below. If the hospital used a sliding fee scale for certain charity patients, only the net charges to charity should be reported (i.e., gross patient charges less any payments received from or billed to the patient.) Total Uncompensated I/C Care must balance to totals reported in Part C.

Patient Type	Indigent Care	Charity Care	Total
Inpatient	4,441,807	691,784	5,133,591
Outpatient	10,442,548	2,015,529	12,458,077
Total	**14,884,355**	**2,707,313**	**17,591,668**

2. Sources of Indigent and Charity Care Funding

Please indicate the source of funding for indigent and/or charity care in the table below.

Source of Funding	Amount
Home County	0
Other Counties	0
City Or Cities	0
Hospital Authority	0
State Programs And Any Other State Funds (Do Not Include Indigent Care Trust Funds)	0
Federal Government	0
Non-Government Sources	0
Charitable Contributions	0
Trust Fund From Sale Of Public Hospital	0
All Other	0
Total	**0**

3. Net Uncompensated Indigent and Charity Care Charges

Total net indigent care must balance to Part C net indigent care and total net charity care must balance to Part C net charity care.

Patient Type	Indigent Care	Charity Care	Total
Inpatient	4,441,807	691,784	5,133,591
Outpatient	10,442,548	2,015,529	12,458,077
Total	**14,884,355**	**2,707,313**	**17,591,668**

Part F : Patient Origin

1. Total Gross Indigent/Charity Care By Charges County

Please report Indigent/Charity Care by County in the following categories. For non Georgia use Alabama, Florida, North Carolina, South Carolina, Tennessee, or Other-Out-of-State.
To add a row press the button. To delete a row press the minus button at the end of the row.
(You may enter the data on the web form or upload the data to the web form using the .csv file.)

Inp Ad-I = Inpatient Admissions (Indigent Care)
Inp Ch-I = Inpatient Charges (Indigent Care)
Out Vis-I = Outpatient Visits (Indigent Care)
Out Ch-I = Outpatient Charges (Indigent Care)

Inp Ad-C = Inpatient Admissions (Charity Care)
Inp Ch-C = Inpatient Charges (Charity Care)
Out Vis-C = Outpatient Visits (Charity Care)
Out Ch-C = Outpatient Charges (Charity Care)

County	Inp Ad-I	Inp Ch-I	Out Vis-I	Out Ch-I	Inp Ad-C	Inp Ch-C	Out Vis-C	Out Ch-C
Clayton	0	0	17	68,373	0	0	0	0
Coweta	0	0	0	0	0	0	1	1,737
Crawford	2	34,215	94	178,440	1	1,138	8	25,976
Lamar	26	531,658	492	1,112,197	13	60,708	188	232,666
Meriwether	24	326,848	135	489,848	9	52,507	63	46,054
Monroe	4	144,494	65	141,772	2	10,454	40	54,175
Other Out of State	14	157,140	172	526,706	0	0	32	50,170
Peach	1	0	3	0	0	0	6	20,587
Pike	115	462,481	586	1,459,095	26	42,541	173	250,730
Spalding	3	68,352	65	277,539	1	14,164	17	59,986
Talbot	0	0	72	204,106	1	1,191	26	13,492
Taylor	12	220,299	136	396,228	5	128,891	34	66,873
Troup	0	0	3	7,801	0	0	0	0
Upson	173	2,496,320	2,795	5,580,442	81	380,190	1,012	1,193,084
Total	**374**	**4,441,807**	**4,635**	**10,442,547**	**139**	**691,784**	**1,600**	**2,015,530**

Indigent Care Trust Fund Addendum

1. Indigent Care Trust Fund

Did your hospital receive funds from the Indigent Care Trust Fund during its Fiscal Year 2018? (Check box if yes.) ☑

2. Amount Charged to ICTF

Indicate the amount charged to the ICTF by each State Fiscal Year (SFY) and for each of the patient categories indicated below during Hospital Fiscal Year 2018.

	Patient Category	SFY 2017 7/1/16-6/30/17	SFY2018 7/1/17-6/30/18	SFY2019 7/1/18-6/30/19
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	5,593,539	7,648,354	7,832,381
B.	Medically Indigent Patients with incomes between 125% and 200% of the Federal Poverty Level Guidelines where adjustments were made to patient amounts due in accordance with an established sliding scale.	1,018,873	1,297,261	1,847,713
C.	Other Patients in accordance with the department approved policy.	0	0	0

3. Patients Served

Indicate the number of patients served by SFY.

SFY 2017 7/1/16-6/30/17	SFY2018 7/1/17-6/30/18	SFY2019 7/1/18-6/30/19
3,126	3,439	3,808

Reconciliation Addendum

This section is printed in landscape format on a separate PDF file.

Electronic Signature

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Executive Officer or Executive Director (principal officer) of the facility. The signature can be completed only AFTER all survey data has been finalized. By law, the signatory is attesting under penalty of law that the information is accurate and complete.

I state, certify and attest that to the best of my knowledge upon conducting due diligence to assure the accuracy and completeness of all data, and based upon my affirmative review of the entire completed survey, this completed survey contains no untrue statement, or incaccurate data, nor omits requested material information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I further understand that inaccurate, incomplete or omitted data could lead to sanctions against me or my facility. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Signature of Chief Executive: Jeffrey Tarrant

Date: 9/23/2019

Title: CEO

I hereby certify that I am the financial officer authorized to sign this form and that the information is true and accurate. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Signature of Financial Officer: John H. Williams

Date: 9/23/2019

Title: CFO

Comments: