



**Transparency Completeness Checklist (HB 321 & HB 186)**

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

<b>HB 321 Document/List/Report Required:</b>	<b>General Instructions:</b>	<b>Special Requirements:</b>	<b>Date Posted:</b>
<b>Audited Financial Statements – Hospital</b>	Most recent version (.pdf)	<i>Contain HB 321 required note (gross patient revenue, allowances, charity care, and net patient revenue)?*</i> <input checked="" type="radio"/> Yes <input type="radio"/> No	07/23/2021
<b>Alternative:</b> Consolidated Financial Statements Including Hospital	Most recent version (.pdf)	<i>List entities included?</i> <input checked="" type="radio"/> Yes <input type="radio"/> No	
<i>Combining or Consolidating Schedules/Financial Information break out for Hospital Subsidiaries</i>	Required for hospitals with subsidiaries and consolidating financial statements. Have balance sheet, statement of operations, or statement of net position?	<i>Contain GAAS required report?*</i> <input checked="" type="radio"/> Yes <input type="radio"/> No	07/23/2021
<b>Audited Financial Statements – Hospital Parent Company</b>	Most recent version (.pdf). Only post for a Georgia entity that directly owns or controls the entity that operates the hospital.		07/23/2021
<i>Combining or Consolidating Schedules/Financial Information break out for Hospital &amp; Brother/Sister Co.</i>	Required for hospitals with parent company and consolidating financial statements. Have balance sheet, statement of operations, or statement of net position?	<i>Contain GAAS required report?*</i> <input checked="" type="radio"/> Yes <input type="radio"/> No	07/23/2021
<b>Audited Financial Statements – Hospital Subsidiaries</b>	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"		07/23/2021
<b>IRS Form 990</b>	As filed with IRS, including Schedule H, but	Post copies of Schedule H and other	07/23/2021

	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.			
<b>AHQ</b>	As filed with DCH.			07/23/2021
<b>Community Benefit Report</b>	As filed with Superior Court Clerk. If none required under O.C.G.A. §31-7-90.1, state "N/A"			07/23/2021
<b>Medicaid DSH Survey</b>	If not required, state "N/A"			07/23/2021
<b>(NEW) List of Real Property Holdings Owned by Hospital</b>  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.			07/23/2021
<b>(NEW) List of Hospital JVs and Ownership Interests</b>  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.			07/23/2021 See Audited Financial Statements Page 8 and 19
<b>(NEW) Listing of Hospital Indebtedness</b>  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?		07/23/2021 See Audited Financial Statements Page 18 - 19
		Yes	No	
<b>(NEW) Report of End of Year Net Assets</b>	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?		07/23/2021 See Audited Financial Statements Page 6
		Yes	No	
<b>Copy of any "going concern" note in Hospital Financial Statements</b>  <b>Alternative:</b> Statement that there is no going concern disclosure in the hospital's audited financial statements	Provide reference (page or section) to portion of financial statements containing note.			N/A
<b>(NEW) Dated Organizational Chart</b>		Includes hospital, parent, subsidiaries and brother/sister companies?		07/23/2021
		Yes	No	
<b>(NEW) Compensation/Benefits Report</b>  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.			07/23/2021 See URM Form 990
<b>Evidence of Hospital Accreditation (e.g., the Joint Commission or DNV)</b>	Copy of certificate or accreditation decision award letter			07/23/2021
<b>Indigent and Charity Care Policy</b>				07/23/2021

<b>Debt Collection Policy</b>			07/23/2021
<b>HB 186 Documents Required:</b>	<b>General Instructions:</b>	<b>Special Requirements:</b>	<b>Date Posted:</b>
<b>Hospital Financial Survey</b>			07/23/2021
<b>Any ASC Surveys Filed by Hospital</b>			N/A
<b>Any Imaging Center Surveys Filed by Hospital</b>			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**

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## **Consolidated Financial Statements**

**Years Ended December 31, 2020 and 2019**



## Table of Contents

<b>Independent Auditors' Report</b> .....	1
<b>Consolidated Financial Statements:</b>	
Consolidated Balance Sheets.....	3
Consolidated Statements of Excess of Revenues over Expenses.....	5
Consolidated Statements of Changes in Net Assets .....	6
Consolidated Statements of Cash Flows.....	7
Notes to Consolidated Financial Statements.....	8
<b>Supplementary Consolidating Information:</b>	
Consolidating Balance Sheet.....	25
Consolidating Statement of Excess of Revenues over Expenses and Changes in Net Assets.....	26



## Independent Auditors' Report

Board of Directors  
Upson County Hospital, Inc. and Affiliates  
d/b/a Upson Regional Medical Center  
Thomaston, GA

We have audited the accompanying consolidated financial statements of Upson County Hospital, Inc. and Affiliates (d/b/a Upson Regional Medical Center) (collectively, the "Hospital"), which comprise the consolidated balance sheets as of December 31, 2020 and 2019, and the related consolidated statements of excess of revenues over expenses, 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.

### ***Auditors' 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 the Hospital has a controlling financial interest, which statements reflect total assets of approximately \$3,709,000 and \$3,361,000 as of December 31, 2020 and 2019, 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 auditors' 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 the Hospital'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 the Hospital's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.



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

***Opinion***

In our opinion, 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, 2020 and 2019, 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.

***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, GA  
April 16, 2021

Upson County Hospital, Inc. and Affiliates  
d/b/a Upson Regional Medical Center  
Consolidated Balance Sheets  
December 31, 2020 and 2019

	<u>2020</u>	<u>2019</u>
<b>ASSETS</b>		
Current assets:		
Cash and cash equivalents	\$ 9,581,740	\$ 2,249,397
Patient accounts receivable	13,233,025	13,994,003
Other receivables	1,375,578	842,468
Supplies	2,916,339	1,867,442
Prepaid expenses	<u>1,738,377</u>	<u>1,605,776</u>
Total current assets	<b>28,845,059</b>	20,559,086
Assets limited as to use internally designated for:		
Capital acquisition	105,604,712	79,802,626
Hospital insurance	<u>3,693,928</u>	<u>3,360,789</u>
Total assets limited as to use	<b>109,298,640</b>	83,163,415
Investments	44,684,251	36,889,099
Property and equipment, net	52,035,898	56,320,371
Other assets	<u>2,865,778</u>	<u>1,690,840</u>
Total assets	<u><b>\$ 237,729,626</b></u>	<u><b>\$ 198,622,811</b></u>



Upson County Hospital, Inc. and Affiliates  
d/b/a Upson Regional Medical Center  
Consolidated Balance Sheets (continued)  
December 31, 2020 and 2019

	<u>2020</u>	<u>2019</u>
<b>LIABILITIES AND NET ASSETS</b>		
Current liabilities:		
Current portion of long-term debt	\$ 1,000,000	\$ 2,964,382
Accounts payable	4,548,901	2,418,626
Accrued payroll	1,320,347	1,040,371
Accrued payroll taxes	155,810	114,131
Accrued benefits	1,524,934	1,353,170
Other accrued liabilities	751,932	505,944
Deferred revenue for provider relief funds	2,142,437	-
Estimated third-party payor settlements	911,439	306,640
	<u>12,355,800</u>	<u>8,703,264</u>
Total current liabilities		
Long-term debt, net of current portion	3,291,992	4,360,819
Accrued insurance reserves	1,141,500	1,213,597
	<u>16,789,292</u>	<u>14,277,680</u>
Total liabilities		
Net assets:		
Net assets without donor restrictions	220,940,334	184,345,131
	<u>220,940,334</u>	<u>184,345,131</u>
Total liabilities and net assets	<u>\$ 237,729,626</u>	<u>\$ 198,622,811</u>

Upson County Hospital, Inc. and Affiliates  
d/b/a Upson Regional Medical Center  
Consolidated Statements of Excess of Revenues over Expenses  
Years Ended December 31, 2020 and 2019

	<u>2020</u>	<u>2019</u>
Revenues:		
Net patient service revenue	\$ 87,129,822	\$ 92,314,833
Provider relief funds	10,758,629	-
Other revenue	<u>2,125,405</u>	<u>1,262,373</u>
Total revenues	<b>100,013,856</b>	93,577,206
Operating expenses:		
Salaries	41,270,722	39,158,467
Employee benefits	8,794,093	9,911,694
Contract labor	3,924,703	3,346,755
Physicians fees	3,621,472	3,422,209
Purchased services	9,071,314	8,713,922
Legal fees	187,967	442,632
Supply expense	14,119,637	12,731,380
Utilities	1,564,104	1,801,979
Repairs and maintenance	2,688,186	2,653,311
Insurance expense	604,092	493,488
Leases and rentals	547,989	601,985
Depreciation	7,630,948	7,597,320
Interest	242,959	322,246
Other	<u>3,539,141</u>	<u>2,312,719</u>
Total operating expenses	<u>97,807,327</u>	<u>93,510,107</u>
Operating income	<b>2,206,529</b>	67,099
Other income:		
Investment income	10,076,165	7,045,183
Net unrealized gains on investments	23,830,781	14,462,466
Other	(106,016)	1,695
Contributions	<u>587,744</u>	<u>499,987</u>
Total other income	<u>34,388,674</u>	<u>22,009,331</u>
Excess of revenues over expenses	<u>\$ 36,595,203</u>	<u>\$ 22,076,430</u>

Upson County Hospital, Inc. and Affiliates  
d/b/a Upson Regional Medical Center  
Consolidated Statements of Changes in Net Assets  
Years Ended December 31, 2020 and 2019

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	<u>2020</u>	<u>2019</u>
Excess of revenues over expenses	<u>\$ 36,595,203</u>	<u>\$ 22,076,430</u>
Change in net assets	<b>36,595,203</b>	22,076,430
Net assets, beginning of year	<u>184,345,131</u>	<u>162,268,701</u>
Net assets, end of year	<u><b>\$ 220,940,334</b></u>	<u><b>\$ 184,345,131</b></u>

Upson County Hospital, Inc. and Affiliates  
d/b/a Upson Regional Medical Center  
Consolidated Statements of Cash Flows  
Years Ended December 31, 2020 and 2019

	<u>2020</u>	<u>2019</u>
Cash flows from operating activities:		
Change in net assets	\$ 36,595,203	\$ 22,076,430
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation	7,630,948	7,597,320
Net realized and unrealized gains on investments and assets limited as to use	(27,526,186)	(16,856,681)
Loss (gain) on disposal of assets	106,016	(1,695)
Changes in:		
Patient accounts receivable	760,978	(1,597,021)
Supplies	(1,048,897)	100,214
Other assets	(1,840,649)	(297,744)
Accounts payable and accrued expenses	2,869,682	(149,109)
Accrued insurance reserves	(72,097)	307,825
Deferred revenue for provider relief funds	2,142,437	-
Estimated third-party payor settlements	604,799	267,761
Net cash provided by operating activities	<u>20,222,234</u>	11,447,300
Cash flows from investing activities:		
Purchase of property and equipment	(3,665,233)	(4,554,901)
Proceeds from disposal of assets	212,742	1,625
Purchases (sales) of investments and assets limited as to use	<u>(6,367,064)</u>	<u>(3,098,492)</u>
Net cash used by investing activities	<u>(9,819,555)</u>	(7,651,768)
Cash flows from financing activities:		
Payments on long-term debt	<u>(3,033,209)</u>	<u>(2,957,139)</u>
Net cash used by financing activities	<u>(3,033,209)</u>	<u>(2,957,139)</u>
Increase in cash and cash equivalents	7,369,470	838,393
Cash and cash equivalents at beginning of year	<u>3,019,026</u>	<u>2,180,633</u>
Cash and cash equivalents at end of year	<u>\$ 10,388,496</u>	<u>\$ 3,019,026</u>
Supplementary disclosure of cash flow information:		
Cash paid during the year for interest	<u>\$ 235,208</u>	<u>\$ 309,530</u>
Reconciliation of cash, cash equivalents and restricted cash:		
Cash and cash equivalents	\$ 9,581,740	\$ 2,249,397
Restricted cash and cash equivalents, included in assets limited as to use	<u>806,756</u>	<u>769,629</u>
Total cash, cash equivalents, and restricted cash	<u>\$ 10,388,496</u>	<u>\$ 3,019,026</u>

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 lease was extended for another 40 years effective February 15, 2012 and will now expire on February 14, 2052.

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 Assets***

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

*Net Assets Without Donor Restrictions* – Net assets available for use in 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. At December 31, 2020 and 2019, 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) and unrealized gains and losses on investments are included in the excess of revenues over expenses unless the income or loss is restricted by donor or law.

### ***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 is 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. After completing the annual impairment review as of December 31, 2020, the Hospital concluded that goodwill was not impaired.

### ***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, 2020 and 2019.

### ***Leases***

Right-of-use ("ROU") assets represent the Hospital's right to use leased assets over the term of the lease. The ROU asset is subsequently measured at cost, less any accumulated amortization and any accumulated impairment losses. Amortization of the ROU asset is recognized over the period from the commencement date to the earlier of (1) the end of the useful life of the ROU asset, or (2) the end of the lease term.

**Upson County Hospital, Inc. and Affiliates**  
**(d/b/a Upson Regional Medical Center)**  
**Notes to Consolidated Financial Statements**

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During 2015, the hospital entered into a finance lease with Banc of America Public Capital Corp for the purpose of financing purchases of equipment. This lease was paid off during 2020.

***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 reflects the estimated net realizable amounts from patients, third-party payors, and others as services are rendered, including a provision for bad debts (implicit price concessions) and estimated retroactive adjustments under reimbursement agreements. Such amounts are recognized 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 considered explicit price concessions and not reported as net patient service 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 consolidated 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, 2020 and 2019 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 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 16, 2021, the date the consolidated financial statements were issued. All significant events have been included in the consolidated financial statements and disclosures.

## **2. Net Patient Service Revenue**

Net patient service revenue is generated by providing patient care and recognized as performance obligations are satisfied. Amounts are reported at the estimated net realizable amount that reflects the consideration to which the Hospital expects to be paid from patients, third-party payors (including health insurer and government programs) and others.

Performance obligations are determined based on the nature of the services provided by the Hospital. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected charges. Generally, performance obligations satisfied over time relate to patients in the hospital receiving inpatient acute care services. The Hospital measures the performance obligation from admission to the point when it is no longer required to provide services to that patient, which is generally the time of discharge. Revenue for performance obligations satisfied at a point in time generally relate to patients receiving outpatient services or patients and customers in a retail setting (for example, pharmaceuticals and medical equipment) where the Hospital does not provide additional goods beyond the point of service.

The Hospital has elected the practical expedients available under the new revenue recognition accounting guidance related to accounting for significant financing components and incremental contract acquisition costs, and such amounts are insignificant. In addition, because all of its performance obligations relate to contracts with a duration of less than one year, the Hospital has elected to apply the optional exemption from disclosure of amounts associated with unsatisfied performance obligations at the end of the reporting period. Such unsatisfied or partially unsatisfied performance obligations primarily relate to inpatient acute care services at the end of the reporting period



**Upton County Hospital, Inc. and Affiliates  
(d/b/a Upton Regional Medical Center)  
Notes to Consolidated Financial Statements**

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for in-house patients, who are generally discharged within days or weeks after the end of the reporting period. The Hospital has an unconditional right to receive payment subject only to the passage of time for services provided to these in-house patients through the end of the reporting period. Such amounts are reported within patient accounts receivable in the consolidated balance sheets.

The transaction price is based on standard charges for goods and services provided, reduced by explicit price concessions (contractual adjustments) provided to third-party payors, explicit price concessions (discounts provided to patients qualifying under the charity policy), and implicit price concessions provided to self-pay patients.

Implicit price concessions for uninsured and underinsured patients that do not qualify for financial assistance are estimated based on historical collection experience with this class of patients using a portfolio approach as a practical expedient. For uninsured and underinsured patients that do not qualify for financial assistance, the Hospital recognizes revenue on the basis of established rates, discounted according to policy for services rendered. Historical experience has shown a significant proportion of the Hospital's uninsured patients, in addition to a growing proportion of the Hospital's insured patients, will be unable or unwilling to pay for their responsible amounts for the services provided. In order to estimate the net realizable value of the revenues and accounts receivable associated with third-party payors and uninsured patients, management regularly assesses their valuation based upon business and economic considerations, trends in healthcare coverage, historical write-off experience and other collection trends.

The Hospital has agreements with third-party payors that provide for payments at amounts different from established rates. These contractual adjustments are explicit price concessions and represent the difference between established charges and the estimated reimbursable amounts from third-party payors. Explicit price concessions are estimated based on contractual agreements, discount policies, and historical experience.

The Hospital disaggregates its net patient service revenue by payor source. The disaggregation by payor source is as follows:

	<u>2020</u>	<u>2019</u>
Medicare	\$ 18,505,656	\$ 18,641,509
Medicare Advantage	17,890,325	16,233,501
Medicaid	2,393,602	3,222,910
Medicaid Managed Care	3,515,411	4,920,130
Self-pay	5,746,653	5,085,922
Blue Cross Blue Shield	24,574,995	25,215,194
Other	<u>14,503,180</u>	<u>18,995,667</u>
	<u>\$ 87,129,822</u>	<u>\$ 92,314,833</u>

Estimated Third-Party Payor Settlements:

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.

**Upson County Hospital, Inc. and Affiliates  
(d/b/a Upson Regional Medical Center)  
Notes to Consolidated Financial Statements**

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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, 2018.

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, 2015.

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.

Indigent Care Trust Fund (ICTF)

The Hospital qualified as a Medicaid disproportionate share hospital for the years ended December 31, 2020 and 2019. By qualifying, the Hospital received payment adjustments of approximately \$1,178,000 and \$1,267,000 in 2020 and 2019, 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. The federal government does not ensure ICTF funding.

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 \$353,000 and \$466,000 in 2020 and 2019, respectively. The federal government does not ensure UPL funding.

**Upson County Hospital, Inc. and Affiliates**  
**(d/b/a Upson Regional Medical Center)**  
**Notes to Consolidated Financial Statements**

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Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. The Hospital believes that is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries have been made, 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.

Settlements with third-party payors for retroactive adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and the Hospital's historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews, and investigations. Net patient service revenue decreased by approximately \$753,000 for the year ended December 31, 2020 and increased by approximately \$76,000 for the year ended December 31, 2019, due to changes in the transaction price.

Patient Accounts Receivable:

Patient accounts receivable represent expected amounts to be collected from the Medicare and Medicaid programs, private insurance carriers, and private-pay residents, as well as residents with co-insurance provisions. The Hospital grants credit without collateral to its patients, most of whom are local residents. The net amount expected to be collected is determined based on an established collection history and review of individual balances. Third-party reimbursement is a complex process which involves submission of claims to multiple payors, each having its own claims requirements. In some cases, the ultimate collection of patient accounts receivable subsequent to service dates may not be known for several months.

The mix of receivables from patients and third-party payors at December 31, 2020 and 2019, was as follows:

	<u>2020</u>	<u>2019</u>
Medicare	29%	29%
Medicaid	6%	9%
Other third-party payors	52%	42%
Patients	<u>13%</u>	<u>20%</u>
Total	<u><u>100%</u></u>	<u><u>100%</u></u>

**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, 2020 and 2019:

	<u>2020</u>	<u>2019</u>
Cash and cash equivalents	\$ 9,581,740	\$ 2,249,397
Patient accounts receivable	13,233,025	13,994,003
Other receivables	<u>1,375,578</u>	<u>842,468</u>
Total	<u><u>\$ 24,190,343</u></u>	<u><u>\$ 17,085,868</u></u>

**Upson County Hospital, Inc. and Affiliates**  
**(d/b/a Upson Regional Medical Center)**  
**Notes to Consolidated Financial Statements**

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The Hospital funds its operations primarily through service charges to patients.

Although the Hospital does not intend to spend from investments or assets limited as to use internally designated for capital acquisition as of December 31, 2020, these amounts could be made available if necessary and approved by the Board of Directors. 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 2020 and 2019 were approximately \$242,002,000 and \$251,084,000, respectively.

Uncompensated care includes charity and indigent care services of approximately \$19,595,000 and \$22,523,000 in 2020 and 2019, respectively. The cost of charity and indigent care services provided during 2020 and 2019 was approximately \$5,926,000 and \$6,216,000, 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 2020 and 2019.

	<u>2020</u>	<u>2019</u>
Gross patient charges	\$ 329,132,028	\$ 343,398,775
Uncompensated services:		
Charity and indigent care	19,594,959	22,523,242
Medicare	110,027,918	120,244,962
Medicaid	53,271,735	56,306,666
Other allowances	43,157,268	36,149,631
Implicit price concessions	<u>15,950,326</u>	<u>15,859,441</u>
Total uncompensated care	<u>242,002,206</u>	<u>251,083,942</u>
Net patient service revenue	<u>\$ 87,129,822</u>	<u>\$ 92,314,833</u>

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.

Upson County Hospital, Inc. and Affiliates  
(d/b/a Upson Regional Medical Center)  
Notes to Consolidated Financial Statements

**5. Assets Limited as to Use**

The composition of assets limited as to use at December 31, 2020 and 2019, is set forth in the following table. Assets limited as to use are classified as other than trading and are stated at fair value.

	<u>2020</u>	<u>2019</u>
Internally designated for capital acquisition:		
Cash and cash equivalents	\$ 133,047	\$ 371,708
U.S. Corporate bonds and notes	5,473,274	4,694,931
Municipal securities	701,207	348,893
Mutual funds - fixed	11,111,737	10,397,663
Mutual funds - equities	81,898,449	57,288,984
Government securities	6,210,956	6,631,762
Interest receivable	<u>76,042</u>	<u>68,685</u>
	<b>105,604,712</b>	79,802,626
	<u>2020</u>	<u>2019</u>
Internally designated for Hospital insurance:		
Cash and cash equivalents	673,709	397,921
U.S. Corporate bonds and notes	1,255,700	1,310,617
Mutual funds - fixed	362,486	599,016
Mutual funds - equities	404,487	432,569
Equity securities	991,655	614,081
Interest receivable	<u>5,891</u>	<u>6,585</u>
	<b>3,693,928</b>	3,360,789
	<u>2020</u>	<u>2019</u>
Total assets limited as to use	<b><u>\$ 109,298,640</u></b>	<b><u>\$ 83,163,415</u></b>

**6. Investments**

Investments, stated at fair value, at December 31, 2020 and 2019, include:

	<u>2020</u>	<u>2019</u>
Cash and cash equivalents	\$ 329,836	\$ 258,407
Certificate of deposit	170,836	174,893
U.S. Corporate bonds and notes	4,669,695	4,661,711
Municipal securities	567,094	256,076
Mutual funds - fixed	10,686,461	11,364,650
Mutual funds - equities	22,380,416	14,455,980
Government securities	5,652,274	5,494,862
Interest receivable	68,249	59,154
Equity securities	<u>159,390</u>	<u>163,366</u>
	<b><u>\$ 44,684,251</u></b>	<b><u>\$ 36,889,099</u></b>

**Upson County Hospital, Inc. and Affiliates**  
**(d/b/a Upson Regional Medical Center)**  
**Notes to Consolidated Financial Statements**

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, 2020 and 2019:

	<u>2020</u>	<u>2019</u>
Income:		
Interest and dividend income	\$ 6,380,760	\$ 4,650,968
Realized gains on sale of investments	<u>3,695,405</u>	<u>2,394,215</u>
	<u>\$ 10,076,165</u>	<u>\$ 7,045,183</u>
Net unrealized gains on investments	<u>\$ 23,830,781</u>	<u>\$ 14,462,466</u>

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.

## 7. Property and Equipment

A summary of property and equipment at December 31, 2020 and 2019 follows:

	<u>2020</u>	<u>2019</u>
Land	\$ 1,856,658	\$ 1,922,815
Land improvements	903,685	896,431
Buildings and improvements	71,233,582	70,841,532
Equipment	<u>70,994,136</u>	<u>68,483,486</u>
	144,988,061	142,144,264
Less accumulated depreciation	<u>93,403,392</u>	<u>86,699,019</u>
	51,584,669	55,445,245
Construction-in-progress	<u>451,229</u>	<u>875,126</u>
Total property and equipment, net	<u>\$ 52,035,898</u>	<u>\$ 56,320,371</u>

Depreciation expense for the years ended December 31, 2020 and 2019 amounted to approximately \$7,631,000 and \$7,597,000, respectively.

## 8. Accrued Insurance Reserves

Activity in accrued insurance reserves is summarized as follows:

	<u>2020</u>	<u>2019</u>
Balance, January 1	\$ 1,213,597	\$ 905,772
Incurred related to current year	348,360	367,034
Incurred related to prior years	(51,507)	43,266
Paid related to current year	(144,654)	(19,132)
Paid related to prior years	<u>(224,296)</u>	<u>(83,343)</u>
Balance, December 31	<u>\$ 1,141,500</u>	<u>\$ 1,213,597</u>

**Upson County Hospital, Inc. and Affiliates**  
**(d/b/a Upson Regional Medical Center)**  
**Notes to Consolidated Financial Statements**

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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, Inc. and Casualty Actuarial Consultants, Inc., in their reports dated January 22, 2021 and February 25, 2021, respectively. 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.

## 9. Long-Term Debt

A summary of long-term debt at December 31, 2020 and 2019 follows:

	<u>2020</u>	<u>2019</u>
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.	\$ 2,685,000	\$ 3,290,000
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.	1,615,000	1,980,000
Finance lease obligations	<u>-</u>	<u>2,070,960</u>
	<b>4,300,000</b>	7,340,960
Less bond discount	3,609	5,390
Less unamortized issuance costs	4,399	10,369
Less current portion	<u>1,000,000</u>	<u>2,964,382</u>
Total	<u>\$ 3,291,992</u>	<u>\$ 4,360,819</u>

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 limited 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 finance lease with Banc of America Public Capital Corp for \$10,000,000. The finance lease was entered into by the Authority for the purpose of financing equipment purchases for Upson Regional Medical Center. The finance lease bears interest at an annual rate of 1.76% and was completely paid off during 2020.

**Upson County Hospital, Inc. and Affiliates**  
**(d/b/a Upson Regional Medical Center)**  
**Notes to Consolidated Financial Statements**

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Scheduled principal repayments on long-term debt are as follows:

	<u>Bonds</u>
2021	\$ 1,010,000
2022	1,055,000
2023	1,095,000
2025 <sup>4</sup>	<u>1,140,000</u>
Total	<u>\$ 4,300,000</u>

## **10. 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 \$4,595,000 and \$6,049,000 during the years ended December 31, 2020 and 2019, respectively.

## **11. 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, 2020 and 2019. 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 2%.

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.

## **12. 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.



**Upson County Hospital, Inc. and Affiliates  
(d/b/a Upson Regional Medical Center)  
Notes to Consolidated Financial Statements**

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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 2020 or 2019. Contributions are subject to certain IRS limitations.

The cost of the Plan to the Hospital was approximately \$596,000 and \$577,000 for the years ended December 31, 2020 and 2019, respectively.

### **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. Related Parties**

The Hospital has a management contract with HealthTech Management, LLC. The Hospital paid management fees and contract labor costs of approximately \$897,000 and \$877,000 in 2020 and 2019, respectively.

### **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.

**Upson County Hospital, Inc. and Affiliates**  
**(d/b/a Upson Regional Medical Center)**  
**Notes to Consolidated Financial Statements**

- *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, 2020 and 2019.

<b><u>December 31, 2020</u></b>	<b><u>Total Fair Value</u></b>	<b><u>Quoted Prices in Active Markets for Identical Assets (Level 1)</u></b>	<b><u>Significant Other Observable Inputs (Level 2)</u></b>	<b><u>Significant Unobservable Inputs (Level 3)</u></b>
Money market funds	\$ 1,136,592	\$ 1,136,952	\$ -	\$ -
Certificates of deposit	170,836	-	170,836	-
U.S. Corporate bonds and notes	11,398,669	-	11,398,669	-
Municipal securities	1,268,301	1,268,301	-	-
Mutual funds - fixed	22,160,684	22,160,684	-	-
Mutual funds - equities	104,683,352	104,683,352	-	-
Government securities	11,863,230	-	11,863,230	-
Interest receivable	150,182	150,182	-	-
Equity securities	<u>1,151,045</u>	<u>1,151,045</u>	<u>-</u>	<u>-</u>
Total	<u>\$153,982,891</u>	<u>\$130,550,156</u>	<u>\$ 23,432,735</u>	<u>\$ -</u>

<b><u>December 31, 2019</u></b>	<b><u>Total Fair Value</u></b>	<b><u>Quoted Prices in Active Markets for Identical Assets (Level 1)</u></b>	<b><u>Significant Other Observable Inputs (Level 2)</u></b>	<b><u>Significant Unobservable Inputs (Level 3)</u></b>
Money market funds	\$ 1,028,036	\$ 1,028,036	\$ -	\$ -
Certificates of deposit	174,893	-	174,893	-
U.S. Corporate bonds and notes	10,667,259	-	10,667,259	-
Municipal securities	604,969	604,969	-	-
Mutual funds - fixed	22,361,329	22,361,329	-	-
Mutual funds - equities	72,177,533	72,177,533	-	-
Government securities	12,126,624	-	12,126,624	-
Interest receivable	134,424	134,424	-	-
Equity securities	<u>777,447</u>	<u>777,447</u>	<u>-</u>	<u>-</u>
Total	<u>\$120,052,514</u>	<u>\$ 97,083,738</u>	<u>\$ 22,968,776</u>	<u>\$ -</u>

Upson County Hospital, Inc. and Affiliates  
(d/b/a Upson Regional Medical Center)  
Notes to Consolidated Financial Statements

**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, 2020 are as follows:

	<u>Healthcare Services</u>	<u>General &amp; Admin</u>	<u>Total</u>
Salaries	\$ 29,073,662	\$ 12,197,060	\$ 41,270,722
Employee benefits	8,794,093	-	8,794,093
Contract labor	2,850,293	1,074,410	3,924,703
Physicians fees	3,621,472	-	3,621,472
Purchased services	2,295,623	6,775,691	9,071,314
Legal fees	-	187,967	187,967
Supply expense	13,523,092	596,545	14,119,637
Utilities	1,512,612	51,492	1,564,104
Repairs and maintenance	1,289,044	1,399,142	2,688,186
Insurance expense	604,092	-	604,092
Leases and rentals	516,185	31,804	547,989
Depreciation	7,630,948	-	7,630,948
Interest	-	242,959	242,959
Other	1,078,675	2,460,466	3,539,141
	<u>\$ 72,789,791</u>	<u>\$ 25,017,536</u>	<u>\$ 97,807,327</u>
Total			

Expenses related to providing these services for the year ended December 31, 2019 are as follows:

	<u>Healthcare Services</u>	<u>General &amp; Admin</u>	<u>Total</u>
Salaries	\$ 28,266,911	\$ 10,891,556	\$ 39,158,467
Employee benefits	9,911,694	-	9,911,694
Contract labor	2,379,863	966,892	3,346,755
Physicians fees	3,422,209	-	3,422,209
Purchased services	1,871,786	6,842,136	8,713,922
Legal fees	-	442,632	442,632
Supply expense	12,010,214	721,166	12,731,380
Utilities	1,726,850	75,129	1,801,979
Repairs and maintenance	1,276,238	1,377,073	2,653,311
Insurance expense	493,488	-	493,488
Leases and rentals	573,148	28,837	601,985
Depreciation	7,597,320	-	7,597,320
Interest	-	322,246	322,246
Other	808,556	1,504,163	2,312,719
	<u>\$ 70,338,277</u>	<u>\$ 23,171,830</u>	<u>\$ 93,510,107</u>
Total			

## 17. 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 \$1,004,000 and \$972,000 relating to the Act is included in other operating expenses in the accompanying statement of operations for the years ended December 31, 2020 and 2019, respectively.

## 18. COVID-19 Pandemic and Provider Relief Funds

On March 11, 2020, the World Health Organization declared the outbreak of COVID-19, a novel strain of coronavirus, a pandemic, and on March 13, 2020, a national emergency was declared in the United States. In response to the COVID-19 pandemic, the Coronavirus Aid, Relief and Economic Security ("CARES") Act was signed into law on March 27, 2020. One provision of the CARES Act was the establishment of the Provider Relief Funds ("PRF"), administered by the U.S. Department of Health and Human Services ("HHS"). The PRF are being distributed to healthcare providers throughout the country to support the battle against the COVID-19 outbreak. During the year ended December 31, 2020, the Hospital received approximately \$12,420,000 in distributions from this fund. The Hospital also received approximately \$481,000 in provider relief funds from other sources that originated through HHS. These funds are intended to reimburse qualifying expenses and lost revenues attributable to COVID-19 and are subject to the terms, conditions, and regulatory requirements set forth by HHS. If the total distributions received by the Hospital exceed the cumulative amount of qualifying expenses and lost revenues attributable to COVID-19 through June 30, 2021, any excess funding may be subject to recoupment. The PRF are accounted for as voluntary nonexchange transactions and related revenues are recognized as eligibility criteria are met. During the year ended December 31, 2020, the Hospital recognized approximately \$10,759,000 in operating revenues, which is presented as provider relief funds on the consolidated statements of operations. Approximately \$2,142,000 has been deferred as of December 31, 2020 and is expected to be recognized in full in fiscal 2021.

On October 22, 2020, November 2, 2020 and January 15, 2021, HHS issued Post-Payment Notices of Reporting Requirements ("PPNRR") which establish the reporting criteria for providers which received PRF funding under the CARES Act. On December 27, 2020, the Coronavirus Response and Relief Supplemental Appropriations Act of 2021 ("CRRSAA") was signed into law which provided on-going assistance to healthcare providers and provided additional clarity around PRF reporting requirements. The guidance provided in the PPNRR and CRRSAA is advisory in nature, and subject to change, and it is unknown at the report date what impacts this, and future guidance will have on PRF funding and revenue recognition. As such, amounts recognized as PRF for the year ended December 31, 2020 are subject to change and those changes could be material. The funds are also subject to future audits and potential adjustment and certain amounts may need to be repaid to the government. In addition to the terms, conditions, and published regulatory guidance, as of April 16, 2021, HHS has published additional guidance related to the nature and allowability of certain qualifying expenses and methods for determining lost revenues attributable to COVID-19 through the publication of Frequently Asked Questions ("FAQs"). These HHS PRF FAQs have been subject to significant amendment and revision over the course of the program. The Hospital relied on the guidance available during the year ended December 31, 2020 and through April 16, 2021 in determining the amounts of qualifying expenses and lost revenues attributable to COVID-19 and the related recognition of revenue during fiscal 2020. Such determinations required management to make subjective interpretations of the available guidance, and to make assumptions and exercise considerable judgment. Subsequent changes or clarifications in guidance from HHS and OMB could have a material impact on management's estimates and the determination of such amounts. The PRF are subject to audit by HHS which may result in disallowed expenditures which may be subject to recoupment. Such amounts, if any, cannot be determined at this time.

**Upson County Hospital, Inc. and Affiliates  
(d/b/a Upson Regional Medical Center)  
Notes to Consolidated Financial Statements**

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Further, the CARES Act provides for an employee retention credit ("ERC") against applicable employment taxes for eligible employers, including tax-exempt organizations, that pay qualified wages, including certain health plan expenses, to some or all employees after March 12, 2020 and before January 1, 2021. This provision of the CARES Act was further amended by the Continuing Appropriations Act to extend the application of the ERC to qualified wages paid after December 31, 2020 and before July 1, 2021 which also included certain modifications of the calculation of the credit amount during that time. During the year ended December 31, 2020, the Hospital recorded a credit of approximately \$1,091,000 which is recorded within other operating revenues in the accompanying consolidated statements of excess of revenues over expenses as management believes conditions for recognition have been substantially met.



## ***Supplementary Consolidating Information***

Upson County Hospital, Inc. and Affiliates  
d/b/a Upson Regional Medical Center  
Consolidating Balance Sheet  
December 31, 2020

	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
<b>ASSETS</b>													
Current assets:													
Cash and cash equivalents	\$ 8,603,171	\$ 167,268	\$ 71,661	\$ 31,616	\$ 67,734	\$ 73,253	\$ 143,824	\$ -	\$ 108,086	\$ 5,000	\$ 310,127	\$ -	\$ 9,581,740
Patient accounts receivable	11,439,402	33,481	-	-	279,835	253,397	332,104	-	666,627	-	228,179	-	13,233,025
Other receivables	1,166,278	4,704	674	-	32,275	39,701	64,299	-	62,474	-	5,173	-	1,375,578
Supplies	2,893,655	-	-	-	-	-	13,920	-	8,764	-	-	-	2,916,339
Prepaid expenses	1,346,769	360	11,872	-	51,484	156,189	28,510	15,000	125,496	-	2,697	-	1,738,377
Total current assets	25,449,275	205,813	84,207	31,616	431,328	522,540	582,657	15,000	971,447	5,000	546,176	-	28,845,059
Assets limited as to use internally designated for:													
Capital acquisition	105,604,712	-	-	-	-	-	-	-	-	-	-	-	105,604,712
Hospital insurance	-	-	-	-	-	-	-	3,693,928	-	-	-	-	3,693,928
Total assets limited as to use	105,604,712	-	-	-	-	-	-	3,693,928	-	-	-	-	109,298,640
Intercompany receivables	70,097,793	-	-	1,626	-	-	-	-	-	-	-	(70,099,419)	-
Investments	41,463,743	-	-	5,683,412	-	-	-	-	-	-	-	(2,462,904)	44,684,251
Property and equipment, net	46,481,121	27,410	78,053	-	144,872	174,644	97,290	-	204,644	4,769,764	58,100	-	52,035,898
Other assets	1,226,575	-	-	-	-	-	-	-	-	-	1,639,203	-	2,865,778
Total assets	<u>\$ 290,323,219</u>	<u>\$ 233,223</u>	<u>\$ 162,260</u>	<u>\$ 5,716,654</u>	<u>\$ 576,200</u>	<u>\$ 697,184</u>	<u>\$ 679,947</u>	<u>\$ 3,708,928</u>	<u>\$ 1,176,091</u>	<u>\$ 4,774,764</u>	<u>\$ 2,243,479</u>	<u>\$ (72,562,323)</u>	<u>\$ 237,729,626</u>
<b>LIABILITIES AND NET ASSETS</b>													
Current liabilities:													
Current portion of													
long-term debt	\$ 1,000,000	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,000,000
Accounts payable	3,766,077	38,042	5,852	-	20,733	48,611	138,180	36,163	378,449	600	116,194	-	4,548,901
Accrued payroll	998,170	3,545	6,691	-	66,056	50,911	76,254	-	88,551	-	30,169	-	1,320,347
Accrued payroll taxes	134,606	271	-	-	2,718	3,653	5,425	-	7,189	-	1,948	-	155,810
Accrued benefits	1,433,777	2,604	-	-	12,370	23,907	23,328	-	15,369	-	13,579	-	1,524,934
Other accrued liabilities	728,710	(3,234)	25,433	-	(6,475)	(33,183)	(23,338)	68,361	28,337	-	(32,679)	-	751,932
Deferred revenue	2,142,437	-	-	-	-	-	-	-	-	-	-	-	2,142,437
Estimated third-party payor settlements	911,439	-	-	-	-	-	-	-	-	-	-	-	911,439
Total current liabilities	11,115,216	41,228	37,976	-	95,402	93,899	219,849	104,524	517,895	600	129,211	-	12,355,800
Long-term debt, net of current portion													
Intercompany payables	3,291,992	-	-	-	-	-	-	-	-	-	-	-	3,291,992
Accrued insurance reserves	-	20,692,066	1,987,825	-	6,644,218	10,895,833	6,873,152	-	14,100,797	5,753,931	3,151,597	(70,099,419)	-
Total liabilities	14,407,208	20,733,294	2,025,801	-	6,739,620	10,989,732	7,093,001	1,246,024	14,618,692	5,754,531	3,280,808	(70,099,419)	16,789,292
Net assets:													
Net assets without donor restrictions	275,916,011	(20,500,071)	(1,863,541)	5,716,654	(6,163,420)	(10,292,548)	(6,413,054)	2,462,904	(13,442,601)	(979,767)	(1,037,329)	(2,462,904)	220,940,334
Total liabilities and net assets	<u>\$ 290,323,219</u>	<u>\$ 233,223</u>	<u>\$ 162,260</u>	<u>\$ 5,716,654</u>	<u>\$ 576,200</u>	<u>\$ 697,184</u>	<u>\$ 679,947</u>	<u>\$ 3,708,928</u>	<u>\$ 1,176,091</u>	<u>\$ 4,774,764</u>	<u>\$ 2,243,479</u>	<u>\$ (72,562,323)</u>	<u>\$ 237,729,626</u>

Upson County Hospital, Inc. and Affiliates  
d/b/a Upson Regional Medical Center  
Consolidating Statement of Excess of Revenues over Expenses and Changes in Net Assets  
December 31, 2020

	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:													
Net patient service revenue	\$ 76,811,627	\$ 173,426	\$ -	\$ -	\$ 1,362,601	\$ 1,673,151	\$ 2,621,248	\$ -	\$ 2,734,246	\$ -	\$ 1,753,523	\$ -	\$ 87,129,822
Provider relief funds	9,659,167	2,319	-	-	317,548	201,514	160,529	-	406,875	-	10,677	-	10,758,629
Other revenue	2,027,818	480,434	338,727	-	41,857	51,108	109,254	692,477	89,985	-	42,839	(1,749,094)	2,125,405
<b>Total revenues</b>	<b>88,498,612</b>	<b>656,179</b>	<b>338,727</b>	<b>-</b>	<b>1,722,006</b>	<b>1,925,773</b>	<b>2,891,031</b>	<b>692,477</b>	<b>3,231,106</b>	<b>-</b>	<b>1,807,039</b>	<b>(1,749,094)</b>	<b>100,013,856</b>
Operating expenses:													
Salaries	31,202,896	101,502	-	-	2,142,170	1,612,977	2,376,978	-	2,794,162	-	1,040,037	-	41,270,722
Employee benefits	7,166,259	22,560	-	-	223,554	226,323	447,523	-	495,710	1,508	210,656	-	8,794,093
Contract labor	3,683,101	-	241,602	-	-	-	-	-	-	-	-	-	3,924,703
Physicians fees	2,895,593	-	-	-	-	418,539	-	-	307,340	-	-	-	3,621,472
Purchased services	7,460,241	50,748	54,533	-	98,197	144,547	228,900	296,853	991,043	2,400	135,784	(391,932)	9,071,314
Legal fees	103,621	-	-	-	-	-	-	-	84,346	-	-	-	187,967
Supply expense	12,940,204	212	13,487	-	78,042	202,236	340,580	-	171,552	-	373,324	-	14,119,637
Utilities	1,372,446	105,155	-	-	17,835	25,386	61,420	-	47,509	18,690	40,802	(125,139)	1,564,104
Repairs and maintenance	2,604,440	34,127	8,505	-	3,813	4,754	2,839	-	15,698	95	13,915	-	2,688,186
Insurance expense	1,054,240	-	-	-	43,210	116,323	-	-	75,746	-	-	(685,427)	604,092
Leases and rentals	278,560	-	182,618	-	76,322	95,879	155,620	-	153,388	-	125,505	(519,903)	547,989
Depreciation	6,732,695	411,784	28,406	-	30,062	51,642	31,630	-	104,957	224,314	15,458	-	7,630,948
Interest	242,959	-	-	-	-	-	-	-	-	-	-	-	242,959
Other	3,145,135	5,772	44,262	5,014	11,777	21,048	24,612	165,181	97,329	14,011	31,693	(26,693)	3,539,141
<b>Total operating expenses</b>	<b>80,882,390</b>	<b>731,860</b>	<b>573,413</b>	<b>5,014</b>	<b>2,724,982</b>	<b>2,919,654</b>	<b>3,670,102</b>	<b>462,034</b>	<b>5,338,780</b>	<b>261,018</b>	<b>1,987,174</b>	<b>(1,749,094)</b>	<b>97,807,327</b>
<b>Operating income (loss)</b>	<b>7,616,222</b>	<b>(75,681)</b>	<b>(234,686)</b>	<b>(5,014)</b>	<b>(1,002,976)</b>	<b>(993,881)</b>	<b>(779,071)</b>	<b>230,443</b>	<b>(2,107,674)</b>	<b>(261,018)</b>	<b>(180,135)</b>	<b>-</b>	<b>2,206,529</b>
Other income (expense):													
Investment income	10,111,263	10	-	270,803	145	459	248	106,032	559	-	853	(414,207)	10,076,165
Net unrealized gains on investments	23,394,329	-	-	358,720	-	-	-	77,732	-	-	-	-	23,830,781
Other	(106,016)	-	-	-	-	-	-	-	-	-	-	-	(106,016)
Contributions	633,652	-	-	(45,908)	-	-	-	-	-	-	-	-	587,744
<b>Total other income</b>	<b>34,033,228</b>	<b>10</b>	<b>-</b>	<b>583,615</b>	<b>145</b>	<b>459</b>	<b>248</b>	<b>183,764</b>	<b>559</b>	<b>-</b>	<b>853</b>	<b>(414,207)</b>	<b>34,388,674</b>
<b>Excess of revenues over (under) expenses</b>	<b>41,649,450</b>	<b>(75,671)</b>	<b>(234,686)</b>	<b>578,601</b>	<b>(1,002,831)</b>	<b>(993,422)</b>	<b>(778,823)</b>	<b>414,207</b>	<b>(2,107,115)</b>	<b>(261,018)</b>	<b>(179,282)</b>	<b>(414,207)</b>	<b>36,595,203</b>
<b>Change in net assets</b>	<b>41,649,450</b>	<b>(75,671)</b>	<b>(234,686)</b>	<b>578,601</b>	<b>(1,002,831)</b>	<b>(993,422)</b>	<b>(778,823)</b>	<b>414,207</b>	<b>(2,107,115)</b>	<b>(261,018)</b>	<b>(179,282)</b>	<b>(414,207)</b>	<b>36,595,203</b>
<b>Net assets, beginning of year</b>	<b>234,266,561</b>	<b>(20,424,400)</b>	<b>(1,628,855)</b>	<b>5,138,053</b>	<b>(5,160,589)</b>	<b>(9,299,126)</b>	<b>(5,634,231)</b>	<b>2,048,697</b>	<b>(11,335,486)</b>	<b>(718,749)</b>	<b>(858,047)</b>	<b>(2,048,697)</b>	<b>184,345,131</b>
<b>Net assets, end of year</b>	<b>\$ 275,916,011</b>	<b>\$ (20,500,071)</b>	<b>\$ (1,863,541)</b>	<b>\$ 5,716,654</b>	<b>\$ (6,163,420)</b>	<b>\$ (10,292,548)</b>	<b>\$ (6,413,054)</b>	<b>\$ 2,462,904</b>	<b>\$ (13,442,601)</b>	<b>\$ (979,767)</b>	<b>\$ (1,037,329)</b>	<b>\$ (2,462,904)</b>	<b>\$ 220,940,334</b>



**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.**

**A For the 2019 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

**D** Employer identification number  
58-1734026

**E** Telephone number  
706-647-8111

**G** Gross receipts\$ 105,802,406

**F** Name and address of principal officer:  
Jeff Tarrant  
801 West Gordon St  
Thomaston GA 30286

**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)

**I** Tax-exempt status:  501(c)(3)  501(c) ( ) **t** (insert no.)  4947(a)(1) or  527

**J** Website: www.URMC.org

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

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

**H(c)** Group exemption number **u**

**Part I Summary**

<b>Activities &amp; Governance</b>	<b>1</b> Briefly describe the organization's mission or most significant activities: <u>Upson Regional Medical Center's mission is to provide quality health care services to the surrounding area, regardless of the ability to pay.</u>		
	<b>2</b> Check this box <input type="checkbox"/> if the organization discontinued its operations or disposed of more than 25% of its net assets.		
	<b>3</b> Number of voting members of the governing body (Part VI, line 1a)	<b>3</b>	<b>9</b>
	<b>4</b> Number of independent voting members of the governing body (Part VI, line 1b)	<b>4</b>	<b>8</b>
	<b>5</b> Total number of individuals employed in calendar year 2019 (Part V, line 2a)	<b>5</b>	<b>885</b>
	<b>6</b> Total number of volunteers (estimate if necessary)	<b>6</b>	<b>64</b>
	<b>7a</b> Total unrelated business revenue from Part VIII, column (C), line 12	<b>7a</b>	<b>647,848</b>
<b>b</b> Net unrelated business taxable income from Form 990-T, line 39	<b>7b</b>	<b>0</b>	
<b>Revenue</b>	<b>8</b> Contributions and grants (Part VIII, line 1h)	Prior Year	Current Year
	<b>9</b> Program service revenue (Part VIII, line 2g)	<u>1,001,679</u>	<u>540,747</u>
	<b>10</b> Investment income (Part VIII, column (A), lines 3, 4, and 7d)	<u>103,905,611</u>	<u>92,810,152</u>
	<b>11</b> Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	<u>8,310,600</u>	<u>6,763,370</u>
	<b>12</b> Total revenue - add lines 8 through 11 (must equal Part VIII, column (A), line 12)	<u>1,826,293</u>	<u>589,809</u>
<b>Expenses</b>	<b>13</b> Grants and similar amounts paid (Part IX, column (A), lines 1-3)	<u>115,044,183</u>	<u>100,704,078</u>
	<b>14</b> Benefits paid to or for members (Part IX, column (A), line 4)	<u>75,286</u>	<u>18,745</u>
	<b>15</b> Salaries, other compensation, employee benefits (Part IX, column (A), lines 5-10)	<u>44,559,918</u>	<u>49,536,674</u>
	<b>16a</b> Professional fundraising fees (Part IX, column (A), line 11e)		<u>0</u>
	<b>b</b> Total fundraising expenses (Part IX, column (D), line 25) <b>u</b>	<u>0</u>	
	<b>17</b> Other expenses (Part IX, column (A), lines 11a-11d, 11f-24e)	<u>65,588,078</u>	<u>43,857,688</u>
	<b>18</b> Total expenses. Add lines 13-17 (must equal Part IX, column (A), line 25)	<u>110,223,282</u>	<u>93,413,107</u>
<b>Net Assets or Fund Balances</b>	<b>19</b> Revenue less expenses. Subtract line 18 from line 12	<u>4,820,901</u>	<u>7,290,971</u>
	<b>20</b> Total assets (Part X, line 16)	Beginning of Current Year	End of Year
	<b>21</b> Total liabilities (Part X, line 26)	<u>174,885,089</u>	<u>193,450,464</u>
	<b>22</b> Net assets or fund balances. Subtract line 21 from line 20	<u>16,808,342</u>	<u>14,243,386</u>
		<u>158,076,747</u>	<u>179,207,078</u>

**Part II Signature Block**

Under penalty 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: John Williams Date: \_\_\_\_\_  
 Type or print name and title: Hospital CFO

**Paid Preparer Use Only**

Print/Type preparer's name: Jacqueline G. Atkins Preparer's signature: Jacqueline Atkins, CPA Date: 11/3/20  
 Check  if PTIN self-employed: P00861721

Firm's name: Draffin & Tucker LLP Firm's EIN: 58-0914992  
 PO Box 71309  
 Firm's address: Albany, GA 31708-1309 Phone no.: 229-883-7878

**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 \$ 75,117,335 including grants of \$ 18,745 ) (Revenue \$ 92,541,379 )

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 13,570 in 2019. The Psych unit saw 3,998 visits while the rural health clinic experienced 2,750 visits in 2019.

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

N/A

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

N/A

4d Other program services (Describe on Schedule O.)

(Expenses \$ including grants of \$ ) (Revenue \$ )

4e Total program service expenses u 75,117,335

**Part IV Checklist of Required Schedules**

		Yes	No
1	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? <i>If "Yes," complete Schedule A</i>	X	
2	Is the organization required to complete <i>Schedule B, Schedule of Contributors</i> (see instructions)?	X	
3	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? <i>If "Yes," complete Schedule C, Part I</i>		X
4	<b>Section 501(c)(3) organizations.</b> Did the organization engage in lobbying activities, or have a section 501(h) election in effect during the tax year? <i>If "Yes," complete Schedule C, Part II</i>	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? <i>If "Yes," complete Schedule C, Part III</i>		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? <i>If "Yes," complete Schedule D, Part I</i>		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? <i>If "Yes," complete Schedule D, Part II</i>		X
8	Did the organization maintain collections of works of art, historical treasures, or other similar assets? <i>If "Yes," complete Schedule D, Part III</i>		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? <i>If "Yes," complete Schedule D, Part IV</i>		X
10	Did the organization, directly or through a related organization, hold assets in donor-restricted endowments or in quasi endowments? <i>If "Yes," complete Schedule D, Part V</i>		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? <i>If "Yes," complete Schedule D, Part VI</i>	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? <i>If "Yes," complete Schedule D, Part VII</i>		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? <i>If "Yes," complete Schedule D, Part VIII</i>		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? <i>If "Yes," complete Schedule D, Part IX</i>		X
e	Did the organization report an amount for other liabilities in Part X, line 25? <i>If "Yes," complete Schedule D, Part X</i>	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)? <i>If "Yes," complete Schedule D, Part X</i>	X	
12a	Did the organization obtain separate, independent audited financial statements for the tax year? <i>If "Yes," complete Schedule D, Parts XI and XII</i>		X
b	Was the organization included in consolidated, independent audited financial statements for the tax year? <i>If "Yes," and if the organization answered "No" to line 12a, then completing Schedule D, Parts XI and XII is optional</i>	X	
13	Is the organization a school described in section 170(b)(1)(A)(ii)? <i>If "Yes," complete Schedule E</i>		X
14a	Did the organization maintain an office, employees, or agents outside of the United States?		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? <i>If "Yes," complete Schedule F, Parts I and IV</i>	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? <i>If "Yes," complete Schedule F, Parts II and IV</i>		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? <i>If "Yes," complete Schedule F, Parts III and IV</i>		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? <i>If "Yes," complete Schedule G, Part I</i> (see instructions)		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? <i>If "Yes," complete Schedule G, Part II</i>		X
19	Did the organization report more than \$15,000 of gross income from gaming activities on Part VIII, line 9a? <i>If "Yes," complete Schedule G, Part III</i>		X
20a	Did the organization operate one or more hospital facilities? <i>If "Yes," complete Schedule H</i>	X	
b	If "Yes" to line 20a, did the organization attach a copy of its audited financial statements to this return?	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? <i>If "Yes," complete Schedule I, Parts I and II</i>		X

**Part IV Checklist of Required Schedules (continued)**

		Yes	No
22	Did the organization report more than \$5,000 of grants or other assistance to or for domestic individuals on Part IX, column (A), line 2? <i>If "Yes," complete Schedule I, Parts I and III</i>	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? <i>If "Yes," complete Schedule J</i>	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? <i>If "Yes," answer lines 24b through 24d and complete Schedule K. If "No," go to line 25a</i>	X	
24b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?		X
24c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?		X
24d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?		X
25a	<b>Section 501(c)(3), 501(c)(4), and 501(c)(29) organizations.</b> Did the organization engage in an excess benefit transaction with a disqualified person during the year? <i>If "Yes," complete Schedule L, Part I</i>		X
25b	Is the organization aware that it engaged in an excess benefit transaction with a disqualified person in a prior year, and that the transaction has not been reported on any of the organization's prior Forms 990 or 990-EZ? <i>If "Yes," complete Schedule L, Part I</i>		X
26	Did the organization report any amount on Part X, line 5 or 22, for receivables from or payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons? <i>If "Yes," complete Schedule L, Part II</i>		X
27	Did the organization provide a grant or other assistance to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor or employee thereof, a grant selection committee member, or to a 35% controlled entity (including an employee thereof) or family member of any of these persons? <i>If "Yes," complete Schedule L, Part III</i>		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):		
28a	A current or former officer, director, trustee, key employee, creator or founder, or substantial contributor? <i>If "Yes," complete Schedule L, Part IV</i>		X
28b	A family member of any individual described in line 28a? <i>If "Yes," complete Schedule L, Part IV</i>	X	
28c	A 35% controlled entity of one or more individuals and/or organizations described in lines 28a or 28b? <i>If "Yes," complete Schedule L, Part IV</i>		X
29	Did the organization receive more than \$25,000 in non-cash contributions? <i>If "Yes," complete Schedule M</i>		X
30	Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? <i>If "Yes," complete Schedule M</i>		X
31	Did the organization liquidate, terminate, or dissolve and cease operations? <i>If "Yes," complete Schedule N, Part I</i>		X
32	Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? <i>If "Yes," complete Schedule N, Part II</i>		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? <i>If "Yes," complete Schedule R, Part I</i>	X	
34	Was the organization related to any tax-exempt or taxable entity? <i>If "Yes," complete Schedule R, Part II, III, or IV, and Part V, line 1</i>	X	
35a	Did the organization have a controlled entity within the meaning of section 512(b)(13)?		X
35b	If "Yes" to line 35a, did the organization receive any payment from or engage in any transaction with a controlled entity within the meaning of section 512(b)(13)? <i>If "Yes," complete Schedule R, Part V, line 2</i>		
36	<b>Section 501(c)(3) organizations.</b> Did the organization make any transfers to an exempt non-charitable related organization? <i>If "Yes," complete Schedule R, Part V, line 2</i>		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? <i>If "Yes," complete Schedule R, Part VI</i>		X
38	Did the organization complete Schedule O and provide explanations in Schedule O for Part VI, lines 11b and 19? <b>Note:</b> All Form 990 filers are required to complete Schedule O.	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		
1b	Enter the number of Forms W-2G included in line 1a. Enter -0- if not applicable		
1c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?		

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

		Yes	No
<b>2a</b>	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 <b>2a</b> <u>885</u>		
<b>b</b>	If at least one is reported on line 2a, did the organization file all required federal employment tax returns? <b>Note:</b> If the sum of lines 1a and 2a is greater than 250, you may be required to e-file (see instructions)	X	
<b>3a</b>	Did the organization have unrelated business gross income of \$1,000 or more during the year?	X	
<b>b</b>	If "Yes," has it filed a Form 990-T for this year? If "No" to line 3b, provide an explanation on Schedule O	X	
<b>4a</b>	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)?	X	
<b>b</b>	If "Yes," enter the name of the foreign country <u>Cayman Islands</u> See instructions for filing requirements for FinCEN Form 114, Report of Foreign Bank and Financial Accounts (FBAR).		
<b>5a</b>	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		X
<b>b</b>	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		X
<b>c</b>	If "Yes" to line 5a or 5b, did the organization file Form 8886-T?		
<b>6a</b>	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?		X
<b>b</b>	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		
<b>7</b>	<b>Organizations that may receive deductible contributions under section 170(c).</b>		
<b>a</b>	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?		X
<b>b</b>	If "Yes," did the organization notify the donor of the value of the goods or services provided?		
<b>c</b>	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		X
<b>d</b>	If "Yes," indicate the number of Forms 8282 filed during the year <b>7d</b>		
<b>e</b>	Did the organization receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		X
<b>f</b>	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		X
<b>g</b>	If the organization received a contribution of qualified intellectual property, did the organization file Form 8899 as required?		
<b>h</b>	If the organization received a contribution of cars, boats, airplanes, or other vehicles, did the organization file a Form 1098-C?		
<b>8</b>	<b>Sponsoring organizations maintaining donor advised funds.</b> Did a donor advised fund maintained by the sponsoring organization have excess business holdings at any time during the year?		
<b>9</b>	<b>Sponsoring organizations maintaining donor advised funds.</b>		
<b>a</b>	Did the sponsoring organization make any taxable distributions under section 4966?		
<b>b</b>	Did the sponsoring organization make a distribution to a donor, donor advisor, or related person?		
<b>10</b>	<b>Section 501(c)(7) organizations.</b> Enter:		
<b>a</b>	Initiation fees and capital contributions included on Part VIII, line 12 <b>10a</b>		
<b>b</b>	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities <b>10b</b>		
<b>11</b>	<b>Section 501(c)(12) organizations.</b> Enter:		
<b>a</b>	Gross income from members or shareholders <b>11a</b>		
<b>b</b>	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them.) <b>11b</b>		
<b>12a</b>	<b>Section 4947(a)(1) non-exempt charitable trusts.</b> Is the organization filing Form 990 in lieu of Form 1041?		
<b>b</b>	If "Yes," enter the amount of tax-exempt interest received or accrued during the year <b>12b</b>		
<b>13</b>	<b>Section 501(c)(29) qualified nonprofit health insurance issuers.</b>		
<b>a</b>	Is the organization licensed to issue qualified health plans in more than one state? <b>Note:</b> See the instructions for additional information the organization must report on Schedule O.		
<b>b</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 <b>13b</b>		
<b>c</b>	Enter the amount of reserves on hand <b>13c</b>		
<b>14a</b>	Did the organization receive any payments for indoor tanning services during the tax year?		X
<b>b</b>	If "Yes," has it filed a Form 720 to report these payments? If "No," provide an explanation on Schedule O		
<b>15</b>	Is the organization subject to the section 4960 tax on payment(s) of more than \$1,000,000 in remuneration or excess parachute payment(s) during the year? If "Yes," see instructions and file Form 4720, Schedule N.		X
<b>16</b>	Is the organization an educational institution subject to the section 4968 excise tax on net investment income? If "Yes," complete Form 4720, Schedule O.		X

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

**Section A. Governing Body and Management**

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

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

		Yes	No
<b>10a</b>	Did the organization have local chapters, branches, or affiliates?		X
<b>10b</b>	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?		
<b>11a</b>	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?	X	
<b>11b</b>	b Describe in Schedule O the process, if any, used by the organization to review this Form 990.		
<b>12a</b>	Did the organization have a written conflict of interest policy? If "No," go to line 13	X	
<b>12b</b>	b Were officers, directors, or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	X	
<b>12c</b>	c Did the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this was done	X	
<b>13</b>	Did the organization have a written whistleblower policy?	X	
<b>14</b>	Did the organization have a written document retention and destruction policy?	X	
<b>15</b>	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?		
<b>15a</b>	a The organization's CEO, Executive Director, or top management official	X	
<b>15b</b>	b Other officers or key employees of the organization If "Yes" to line 15a or 15b, describe the process in Schedule O (see instructions).	X	
<b>16a</b>	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?		X
<b>16b</b>	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?		

**Section C. Disclosure**

- 17** List the states with which a copy of this Form 990 is required to be filed **u** None
- 18** Section 6104 requires an organization to make its Forms 1023 (1024 or 1024-A, if applicable), 990, and 990-T (Section 501(c)(3)s only) available for public inspection. Indicate how you made these available. Check all that apply.  
 Own website  Another's website  Upon request  Other (explain on Schedule O)
- 19** Describe on Schedule O whether (and if so, how) the organization made its governing documents, conflict of interest policy, and financial statements available to the public during the tax year.
- 20** State the name, address, and telephone number of the person who possesses the organization's books and records **u**  
 John Williams 801 West Gordon Street  
 Thomaston GA 30286-0227 706-647-8111

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

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

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

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

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

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

(A) Name and title	(B) Average hours per week per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(1) Orthopedic Surgeon	40.00 0.00					X	1,149,402	0	39,913	
(2) Surgeon	40.00 0.00					X	599,106	0	39,913	
(3) Surgeon	40.00 0.00					X	535,860	0	39,913	
(4) Urology Surgeon	40.00 0.00					X	525,269	0	38,951	
(5) Cardiologist	40.00 0.00					X	441,870	0	38,951	
(6) Hospital CEO/Pres	40.00 1.00			X			331,296	0	0	
(7) Hospital CFO	40.00 1.00			X			281,842	0	15,861	
(8) Hospital ICEO/Pres	40.00 1.00			X			203,954	0	0	
(9) Hospital CEO/Pres	0.00 0.00					X	120,912	0	0	
(10) Jim Edwards Vice Chairman	0.75 0.20	X		X			0	0	0	
(11) Jonathan Busbee, MD Board Member	0.75 0.20	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 per week (list any hours for related organizations below dotted line)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)						(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			
(12) Kay Robinson	0.75									
Board Member	0.20	X						0	0	
(13) Kay Searcy	0.75									
Board Member	0.20	X						0	0	
(14) Ralph Warnock, MD	0.75									
Asst Secretary	0.20	X		X				0	0	
(15) Scott Blackstock	0.75									
Board Member	0.20	X						0	0	
(16) Steve Keadle	0.75									
Board Member	0.20	X						0	0	
(17) William Hightower IV	0.75									
Chairman	0.20	X		X				0	0	
(18) Barney Hancock	0.75									
Secretary	0.20	X		X				0	0	
<b>1b Subtotal</b>								<b>4,189,511</b>	<b>213,502</b>	
<b>c Total from continuation sheets to Part VII, Section A</b>										
<b>d Total (add lines 1b and 1c)</b>								<b>4,189,511</b>	<b>213,502</b>	

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 **u 62**

	Yes	No
3 Did the organization list any <b>former</b> officer, director, trustee, key employee, or highest compensated employee on line 1a? <i>If "Yes," complete Schedule J for such individual</i>	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? <i>If "Yes," complete Schedule J for such individual</i>	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? <i>If "Yes," complete Schedule J for such person</i>	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
Innovative Therapy Concepts LLC Hawkinsville GA 31036	2 Mashburn St, Suite 102 Physical Ther	1,269,486
Sodexo, Inc. & Affiliates Pittsburgh PA 15251	P O Box 360170 Food Service	1,188,577
Cloudwave Chagrin Falls OH 44023	8401 Chagrin Rd, Suite 6B Remote Cloud	984,127
Medical Information Technology Inc Westwood MA 02090	Meditech Circle Software & Svc	753,198
Salveo Integrative Health Lawrenceville GA 30046	311 Gwinnett Drive Counseling/MH	733,000

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

27



**Part VIII Statement of Revenue**

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

			(A) Total revenue	(B) Related or exempt function revenue	(C) Unrelated business revenue	(D) Revenue excluded from tax under sections 512-514	
<b>Contributions, Gifts, Grants and Other Similar Amounts</b>	<b>1a</b> Federated campaigns	<b>1a</b>					
	<b>b</b> Membership dues	<b>1b</b>					
	<b>c</b> Fundraising events	<b>1c</b>					
	<b>d</b> Related organizations	<b>1d</b>	75,953				
	<b>e</b> Government grants (contributions)	<b>1e</b>					
	<b>f</b> All other contributions, gifts, grants, and similar amounts not included above	<b>1f</b>	464,794				
	<b>g</b> Noncash contributions included in lines 1a-1f	<b>1g</b>	\$				
	<b>h Total.</b> Add lines 1a-1f	<b>u</b>	540,747				
<b>Program Service Revenue</b>	<b>2a</b> Net patient service revenue	Business Code	621990	92,162,304	92,162,304		
	<b>b</b> Wellness Center		713940	618,433		618,433	
	<b>c</b> Catering Sales		722320	29,415		29,415	
	<b>d</b>						
	<b>e</b>						
	<b>f</b> All other program service revenue						
	<b>g Total.</b> Add lines 2a-2f	<b>u</b>		92,810,152			
<b>Other Revenue</b>	<b>3</b> Investment income (including dividends, interest, and other similar amounts)	<b>u</b>		4,537,719		4,537,719	
	<b>4</b> Income from investment of tax-exempt bond proceeds	<b>u</b>					
	<b>5</b> Royalties	<b>u</b>					
	<b>6a</b> Gross rents	(i) Real	2,447				
		(ii) Personal					
		<b>6b</b> Less: rental expenses					
	<b>c</b> Rental inc. or (loss)	<b>6c</b>	2,447				
	<b>d</b> Net rental income or (loss)	<b>u</b>		2,447		2,447	
	<b>7a</b> Gross amount from sales of assets other than inventory	(i) Securities	7,322,284				
		(ii) Other	1,695				
		<b>7b</b> Less: cost or other basis and sales exps.	5,098,328				
		<b>7c</b> Gain or (loss)	2,223,956	1,695			
	<b>d</b> Net gain or (loss)	<b>u</b>		2,225,651		2,225,651	
	<b>8a</b> Gross income from fundraising events (not including \$ of contributions reported on line 1c). See Part IV, line 18	<b>8a</b>					
		<b>8b</b> Less: direct expenses					
<b>c</b> Net income or (loss) from fundraising events	<b>u</b>						
<b>9a</b> Gross income from gaming activities. See Part IV, line 19	<b>9a</b>						
	<b>9b</b> Less: direct expenses						
<b>c</b> Net income or (loss) from gaming activities	<b>u</b>						
<b>10a</b> Gross sales of inventory, less returns and allowances	<b>10a</b>						
	<b>10b</b> Less: cost of goods sold						
<b>c</b> Net income or (loss) from sales of inventory	<b>u</b>						
<b>Miscellaneous Revenue</b>	<b>11a</b> Discounts and rebates	Business Code	621990	280,170	280,170		
	<b>b</b> Computer fee		561499	208,287		208,287	
	<b>c</b> Management fees		561499	59,067	59,067		
	<b>d</b> All other revenue		561499	39,838	39,838		
	<b>e Total.</b> Add lines 11a-11d	<b>u</b>		587,362			
<b>12 Total revenue.</b> See instructions	<b>u</b>		100,704,078	92,541,379	647,848	6,974,104	

**Part IX Statement of Functional Expenses**

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

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

Do not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
<b>1</b> Grants and other assistance to domestic organizations and domestic governments. See Part IV, line 21				
<b>2</b> Grants and other assistance to domestic individuals. See Part IV, line 22	18,745	18,745		
<b>3</b> Grants and other assistance to foreign organizations, foreign governments, and foreign individuals. See Part IV, lines 15 and 16				
<b>4</b> Benefits paid to or for members				
<b>5</b> Compensation of current officers, directors, trustees, and key employees	832,952		832,952	
<b>6</b> Compensation not included above to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)	120,912		120,912	
<b>7</b> Other salaries and wages	38,714,274	32,974,440	5,739,834	
<b>8</b> Pension plan accruals and contributions (include section 401(k) and 403(b) employer contributions)	571,613	475,353	96,260	
<b>9</b> Other employee benefits	6,590,699	5,480,825	1,109,874	
<b>10</b> Payroll taxes	2,706,224	2,250,496	455,728	
<b>11</b> Fees for services (nonemployees):				
<b>a</b> Management	528,493	71,487	457,006	
<b>b</b> Legal	402,832		402,832	
<b>c</b> Accounting	125,000		125,000	
<b>d</b> Lobbying				
<b>e</b> Professional fundraising services. See Part IV, line 7				
<b>f</b> Investment management fees	60,181		60,181	
<b>g</b> Other. (If line 11g amount exceeds 10% of line 25, column (A) amount, list line 11g expenses on Schedule O.)	11,245,176	8,207,881	3,037,295	
<b>12</b> Advertising and promotion	184,964	2,186	182,778	
<b>13</b> Office expenses	2,152,850	1,474,919	677,931	
<b>14</b> Information technology	2,636,637	612,057	2,024,580	
<b>15</b> Royalties				
<b>16</b> Occupancy	2,332,645	2,095,182	237,463	
<b>17</b> Travel	223,338	118,387	104,951	
<b>18</b> Payments of travel or entertainment expenses for any federal, state, or local public officials				
<b>19</b> Conferences, conventions, and meetings				
<b>20</b> Interest	6,557		6,557	
<b>21</b> Payments to affiliates				
<b>22</b> Depreciation, depletion, and amortization	7,599,967	6,826,290	773,677	
<b>23</b> Insurance	397,415	365,642	31,773	
<b>24</b> Other expenses. Itemize expenses not covered above (List miscellaneous expenses on line 24e. If line 24e amount exceeds 10% of line 25, column (A) amount, list line 24e expenses on Schedule O.)				
<b>a</b> Medical supplies	11,665,583	11,665,583		
<b>b</b> Repairs & maintenance	2,404,827	1,398,292	1,006,535	
<b>c</b> Provider fees	972,024	972,024		
<b>d</b> Recruitment	482,452		482,452	
<b>e</b> All other expenses	436,747	107,546	329,201	
<b>25</b> Total functional expenses. Add lines 1 through 24e	93,413,107	75,117,335	18,295,772	0
<b>26</b> Joint costs. Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation. Check here <input type="checkbox"/> if following SOP 98-2 (ASC 958-720)				

**Part X Balance Sheet**

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

		(A)		(B)
		Beginning of year		End of year
<b>Assets</b>	<b>1</b> Cash—non-interest-bearing .....		<b>1</b>	6,339
	<b>2</b> Savings and temporary cash investments .....	1,742,967	<b>2</b>	2,500,870
	<b>3</b> Pledges and grants receivable, net .....		<b>3</b>	
	<b>4</b> Accounts receivable, net .....	12,396,982	<b>4</b>	13,991,608
	<b>5</b> Loans and other receivables from any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons .....		<b>5</b>	
	<b>6</b> Loans and other receivables from other disqualified persons (as defined under section 4958(f)(1)), and persons described in section 4958(c)(3)(B) .....		<b>6</b>	
	<b>7</b> Notes and loans receivable, net .....		<b>7</b>	325,083
	<b>8</b> Inventories for sale or use .....	1,967,656	<b>8</b>	1,867,441
	<b>9</b> Prepaid expenses and deferred charges .....	2,153,329	<b>9</b>	1,605,777
	<b>10a</b> Land, buildings, and equipment: cost or other basis. Complete Part VI of Schedule D .....	<b>10a</b> 143,019,388		
	<b>b</b> Less: accumulated depreciation .....	<b>10b</b> 86,699,016	59,362,720	<b>10c</b> 56,320,372
	<b>11</b> Investments—publicly traded securities .....	95,584,288	<b>11</b>	114,606,592
	<b>12</b> Investments—other securities. See Part IV, line 11 .....		<b>12</b>	
	<b>13</b> Investments—program-related. See Part IV, line 11 .....		<b>13</b>	
	<b>14</b> Intangible assets .....	1,639,203	<b>14</b>	1,639,203
	<b>15</b> Other assets. See Part IV, line 11 .....	37,944	<b>15</b>	587,179
<b>16 Total assets.</b> Add lines 1 through 15 (must equal line 33) .....	174,885,089	<b>16</b>	193,450,464	
<b>Liabilities</b>	<b>17</b> Accounts payable and accrued expenses .....	5,581,351	<b>17</b>	6,572,722
	<b>18</b> Grants payable .....		<b>18</b>	
	<b>19</b> Deferred revenue .....		<b>19</b>	29,542
	<b>20</b> Tax-exempt bond liabilities .....	6,205,000	<b>20</b>	5,270,000
	<b>21</b> Escrow or custodial account liability. Complete Part IV of Schedule D .....		<b>21</b>	
	<b>22</b> Loans and other payables to any current or former officer, director, trustee, key employee, creator or founder, substantial contributor, or 35% controlled entity or family member of any of these persons .....		<b>22</b>	
	<b>23</b> Secured mortgages and notes payable to unrelated third parties .....	4,105,815	<b>23</b>	2,070,959
	<b>24</b> Unsecured notes and loans payable to unrelated third parties .....		<b>24</b>	
	<b>25</b> Other liabilities (including federal income tax, payables to related third parties, and other liabilities not included on lines 17-24). Complete Part X of Schedule D .....	916,176	<b>25</b>	300,163
	<b>26 Total liabilities.</b> Add lines 17 through 25 .....	16,808,342	<b>26</b>	14,243,386
	<b>Net Assets or Fund Balances</b>	<b>Organizations that follow FASB ASC 958, check here <input checked="" type="checkbox"/></b> <b>and complete lines 27, 28, 32, and 33.</b>		
<b>27</b> Net assets without donor restrictions .....		158,076,747	<b>27</b>	179,207,078
<b>28</b> Net assets with donor restrictions .....			<b>28</b>	
<b>Organizations that do not follow FASB ASC 958, check here <input type="checkbox"/></b> <b>and complete lines 29 through 33.</b>				
<b>29</b> Capital stock or trust principal, or current funds .....			<b>29</b>	
<b>30</b> Paid-in or capital surplus, or land, building, or equipment fund .....			<b>30</b>	
<b>31</b> Retained earnings, endowment, accumulated income, or other funds .....			<b>31</b>	
<b>32</b> Total net assets or fund balances .....		158,076,747	<b>32</b>	179,207,078
<b>33</b> Total liabilities and net assets/fund balances .....	174,885,089	<b>33</b>	193,450,464	

**Part XI Reconciliation of Net Assets**

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

<b>1</b>	Total revenue (must equal Part VIII, column (A), line 12)	<b>1</b>	100,704,078
<b>2</b>	Total expenses (must equal Part IX, column (A), line 25)	<b>2</b>	93,413,107
<b>3</b>	Revenue less expenses. Subtract line 2 from line 1	<b>3</b>	7,290,971
<b>4</b>	Net assets or fund balances at beginning of year (must equal Part X, line 32, column (A))	<b>4</b>	158,076,747
<b>5</b>	Net unrealized gains (losses) on investments	<b>5</b>	13,839,360
<b>6</b>	Donated services and use of facilities	<b>6</b>	
<b>7</b>	Investment expenses	<b>7</b>	
<b>8</b>	Prior period adjustments	<b>8</b>	
<b>9</b>	Other changes in net assets or fund balances (explain on Schedule O)	<b>9</b>	
<b>10</b>	Net assets or fund balances at end of year. Combine lines 3 through 9 (must equal Part X, line 32, column (B))	<b>10</b>	179,207,078

**Part XII Financial Statements and Reporting**

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

		Yes	No
<b>1</b>	Accounting method used to prepare the Form 990: <input type="checkbox"/> Cash <input checked="" type="checkbox"/> Accrual <input type="checkbox"/> Other If the organization changed its method of accounting from a prior year or checked "Other," explain in Schedule O.		
<b>2a</b>	Were the organization's financial statements compiled or reviewed by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were compiled or reviewed on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis		X
<b>2b</b>	Were the organization's financial statements audited by an independent accountant? If "Yes," check a box below to indicate whether the financial statements for the year were audited on a separate basis, consolidated basis, or both: <input type="checkbox"/> Separate basis <input checked="" type="checkbox"/> Consolidated basis <input type="checkbox"/> Both consolidated and separate basis	X	
<b>2c</b>	If "Yes" to line 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant? If the organization changed either its oversight process or selection process during the tax year, explain on Schedule O.	X	
<b>3a</b>	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?		X
<b>3b</b>	If "Yes," did the organization undergo the required audit or audits? If the organization did not undergo the required audit or audits, explain why on Schedule O and describe any steps taken to undergo such audits		

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

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.

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

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

OMB No. 1545-0047

**2019**

**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?		(v) Amount of monetary support (see instructions)	(vi) Amount of other support (see instructions)
			Yes	No		
(A)						
(B)						
(C)						
(D)						
(E)						
<b>Total</b>						

**Part II Support Schedule for Organizations Described in Sections 170(b)(1)(A)(iv) and 170(b)(1)(A)(vi)**  
(Complete only if you checked the box on line 5, 7, or 8 of Part I or if the organization failed to qualify under Part III. If the organization fails to qualify under the tests listed below, please complete Part III.)

**Section A. Public Support**

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

**Section B. Total Support**

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

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

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

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

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

Section A. Public Support

Table with 7 columns: (a) 2015, (b) 2016, (c) 2017, (d) 2018, (e) 2019, (f) Total. Rows include: 1 Gifts, grants, contributions, and membership fees received; 2 Gross receipts from admissions, merchandise sold or services performed; 3 Gross receipts from activities that are not an unrelated trade or business; 4 Tax revenues levied for the organization's benefit; 5 The value of services or facilities furnished by a governmental unit; 6 Total. Add lines 1 through 5; 7a Amounts included on lines 1, 2, and 3 received from disqualified persons; 7b Amounts included on lines 2 and 3 received from other than disqualified persons; 7c Add lines 7a and 7b; 8 Public support. (Subtract line 7c from line 6.)

Section B. Total Support

Table with 7 columns: (a) 2015, (b) 2016, (c) 2017, (d) 2018, (e) 2019, (f) Total. Rows include: 9 Amounts from line 6; 10a Gross income from interest, dividends, payments received on securities loans, rents, royalties, and income from similar sources; 10b Unrelated business taxable income (less section 511 taxes) from businesses acquired after June 30, 1975; 10c Add lines 10a and 10b; 11 Net income from unrelated business activities not included in line 10b; 12 Other income. Do not include gain or loss from the sale of capital assets; 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

Table with 3 columns: Description, Line Number, Percentage. Row 15: Public support percentage for 2019 (line 8, column (f), divided by line 13, column (f)) - 15 - %; Row 16: Public support percentage from 2018 Schedule A, Part III, line 15 - 16 - %

Section D. Computation of Investment Income Percentage

Table with 3 columns: Description, Line Number, Percentage. Row 17: Investment income percentage for 2019 (line 10c, column (f), divided by line 13, column (f)) - 17 - %; Row 18: Investment income percentage from 2018 Schedule A, Part III, line 17 - 18 - %

19a 33 1/3% support tests—2019. If the organization did not check the box on line 14, and line 15 is more than 33 1/3%, and line 17 is not more than 33 1/3%, check this box and stop here. The organization qualifies as a publicly supported organization

b 33 1/3% support tests—2018. If the organization did not check a box on line 14 or line 19a, and line 16 is more than 33 1/3%, and line 18 is not more than 33 1/3%, check this box and stop here. The organization qualifies as a publicly supported organization

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? <i>If "No," describe in Part VI how the supported organizations are designated. If designated by class or purpose, describe the designation. If historic and continuing relationship, explain.</i>		
2 Did the organization have any supported organization that does not have an IRS determination of status under section 509(a)(1) or (2)? <i>If "Yes," explain in Part VI how the organization determined that the supported organization was described in section 509(a)(1) or (2).</i>		
3a Did the organization have a supported organization described in section 501(c)(4), (5), or (6)? <i>If "Yes," answer (b) and (c) below.</i>		
b Did the organization confirm that each supported organization qualified under section 501(c)(4), (5), or (6) and satisfied the public support tests under section 509(a)(2)? <i>If "Yes," describe in Part VI when and how the organization made the determination.</i>		
c Did the organization ensure that all support to such organizations was used exclusively for section 170(c)(2)(B) purposes? <i>If "Yes," explain in Part VI what controls the organization put in place to ensure such use.</i>		
4a Was any supported organization not organized in the United States ("foreign supported organization")? <i>If "Yes," and if you checked 12a or 12b in Part I, answer (b) and (c) below.</i>		
b Did the organization have ultimate control and discretion in deciding whether to make grants to the foreign supported organization? <i>If "Yes," describe in Part VI how the organization had such control and discretion despite being controlled or supervised by or in connection with its supported organizations.</i>		
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)? <i>If "Yes," explain in Part VI what controls the organization used to ensure that all support to the foreign supported organization was used exclusively for section 170(c)(2)(B) purposes.</i>		
5a Did the organization add, substitute, or remove any supported organizations during the tax year? <i>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).</i>		
b <b>Type I or Type II only.</b> Was any added or substituted supported organization part of a class already designated in the organization's organizing document?		
c <b>Substitutions only.</b> Was the substitution the result of an event beyond the organization's control?		
6 Did the organization provide support (whether in the form of grants or the provision of services or facilities) to anyone other than (i) its supported organizations, (ii) individuals that are part of the charitable class benefited by one or more of its supported organizations, or (iii) other supporting organizations that also support or benefit one or more of the filing organization's supported organizations? <i>If "Yes," provide detail in Part VI.</i>		
7 Did the organization provide a grant, loan, compensation, or other similar payment to a substantial contributor (as defined in section 4958(c)(3)(C)), a family member of a substantial contributor, or a 35% controlled entity with regard to a substantial contributor? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>		
8 Did the organization make a loan to a disqualified person (as defined in section 4958) not described in line 7? <i>If "Yes," complete Part I of Schedule L (Form 990 or 990-EZ).</i>		
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))? <i>If "Yes," provide detail in Part VI.</i>		
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? <i>If "Yes," provide detail in Part VI.</i>		
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? <i>If "Yes," provide detail in Part VI.</i>		
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)? <i>If "Yes," answer 10b below.</i>		
b Did the organization have any excess business holdings in the tax year? <i>(Use Schedule C, Form 4720, to determine whether the organization had excess business holdings.)</i>		



**Part IV Supporting Organizations** (continued)

- 11 Has the organization accepted a gift or contribution from any of the following persons?
  - a A person who directly or indirectly controls, either alone or together with persons described in (b) and (c) below, the governing body of a supported organization?
  - b A family member of a person described in (a) above?
  - c A 35% controlled entity of a person described in (a) or (b) above? *If "Yes" to a, b, or c, provide detail in Part VI.*

	Yes	No
11a		
11b		
11c		

**Section B. Type I Supporting Organizations**

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

	Yes	No
1		
2		

**Section C. Type II Supporting Organizations**

- 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).*

	Yes	No
1		

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

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

	Yes	No
1		
2		
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).*

2 Activities Test. Answer (a) and (b) below.

- a Did substantially all of the organization's activities during the tax year directly further the exempt purposes of the supported organization(s) to which the organization was responsive? *If "Yes," then in Part VI identify those supported organizations and explain how these activities directly furthered their exempt purposes, how the organization was responsive to those supported organizations, and how the organization determined that these activities constituted substantially all of its activities.*
  - b Did the activities described in (a) constitute activities that, but for the organization's involvement, one or more of the organization's supported organization(s) would have been engaged in? *If "Yes," explain in Part VI the reasons for the organization's position that its supported organization(s) would have engaged in these activities but for the organization's involvement.*
- 3 Parent of Supported Organizations. Answer (a) and (b) below.
- a Did the organization have the power to regularly appoint or elect a majority of the officers, directors, or trustees of each of the supported organizations? *Provide details in Part VI.*
  - b Did the organization exercise a substantial degree of direction over the policies, programs, and activities of each of its supported organizations? *If "Yes," describe in Part VI the role played by the organization in this regard.*

	Yes	No
2a		
2b		
3a		
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	<b>Adjusted Net Income</b> (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	<b>Total</b> (add lines 1a, 1b, and 1c)	1d	
e	<b>Discount</b> 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	<b>Minimum Asset Amount</b> (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	<b>Distributable Amount.</b> Subtract line 5 from line 4, unless subject to emergency temporary reduction (see instructions).	6	
7	<input type="checkbox"/> Check here if the current year is the organization's first as a non-functionally integrated Type III supporting organization (see instructions).		

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

<b>Section D - Distributions</b>		<b>Current Year</b>		
<b>1</b>	Amounts paid to supported organizations to accomplish exempt purposes			
<b>2</b>	Amounts paid to perform activity that directly furthers exempt purposes of supported organizations, in excess of income from activity			
<b>3</b>	Administrative expenses paid to accomplish exempt purposes of supported organizations			
<b>4</b>	Amounts paid to acquire exempt-use assets			
<b>5</b>	Qualified set-aside amounts (prior IRS approval required)			
<b>6</b>	Other distributions (describe in <b>Part VI</b> ). See instructions.			
<b>7</b>	<b>Total annual distributions.</b> Add lines 1 through 6.			
<b>8</b>	Distributions to attentive supported organizations to which the organization is responsive (provide details in <b>Part VI</b> ). See instructions.			
<b>9</b>	Distributable amount for 2019 from Section C, line 6			
<b>10</b>	Line 8 amount divided by line 9 amount			
<b>Section E - Distribution Allocations</b> (see instructions)		<b>(i) Excess Distributions</b>	<b>(ii) Underdistributions Pre-2019</b>	<b>(iii) Distributable Amount for 2019</b>
<b>1</b>	Distributable amount for 2019 from Section C, line 6			
<b>2</b>	Underdistributions, if any, for years prior to 2019 (reasonable cause required-explain in <b>Part VI</b> ). See instructions.			
<b>3</b>	Excess distributions carryover, if any, to 2019			
<b>a</b>	From 2014 .....			
<b>b</b>	From 2015 .....			
<b>c</b>	From 2016 .....			
<b>d</b>	From 2017 .....			
<b>e</b>	From 2018 .....			
<b>f</b>	<b>Total</b> of lines 3a through e			
<b>g</b>	Applied to underdistributions of prior years			
<b>h</b>	Applied to 2019 distributable amount			
<b>i</b>	Carryover from 2014 not applied (see instructions)			
<b>j</b>	Remainder. Subtract lines 3g, 3h, and 3i from 3f.			
<b>4</b>	Distributions for 2019 from Section D, line 7: \$			
<b>a</b>	Applied to underdistributions of prior years			
<b>b</b>	Applied to 2019 distributable amount			
<b>c</b>	Remainder. Subtract lines 4a and 4b from 4.			
<b>5</b>	Remaining underdistributions for years prior to 2019, if any. Subtract lines 3g and 4a from line 2. For result greater than zero, explain in <b>Part VI</b> . See instructions.			
<b>6</b>	Remaining underdistributions for 2019. Subtract lines 3h and 4b from line 1. For result greater than zero, explain in <b>Part VI</b> . See instructions.			
<b>7</b>	<b>Excess distributions carryover to 2020.</b> Add lines 3j and 4c.			
<b>8</b>	Breakdown of line 7:			
<b>a</b>	Excess from 2015 .....			
<b>b</b>	Excess from 2016 .....			
<b>c</b>	Excess from 2017 .....			
<b>d</b>	Excess from 2018 .....			
<b>e</b>	Excess from 2019 .....			



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

**Political Campaign and Lobbying Activities**

OMB No. 1545-0047

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

**2019**

Department of the Treasury  
Internal Revenue Service

**u** Complete if the organization is described below. **u** Attach to Form 990 or Form 990-EZ.  
**u** Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

**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 <p style="text-align:center;">Upson County Hospital, Inc.</p>	Employer identification number <p style="text-align:center;">58-1734026</p>
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**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. (see instructions for definition of "political campaign activities")
- 2 Political campaign activity expenditures (see instructions) u \$
- 3 Volunteer hours for political campaign activities (see instructions)

**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 u \$
- 2 Enter the amount of any excise tax incurred by organization managers under section 4955 u \$
- 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 u \$
- 2 Enter the amount of the filing organization's funds contributed to other organizations for section 527 exempt function activities u \$
- 3 Total exempt function expenditures. Add lines 1 and 2. Enter here and on Form 1120-POL, line 17b u \$
- 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-.
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				

**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.

<b>Limits on Lobbying Expenditures</b> (The term "expenditures" means amounts paid or incurred.)	(a) Filing organization's totals	(b) Affiliated group totals												
<b>1a</b> Total lobbying expenditures to influence public opinion (grassroots lobbying) .....														
<b>b</b> Total lobbying expenditures to influence a legislative body (direct lobbying) .....														
<b>c</b> Total lobbying expenditures (add lines 1a and 1b) .....														
<b>d</b> Other exempt purpose expenditures .....														
<b>e</b> Total exempt purpose expenditures (add lines 1c and 1d) .....														
<b>f</b> Lobbying nontaxable amount. Enter the amount from the following table in both columns.														
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;">If the amount on line 1e, column (a) or (b) is:</th> <th style="width:70%;">The lobbying nontaxable amount is:</th> </tr> </thead> <tbody> <tr> <td>Not over \$500,000</td> <td>20% of the amount on line 1e.</td> </tr> <tr> <td>Over \$500,000 but not over \$1,000,000</td> <td>\$100,000 plus 15% of the excess over \$500,000.</td> </tr> <tr> <td>Over \$1,000,000 but not over \$1,500,000</td> <td>\$175,000 plus 10% of the excess over \$1,000,000.</td> </tr> <tr> <td>Over \$1,500,000 but not over \$17,000,000</td> <td>\$225,000 plus 5% of the excess over \$1,500,000.</td> </tr> <tr> <td>Over \$17,000,000</td> <td>\$1,000,000.</td> </tr> </tbody> </table>	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.		
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.													
<b>g</b> Grassroots nontaxable amount (enter 25% of line 1f) .....														
<b>h</b> Subtract line 1g from line 1a. If zero or less, enter -0- .....														
<b>i</b> Subtract line 1f from line 1c. If zero or less, enter -0- .....														
<b>j</b> 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? .....		<input type="checkbox"/> Yes <input type="checkbox"/> 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.)

<b>Lobbying Expenditures During 4-Year Averaging Period</b>					
Calendar year (or fiscal year beginning in)	(a) 2016	(b) 2017	(c) 2018	(d) 2019	(e) Total
<b>2a</b> Lobbying nontaxable amount					
<b>b</b> Lobbying ceiling amount (150% of line 2a, column (e))					
<b>c</b> Total lobbying expenditures					
<b>d</b> Grassroots nontaxable amount					
<b>e</b> Grassroots ceiling amount (150% of line 2d, column (e))					
<b>f</b> 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)		(b)
	Yes	No	Amount
<b>1</b> 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:			
<b>a</b> Volunteers?		X	
<b>b</b> Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?		X	
<b>c</b> Media advertisements?		X	
<b>d</b> Mailings to members, legislators, or the public?		X	
<b>e</b> Publications, or published or broadcast statements?		X	
<b>f</b> Grants to other organizations for lobbying purposes?		X	
<b>g</b> Direct contact with legislators, their staffs, government officials, or a legislative body?		X	
<b>h</b> Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?		X	
<b>i</b> Other activities?	X		23,797
<b>j</b> Total. Add lines 1c through 1i			23,797
<b>2a</b> Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?		X	
<b>b</b> If "Yes," enter the amount of any tax incurred under section 4912			
<b>c</b> If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
<b>d</b> 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
<b>1</b> Were substantially all (90% or more) dues received nondeductible by members?		
<b>2</b> Did the organization make only in-house lobbying expenditures of \$2,000 or less?		
<b>3</b> Did the organization agree to carry over lobbying and political campaign activity expenditures from the prior year?		

**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."**

<b>1</b> Dues, assessments and similar amounts from members	<b>1</b>	
<b>2</b> Section 162(e) nondeductible lobbying and political expenditures (do not include amounts of political expenses for which the section 527(f) tax was paid).		
<b>a</b> Current year	<b>2a</b>	
<b>b</b> Carryover from last year	<b>2b</b>	
<b>c</b> Total	<b>2c</b>	
<b>3</b> Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	<b>3</b>	
<b>4</b> 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?	<b>4</b>	
<b>5</b> Taxable amount of lobbying and political expenditures (see instructions)	<b>5</b>	

**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.

Schedule C, Part II-B, Line 1

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

u 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. u Attach to Form 990.

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

OMB No. 1545-0047

2019

Open to Public Inspection

Name of the organization

Employer identification number

Upson County Hospital, Inc.

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.

Table with 2 columns: (a) Donor advised funds, (b) Funds and other accounts. Rows include: 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... Yes No, 6 Did the organization inform all grantees... Yes No.

Part II Conservation Easements.

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

Table with 2 columns: Description, Held at the End of the Tax Year. Rows include: 1 Purpose(s) of conservation easements, 2 Complete lines 2a through 2d if the organization held a qualified conservation contribution... 2a Total number of conservation easements, 2b Total acreage restricted by conservation easements, 2c Number of conservation easements on a certified historic structure, 2d Number of conservation easements included in (c) acquired after 7/25/06, 3 Number of conservation easements modified, transferred, released, extinguished, or terminated, 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.

Table with 2 columns: Description, Amount. Rows include: 1a If the organization elected, as permitted under FASB ASC 958, not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide in Part XIII the text of the footnote to its financial statements that describes these items. b If the organization elected, as permitted under FASB ASC 958, to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items: (i) Revenue included on Form 990, Part VIII, line 1 u \$, (ii) Assets included in Form 990, Part X u \$, 2 If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under FASB ASC 958 relating to these items: a Revenue included on Form 990, Part VIII, line 1 u \$, b Assets included in Form 990, Part X u \$.

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

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

**Part IV Escrow and Custodial Arrangements.**

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

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

**Part V Endowment Funds.**

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

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

- 2 Provide the estimated percentage of the current year end balance (line 1g, column (a)) held as:
- a Board designated or quasi-endowment **u** .....
  - b Permanent endowment **u** .....
  - c Term endowment **u** .....
- 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 .....		1,922,813		1,922,813
b Buildings .....		70,841,530	39,371,207	31,470,323
c Leasehold improvements .....		896,431	757,172	139,259
d Equipment .....		68,483,488	46,570,637	21,912,851
e Other .....		875,126		875,126
<b>Total.</b> Add lines 1a through 1e. (Column (d) must equal Form 990, Part X, column (B), line 10c.) .....	<b>u</b>			56,320,372

**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) .....		
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 12.) ..... <b>u</b>		

**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) .....		
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 13.) ..... <b>u</b>		

**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) .....	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 15.) ..... <b>u</b>	

**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) Estimated third party settlements	306,640
(3) Due to related parties	-6,477
(4) .....	
(5) .....	
(6) .....	
(7) .....	
(8) .....	
(9) .....	
<b>Total.</b> (Column (b) must equal Form 990, Part X, col. (B) line 25.) ..... <b>u</b>	300,163

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

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

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

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

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

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

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

**Part XIII Supplemental Information.**

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

**Part X - FIN 48 Footnote**

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, 2019 and 2018 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**

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

u Attach to Form 990.

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

OMB No. 1545-0047

**2019**

**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		Investments		3,360,789
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					
(11)					
(12)					
(13)					
(14)					
(15)					
(16)					
(17)					
<b>3a Subtotal</b> . . . . .	1				3,360,789
<b>b Total from continuation sheets to Part I</b> . . . . .					
<b>c Totals</b> (add lines 3a and 3b)	1				3,360,789

**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)
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									
(8)									
(9)									
(10)									
(11)									
(12)									
(13)									
(14)									
(15)									
(16)									

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 ..... **u** \_\_\_\_\_

3 Enter total number of other organizations or entities ..... **u** \_\_\_\_\_

**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)
(1)							
(2)							
(3)							
(4)							
(5)							
(6)							
(7)							
(8)							
(9)							
(10)							
(11)							
(12)							
(13)							
(14)							
(15)							
(16)							
(17)							
(18)							



**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.

Part I, Line 3 - Activities per Region

Region	Expenditures	Investments
Central America & the Caribbean	\$ 0	\$ 3,360,789

**SCHEDULE H  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

Name of the organization

**Hospitals**

u Complete if the organization answered "Yes" on Form 990, Part IV, question 20.

u Attach to Form 990.

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

OMB No. 1545-0047

**2019**

Open to Public Inspection

Upson County Hospital, Inc.

Employer identification number

58-1734026

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

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

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
<b>a</b> Financial Assistance at cost (from Worksheet 1)			5,939,334		5,939,334	6.36
<b>b</b> Medicaid (from Worksheet 3, column a)			16,617,348	12,295,757	4,321,591	4.63
<b>c</b> Costs of other means-tested government programs (from Worksheet 3, column b)					0	0.00
<b>d</b> <b>Total.</b> Financial Assistance and Means-Tested Government Programs			22,556,682	12,295,757	10,260,925	10.98
<b>Other Benefits</b>						
<b>e</b> Community health improvement services and community benefit operations (from Worksheet 4)			9,056		9,056	0.01
<b>f</b> Health professions education (from Worksheet 5)			138,818		138,818	0.15
<b>g</b> Subsidized health services (from Worksheet 6)			19,895,502	9,358,277	10,537,225	11.28
<b>h</b> Research (from Worksheet 7)					0	0.00
<b>i</b> Cash and in-kind contributions for community benefit (from Worksheet 8)			13,916		13,916	0.01
<b>j</b> <b>Total.</b> Other Benefits			20,057,292	9,358,277	10,699,015	11.45
<b>k</b> <b>Total.</b> Add lines 7d and 7j			42,613,974	21,654,034	20,959,940	22.44

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

	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community building expense	(d) Direct offsetting revenue	(e) Net community building expense	(f) Percent of total expense
1 Physical improvements and housing					0	0.00
2 Economic development			3,000		3,000	
3 Community support					0	0.00
4 Environmental improvements					0	0.00
5 Leadership development and training for community members					0	0.00
6 Coalition building					0	0.00
7 Community health improvement advocacy					0	0.00
8 Workforce development			433,020		433,020	0.46
9 Other					0	0.00
<b>10 Total</b>			<b>436,020</b>		<b>436,020</b>	<b>0.47</b>

**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		X
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	15,859,007	
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	7,929,504	
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	18,735,552
6 Enter Medicare allowable costs of care relating to payments on line 5	6	16,754,017
7 Subtract line 6 from line 5. This is the surplus (or shortfall)	7	1,981,535
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: <input type="checkbox"/> Cost accounting system <input type="checkbox"/> Cost to charge ratio <input checked="" type="checkbox"/> 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 %
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				



**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

Line number of hospital facility, or line numbers of hospital

facilities in a facility reporting group (from Part V, Section A): 1

**Community Health Needs Assessment**

	Yes	No
<b>1</b> Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year? .....		X
<b>2</b> Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year? If "Yes," provide details of the acquisition in Section C .....		X
<b>3</b> During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 12 .....	X	
If "Yes," indicate what the CHNA report describes (check all that apply):		
<b>a</b> <input checked="" type="checkbox"/> A definition of the community served by the hospital facility		
<b>b</b> <input checked="" type="checkbox"/> Demographics of the community		
<b>c</b> <input type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
<b>d</b> <input checked="" type="checkbox"/> How data was obtained		
<b>e</b> <input checked="" type="checkbox"/> The significant health needs of the community		
<b>f</b> <input checked="" type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
<b>g</b> <input checked="" type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
<b>h</b> <input checked="" type="checkbox"/> The process for consulting with persons representing the community's interests		
<b>i</b> <input checked="" type="checkbox"/> The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)		
<b>j</b> <input type="checkbox"/> Other (describe in Section C)		
<b>4</b> Indicate the tax year the hospital facility last conducted a CHNA <u>20 18</u>		
<b>5</b> In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Section C how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted .....	X	
<b>6a</b> Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Section C .....		X
<b>6b</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 .....		X
<b>7</b> Did the hospital facility make its CHNA report widely available to the public? .....	X	
If "Yes," indicate how the CHNA report was made widely available (check all that apply):		
<b>a</b> <input checked="" type="checkbox"/> Hospital facility's website (list url): <u>www.urmc.org</u>		
<b>b</b> <input type="checkbox"/> Other website (list url): _____		
<b>c</b> <input checked="" type="checkbox"/> Made a paper copy available for public inspection without charge at the hospital facility		
<b>d</b> <input checked="" type="checkbox"/> Other (describe in Section C)		
<b>8</b> Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA? If "No," skip to line 11 .....	X	
<b>9</b> Indicate the tax year the hospital facility last adopted an implementation strategy <u>20 19</u>		
<b>10</b> Is the hospital facility's most recently adopted implementation strategy posted on a website? .....	X	
<b>a</b> If "Yes," (list url): <u>www.urmc.org</u>		
<b>b</b> If "No," is the hospital facility's most recently adopted implementation strategy attached to this return? .....		X
<b>11</b> Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.		
<b>12a</b> Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)? .....		X
<b>b</b> If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax? .....		
<b>c</b> 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? <u>\$</u>		

**Part V Facility Information (continued)**

**Financial Assistance Policy (FAP)**

Name of hospital facility or letter of facility reporting group Upson County Hospital

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

**Part V Facility Information (continued)**

**Billing and Collections**

Name of hospital facility or letter of facility reporting group Upson County Hospital

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

	Yes	No
<b>17</b>	<input checked="" type="checkbox"/>	
<b>18</b>		
<b>19</b>		<input checked="" type="checkbox"/>
<b>20</b>		

**Policy Relating to Emergency Medical Care**

- 21** Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy? .....
- If "No," indicate why:
- a**  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)

	Yes	No
<b>21</b>	<input checked="" type="checkbox"/>	



**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

**22** Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.

- a  The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period
- b  The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- c  The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period
- d  The hospital facility used a prospective Medicare or Medicaid method

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

If "Yes," explain in Section C.

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

If "Yes," explain in Section C.

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

**Part V Facility Information** (continued)

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

Facility 1, Upson County Hospital - Part V, Line 3e

The prioritization of significant health needs of the community is identified and the methodology for prioritizing each need is described on page 35 of the 2018 CHNA.

Facility 1, Upson County Hospital - Part V, 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 19 community members to

**Part V Facility Information** (continued)

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

participate in the stakeholder interviews.

Facility 1, Upson County Hospital - Part V, Line 7d

A copy is available through the organization's Facebook page.

Facility 1, Upson County Hospital - Part V, Line 11

Information gathered from community-wide 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.

Both the 2018 CHNA and 2019 Implmentation Strategy documents are located at the following web address:

**Part V Facility Information** (continued)

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

<https://urmc.org/about/community-health-needs-assessment>

Facility 1, Upson County Hospital - Part V, Line 15e

Information is mailed to all patients on each statement as long as a  
balance is outstanding. It is available on the hospital website and at any  
entrance point of the hospital.

Facility 1, Upson County Hospital - Part V, 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? 8

Name and address	Type of Facility (describe)
1 Upson Medical Associates, LLC 801 W. Gordon St  Thomaston GA 30286	Physicians Office
2 Upson Regional Wellness Center, LLC 801 W. Gordon St  Thomaston GA 30286	Wellness Center
3 Orthopedics Sports Medicine & Surg 801 W. Gordon St  Thomaston GA 30286	Physicians Office
4 Upson Women's Services, LLC 801 W. Gordon St  Thomaston GA 30286	Physicians Office
5 Upson Family Physicians, LLC 801 W. Gordon St  Thomaston GA 30286	Physicians Office
6 Upson Surgical Associates, LLC 801 W. Gordon St  Thomaston GA 30286	Physicians Office
7 Upson Family Medical Center 801 W. Gordon St  Thomaston GA 30286	Family Medical Center
8 URMC Psych Unit 801 W. Gordon St  Thomaston GA 30286	Psychiatric Unit

**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 Explanation

Subsidized Health service costs include those attributable to Upson Medical Associates, Upson Women's Services, Upson Surgical Associates, Orthopedic Sports Medicine, and Upson Family Physicians totaling \$19,895,502. These clinics promote health care for underserved populations in the area.

Part I, Line 7 - Costing Methodology Explanation

The data reported in this area is reported as instructed by Catholic Health Association's "A Guide for Planning and Reporting Community Benefits, 2008".

For line 7a, costs were calculated using the cost-to-charge ratio derived from Worksheet 2 as provided in the IRS instructions.

Subsidized health services presented on line 7g were based on actual costs per the Medicare Cost Report net of associated bad debt, charity and Medicaid expense.

**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.
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- 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.

All other costs presented in the table were accumulated through the  
community benefits software CBISA.

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 - Bad Debt Expense Methodology

Bad debt expense amount represents the amount of charges considered  
uncollectible after reasonable attempts to collect and written off to bad  
debt expense.

Part III, Line 3 - Bad Debt Expense, Patients Eligible for Assistance

The figure on Part III line 3 represents management's estimate  
(approximately 50%) based on an analysis of self pay patients' ability to  
pay their outstanding account. This analysis includes reviewing the  
patient's credit history, income levels and overall collectibility of the

**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.
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- 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.

account.

Part III, Line 4 - Bad Debt Expense Footnote to Financial Statements

The footnote discussing the allowance for doubtful accounts and bad debts (implicit price concessions) can be found on pages 12-14 of the attached audited financial statements.

Part III, Line 8 - Medicare Explanation

Medicare costs reflect allowable costs per the Medicare Cost Report using acceptable allocations of indirect costs based on appropriate statistics.

Part III, Line 9b - Collection Practices Explanation

Accounts known to have qualified for financial assistance are written off to indigent/charity care.

Part VI, Line 2 - Needs Assessment

Upson Regional Medical Center (URMC) is a 115-bed not-for-profit community hospital located in Thomaston, Georgia. URMC conducts triennial Community

Schedule H (Form 990) 2019



**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.

Health Needs Assessments (CHNA) to identify the health needs of  
Upson County. The Implementation Strategy for URMC was developed based on  
findings and priorities established in the CHNA and a review of the  
hospital's existing community benefit activities.

URMC sustains and develops community benefit programs that 1)address  
prioritized needs from the URMC CHNA and 2)respond to other identified  
community health needs.

The following prioritized needs were identified by the community and the  
CHNA steering committee. Particular focus was placed upon these needs in  
developing the implementation strategy.

1. Poverty/jobs

2. Access to care/obesity/education

3. Child health

4. Mental health

5. Chronic Diseases

6. Substance Abuse

**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.

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Part VI, Line 3 - Patient Education of Eligibility for Assistance

URMC 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 departments and other areas of the facility in which eligible patients are present. A copy of the policy and financial assistance contact information is provided to the patients as part of the admission process. Additionally, the policy is available on the hospital website as is the 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 qualifying for such programs, where applicable. We provide training to the staff on financial assistance and contract with Chamberlon & Edmonds for screening our patients for Medicaid eligibility and/or other sources of assistance. We also provide information on the admissions package explaining the availability, criteria, and the process for applying for

**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.
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- 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.

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 - Community Information

Upson County is located in West Central Georgia and has a population of 26,197 as of 2019. The population of Upson County is expected to decrease 0.32% from 2017 to 2022. The racial and ethnic makeup of Upson County is 68% Caucasian, 28% Black, 1% mixed race, 2% other, and 2% Hispanic origin. The percentage of residents aged 55 and older is set to increase 0.6% by 2022; this identified an increased need for delivery of healthcare that serves individuals with chronic conditions. URMC, a regional healthcare 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 - Promotion of Community Health

**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.

Since 2015, URMC has recruited family physicians, a cardiologist, urologist, obstetrician, audiologist, ENT, family practice, orthopedic surgeon, and advanced practice professionals. URMC's award-winning dieticians implement the quarterly Sodexo community education programming and actively participate in community events, health fairs, and at the Wellness Center to increase awareness of good eating habits and their impact on health. URMC also provides monthly diabetes education on disease management and nutrition. In 2017, URMC was designated as a remote stroke treatment center, providing timely consults with neurologists. URMC consistently offers blood pressure checks and education at community events and health fairs. In 2017, URMC opened Silvercare, an 18-bed inpatient geriatric behavioral health unit. In 2018, URMC opened a Rural Health Clinic as well as purchasing an urgent care facility to improve access to care. In early 2019, URMC recruited a new cardiologist as well as a new family medicine provider. In late 2019, URMC added two new family medicine physicians, a new OB/GYN, a new orthopedic surgeon, and a new ENT. We also added Saturday hours at one of our walk-in primary care clinics.

**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.

The governing body is primarily comprised of persons who are not employees, contractors (nor family members thereof), and generally represent the interests of the population served. The medical staff is open to all qualified physicians in the region. The emergency room is open 24/7, serving patients regardless of ability to pay.

As a nonprofit organization dedicated to improving the health of the communities it serves, URMC reinvests all of its surplus funds from its operating and investment activities to improve access to care, expand and replace existing facilities and equipment, invest in technological advancements, support community health programs and advance medical training, education and research.

Part VI, Line 7 - State Filing of Community Benefit Report  
Georgia

**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.  
**u** Attach to Form 990.  
**u** Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for the latest information.

OMB No. 1545-0047

**2019**

**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?  **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.

<b>1</b>	<b>(a) Name and address of organization or government</b>	<b>(b) EIN</b>	<b>(c) IRC section (if applicable)</b>	<b>(d) Amount of cash grant</b>	<b>(e) Amount of non-cash assistance</b>	<b>(f) Method of valuation (book, FMV, appraisal, other)</b>	<b>(g) Description of noncash assistance</b>	<b>(h) Purpose of grant or assistance</b>
(1)								
(2)								
(3)								
(4)								
(5)								
(6)								
(7)								
(8)								
(9)								

- 2** Enter total number of section 501(c)(3) and government organizations listed in the line 1 table **u**
- 3** Enter total number of other organizations listed in the line 1 table **u**

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

Schedule I (Form 990) (2019)

**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 noncash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f) Description of noncash assistance
1 Education Scholarship	2	6,565			
2 Tuition Reimbursement	5	12,180			
3					
4					
5					
6					
7					

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

See Schedule I Supplemental Information Worksheet

<b>SCHEDULE I (Form 990)</b>	<b>Supplemental Information</b>	<b>2019</b>
For calendar year 2019, or tax year beginning _____, and ending _____		Employer identification number
Name of the organization Upson County Hospital, Inc.		58-1734026

Part I, Line 2 - Procedures for Monitoring the Use of Grant Funds

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 every school term, and serve as an employee a minimum of one year for each school year for which scholarship monies were 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 prorata fashion based on employment term.

Tuition reimbursement is awarded fulltime and regularly scheduled part time employees. Monies are granted to cover tuition, books and laboratory fees. 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 grade 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  
u Complete if the organization answered "Yes" on Form 990, Part IV, line 23.  
u Attach to Form 990.  
u Go to [www.irs.gov/Form990](http://www.irs.gov/Form990) for instructions and the latest information.

OMB No. 1545-0047

**2019**

**Open to Public  
Inspection**

Name of the organization

Upson County Hospital, Inc.

Employer identification number

58-1734026

**Part I Questions Regarding Compensation**

**1a** Check the appropriate box(es) if the organization provided any of the following to or for a person listed on Form 990, Part VII, Section A, line 1a. Complete Part III to provide any relevant information regarding these items.

- |  |   |
|--|---|
| <input type="checkbox"/> First-class or charter travel             | <input checked="" type="checkbox"/> Housing allowance or residence for personal use |
| <input type="checkbox"/> Travel for companions                     | <input type="checkbox"/> Payments for business use of personal residence            |
| <input type="checkbox"/> Tax indemnification and gross-up payments | <input type="checkbox"/> Health or social club dues or initiation fees              |
| <input type="checkbox"/> Discretionary spending account            | <input type="checkbox"/> Personal services (such as maid, chauffeur, chef)          |

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

	Yes	No
<b>1b</b>	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?

<b>2</b>	X	
----------	---	--

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

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

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

- a** Receive a severance payment or change-of-control payment? **4a**  Yes  No
- b** Participate in, or receive payment from, a supplemental nonqualified retirement plan? **4b**  Yes  No
- c** Participate in, or receive payment from, an equity-based compensation arrangement? **4c**  Yes  No
- If "Yes" to any of lines 4a–c, list the persons and provide the applicable amounts for each item in Part III.

<b>4a</b>	X	
<b>4b</b>		X
<b>4c</b>		X

**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**  Yes  No
- b** Any related organization? **5b**  Yes  No
- If "Yes" on line 5a or 5b, describe in Part III.

<b>5a</b>		X
<b>5b</b>		X

**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**  Yes  No
- b** Any related organization? **6b**  Yes  No
- If "Yes" on line 6a or 6b, describe in Part III.

<b>6a</b>		X
<b>6b</b>		X

**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

<b>7</b>		X
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**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

<b>8</b>		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**

<b>9</b>		
----------	--	--

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

For each individual whose compensation must be reported on Schedule J, report compensation from the organization on row (i) and from related organizations, described in the instructions, on row (ii). Do not list any individuals that 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 Orthopedic Surgeon	(i) 637,862	464,790	46,750	5,500	34,413	1,189,315	0
	(ii) 0	0	0	0	0	0	0
2 Surgeon	(i) 365,243	146,749	87,114	5,500	34,413	639,019	0
	(ii) 0	0	0	0	0	0	0
3 Surgeon	(i) 339,919	164,591	31,350	5,500	34,413	575,773	0
	(ii) 0	0	0	0	0	0	0
4 Urology Surgeon	(i) 488,766	21,303	15,200	5,500	33,451	564,220	0
	(ii) 0	0	0	0	0	0	0
5 Cardiologist	(i) 314,450	115,328	12,092	5,500	33,451	480,821	0
	(ii) 0	0	0	0	0	0	0
6 Hospital CEO/Pres	(i) 0	0	331,296	0	0	331,296	0
	(ii) 0	0	0	0	0	0	0
7 Hospital CFO	(i) 281,842	0	0	5,500	10,361	297,703	0
	(ii) 0	0	0	0	0	0	0
8 Hospital ICEO/Pres	(i) 0	0	203,954	0	0	203,954	0
	(ii) 0	0	0	0	0	0	0
9 Hospital CEO/Pres	(i) 0	0	120,912	0	0	120,912	0
	(ii) 0	0	0	0	0	0	0
10	(i)						
	(ii)						
11	(i)						
	(ii)						
12	(i)						
	(ii)						
13	(i)						
	(ii)						
14	(i)						
	(ii)						
15	(i)						
	(ii)						
16	(i)						
	(ii)						

**Part III Supplemental Information**

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

Part I, Line 1a - Fringe or Expense Explanation

The interim Chief Executive Officer was provided temporary housing as part of the contract terms of employment.

Part I, Line 4 - Severance, Nonqualified, and Equity-Based Payments

	Severance	Nonqualified	Equity-based
--	-----------	--------------	--------------

	120,912	0	0
--	---------	---	---

Part III - Other Additional Information

Management Services:

The Organization's CEO is contractually provided by Healthtech Management, an unrelated firm hired to provide CEO services. Healthtech was paid a total of \$295,000 in 2019 for these services. During the year, were compensated \$321,296 and \$203,954, respectively for their CEO services provided to the Foundation and URMC.

Bonuses/Awards

Physician bonuses are paid based on Relative Value Units (RVUs) achieved

**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.

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**  
 u Complete if the organization answered "Yes" on Form 990, Part IV, line 24a. Provide descriptions, explanations, and any additional information in Part VI.

u Attach to Form 990.

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

OMB No. 1545-0047

**2019**

**Open to Public Inspection**

Name of the organization **Upson County Hospital, Inc.** Employer identification number **58-1734026**

**Part I Bond Issues**

(a) Issuer name	(b) Issuer EIN	(c) CUSIP #	(d) Date issued	(e) Issue price	(f) Description of purpose	(g) Defeased		(h) On behalf of issuer		(i) Pooled financing	
						Yes	No	Yes	No	Yes	No
<b>A</b> Hospital Authority of Upson County	58-6002427		12/31/04	10,000,000	See Part VI		X	X			X
<b>B</b> Hospital Authority of Upson County	58-6002427		01/20/05	6,000,000	See Part VI		X	X			X
<b>C</b>											
<b>D</b>											

**Part II Proceeds**

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
<b>1</b> Amount of bonds retired .....		6,710,000		4,020,000				
<b>2</b> Amount of bonds legally defeased .....								
<b>3</b> Total proceeds of issue .....		10,000,000		6,000,000				
<b>4</b> Gross proceeds in reserve funds .....								
<b>5</b> Capitalized interest from proceeds .....								
<b>6</b> Proceeds in refunding escrows .....								
<b>7</b> Issuance costs from proceeds .....		124,175		79,846				
<b>8</b> Credit enhancement from proceeds .....								
<b>9</b> Working capital expenditures from proceeds .....								
<b>10</b> Capital expenditures from proceeds .....		9,875,825		5,920,154				
<b>11</b> Other spent proceeds .....								
<b>12</b> Other unspent proceeds .....								
<b>13</b> Year of substantial completion .....		2007		2007				
	Yes	No	Yes	No	Yes	No	Yes	No
<b>14</b> Were the bonds issued as part of a refunding issue of tax-exempt bonds (or, if issued prior to 2018, a current refunding issue)? .....		X		X				
<b>15</b> Were the bonds issued as part of a refunding issue of taxable bonds (or, if issued prior to 2018, an advance refunding issue)? .....		X		X				
<b>16</b> Has the final allocation of proceeds been made? .....	X		X					
<b>17</b> Does the organization maintain adequate books and records to support the final allocation of proceeds? .....	X		X					

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

**Part III Private Business Use**

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
<b>1</b> Was the organization a partner in a partnership, or a member of an LLC, which owned property financed by tax-exempt bonds? .....		X		X				
<b>2</b> Are there any lease arrangements that may result in private business use of bond-financed property? .....		X		X				
<b>3a</b> Are there any management or service contracts that may result in private business use of bond-financed property? .....		X		X				
<b>b</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? .....								
<b>c</b> Are there any research agreements that may result in private business use of bond-financed property? .....		X		X				
<b>d</b> 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? ..								
<b>4</b> 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 ..... <b>u</b>		%		%		%		%
<b>5</b> 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 ..... <b>u</b>		%		%		%		%
<b>6</b> Total of lines 4 and 5 .....		%		%		%		%
<b>7</b> Does the bond issue meet the private security or payment test? .....		X		X				
<b>8a</b> Has there been a sale or disposition of any of the bond-financed property to a nongovernmental person other than a 501(c)(3) organization since the bonds were issued? .....		X		X				
<b>b</b> If "Yes" to line 8a, enter the percentage of bond-financed property sold or disposed of .....		%		%		%		%
<b>c</b> If "Yes" to line 8a, was any remedial action taken pursuant to Regulations sections 1.141-12 and 1.145-2? .....								
<b>9</b> 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
<b>1</b> Has the issuer filed Form 8038-T, Arbitrage Rebate, Yield Reduction and Penalty in Lieu of Arbitrage Rebate? .....		X		X				
<b>2</b> If "No" to line 1, did the following apply? .....								
<b>a</b> Rebate not due yet? .....		X		X				
<b>b</b> Exception to rebate? .....		X		X				
<b>c</b> No rebate due? .....	X		X					
If "Yes" to line 2c, provide in Part VI the date the rebate computation was performed .....								
<b>3</b> Is the bond issue a variable rate issue? .....		X		X				

**Part IV Arbitrage (continued)**

	A		B		C		D	
	Yes	No	Yes	No	Yes	No	Yes	No
<b>4a</b> Has the organization or the governmental issuer entered into a qualified hedge with respect to the bond issue? .....		X		X				
<b>b</b> Name of provider .....								
<b>c</b> Term of hedge .....								
<b>d</b> Was the hedge superintegrated? .....								
<b>e</b> Was the hedge terminated? .....								
<b>5a</b> Were gross proceeds invested in a guaranteed investment contract (GIC)? ..		X		X				
<b>b</b> Name of provider .....								
<b>c</b> Term of GIC .....								
<b>d</b> Was the regulatory safe harbor for establishing the fair market value of the GIC satisfied?								
<b>6</b> Were any gross proceeds invested beyond an available temporary period? ..		X		X				
<b>7</b> 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 - Purpose of Issue Description  
 Hospital Authority of Upson County  
 Renovation and expansion of hospital

Hospital Authority of Upson County  
 Renovation & expansion of hospital

Schedule K - Date Rebate Computation Performed  
 Hospital Authority of Upson County 12/30/09  
 Hospital Authority of Upson County 01/20/10





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

Department of the Treasury  
Internal Revenue Service

Name of the organization

**Transactions With Interested Persons**

**u** 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.

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

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

OMB No. 1545-0047

**2019**

Open To Public Inspection

Employer identification number

Upson County Hospital, Inc.

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	No
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					

**2** Enter the amount of tax incurred by the organization managers or disqualified persons during the year under section 4958 ..... **u** \$ \_\_\_\_\_

**3** Enter the amount of tax, if any, on line 2, above, reimbursed by the organization ..... **u** \$ \_\_\_\_\_

**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.

1	(a) Name of interested person	(b) Relationship with organization	(c) Purpose of loan	(d) Loan to or from the org.?		(e) Original principal amount	(f) Balance due	(g) In default?		(h) Approved by board or committee?		(i) Written agreement?	
				To	From			Yes	No	Yes	No	Yes	No
				(1)									
(2)													
(3)													
(4)													
(5)													
(6)													
(7)													
(8)													
(9)													
(10)													

**Total** ..... **u** \$ \_\_\_\_\_

**Part III Grants or Assistance Benefiting Interested Persons.**

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

1	(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
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

**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 org. revenues?	
				Yes	No
(1) Stephanie Davis	Family-Bd Mbr	67,332	Employee Wages		X
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					

**Part V Supplemental Information.**

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

Schedule L, Part V - Additional Information

Stephanie Davis is a family member of an active member of the hospital board. Ms. Davis is employed and compensated by 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.

u Attach to Form 990 or 990-EZ.

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

OMB No. 1545-0047

**2019****Open to Public  
Inspection**

Name of the organization Upson County Hospital, Inc.	Employer identification number 58-1734026
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Form 990, Part V, Line 4b - Financial Accounts in Foreign Countries  
Cayman Islands

Form 990, Part VI, Line 3 - Management Delegated  
The Organization engaged Healthtech Management to provide the services of  
an interim CEO. Healthtech was compensated \$295,000 for these services.

Form 990, Part VI, Line 11b - Organization's Process to Review Form 990  
The Organization posts the Form 990 on a secure website for board members  
only and each current voting board member is alerted by email as to its  
availability. The CFO performs a detailed review prior to filing with the  
IRS.

Form 990, Part VI, Line 12c - Enforcement of Conflicts Policy  
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, Line 15a - Compensation Process for Top Official  
In determining compensation for top officials, Human Resources obtains the

Name of the organization Upson County Hospital, Inc.	Employer identification number 58-1734026
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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.

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 CEO who makes the final decision. The individual in the consideration process is not present during the discussion and decision-making process. Annual merit adjustment: salary adjustment is determined by organizational performance as reflected in the score of the established performance measurement instrument.

(Payscale) - 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, Line 15b - Compensation Process for Officers  
See response at 15a.

Form 990, Part VI, Line 19 - Governing Documents Disclosure Explanation  
The governing documents, conflict of interest policy, and financial statements are available for inspection, with notice, in the office of the organization. In addition, the financial statements are available on the organization's website.

Name of the organization	Employer identification number
Upson County Hospital, Inc.	58-1734026

## Form 990, Part IX, Line 11g - Other Fees for Services

Description	Tot/Prog Service	Mgt & General	Fundraising
Physician fees	\$ 3,429,724	\$ 0	\$ 0
Contracted services	\$ 2,353,477	\$ 938,488	\$ 0
Purchased services	\$ 1,675,061	\$ 942,991	\$ 0
Professional fees	\$ 310,736	\$ 100,240	\$ 0
Therapy fees	\$ 54,790	\$ 0	\$ 0
Consulting fees	\$ 2,846	\$ 410,994	\$ 0
Other fees	\$ 352,484	\$ 109,601	\$ 0
Collection fees	\$ 28,763	\$ 534,981	\$ 0
<b>Total</b>	<b>\$ 8,207,881</b>	<b>\$ 3,037,295</b>	<b>\$ 0</b>

**SCHEDULE R  
(Form 990)**

**Related Organizations and Unrelated Partnerships**

OMB No. 1545-0047

**2019**

**Open to Public Inspection**

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

u Attach to Form 990.

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

Department of the Treasury  
Internal Revenue Service

Name of the organization

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
(1) Upson Medical Associates LLC 801 West Gordon Street 55-0840991 Thomaston GA 30286	Phys Ofc	GA	-153,076	173,103	UCH
(2) Upson Regional Wellness Ctr LLC 801 West Gordon Street 20-5095610 Thomaston GA 30286	Wellness	GA	-93,896	152,233	UCH
(3) Upson Women's Svcs, LLC 801 West Gordon Street 26-3227893 Thomaston GA 30286	Phys Ofc	GA	-691,057	873,106	UCH
(4) Upson Family Physicians LLC 801 West Gordon Street 27-0192553 Thomaston GA 30286	Phys Ofc	GA	-800,335	570,564	UCH
(5) Upson Surgical Associates LLC 801 West Gordon Street 27-5252545 Thomaston GA 30286	Phys Ofc	GA	-2,058,273	1,260,412	UCH

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1) URM Health Foundation P O Box 1089 83-0411781 Thomaston GA 30286	Foundation	GA	501c3	12a	UCH	X	
(2) Hospital Authority of Upson County 801 West Gordon Street 58-6002427 Thomaston GA 30286-0027	Mgmt	GA	Govt	6	N/A		X
(3)							
(4)							
(5)							

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

Schedule R (Form 990) 2019

**SCHEDULE R  
(Form 990)**

Department of the Treasury  
Internal Revenue Service

Name of the organization

**Related Organizations and Unrelated Partnerships**

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

u Attach to Form 990.

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

OMB No. 1545-0047

**2019**

**Open to Public  
Inspection**

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
(1) Orthopedics Sports Medicine & Surg 801 West Gordon Street 27-2123255 Thomaston GA 30286	Phys Ofc	GA	-996,073	456,391	UCH
(2) URM Medical Office Bldg LLC 801 West Gordon Street 47-4279645 Thomaston GA 30286	Med Ofc Bl	GA	-253,183	4,996,874	UCH
(3) Upson Family Medical Center LLC 801 West Gordon Street 82-4385128 Thomaston GA 30286	Phys Ofc	GA	-442,949	1,950,210	UCH
(4)					
(5)					

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

(a) Name, address, and EIN of related organization	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Exempt Code section	(e) Public charity status (if section 501(c)(3))	(f) Direct controlling entity	(g) Section 512(b)(13) controlled entity?	
						Yes	No
(1)							
(2)							
(3)							
(4)							
(5)							

**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) Dispro- portionate alloc.?		(i) Code V—UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
							Yes	No		Yes	No	
(1) .....												
(2) .....												
(3) .....												
(4) .....												

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

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



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

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

**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?

	Yes	No
<b>a</b> Receipt of (i) interest, (ii) annuities, (iii) royalties, or (iv) rent from a controlled entity		X
<b>b</b> Gift, grant, or capital contribution to related organization(s)		X
<b>c</b> Gift, grant, or capital contribution from related organization(s)	X	
<b>d</b> Loans or loan guarantees to or for related organization(s)		X
<b>e</b> Loans or loan guarantees by related organization(s)		X
<b>f</b> Dividends from related organization(s)		X
<b>g</b> Sale of assets to related organization(s)		X
<b>h</b> Purchase of assets from related organization(s)		X
<b>i</b> Exchange of assets with related organization(s)		X
<b>j</b> Lease of facilities, equipment, or other assets to related organization(s)		X
<b>k</b> Lease of facilities, equipment, or other assets from related organization(s)		X
<b>l</b> Performance of services or membership or fundraising solicitations for related organization(s)	X	
<b>m</b> Performance of services or membership or fundraising solicitations by related organization(s)	X	
<b>n</b> Sharing of facilities, equipment, mailing lists, or other assets with related organization(s)	X	
<b>o</b> Sharing of paid employees with related organization(s)	X	
<b>p</b> Reimbursement paid to related organization(s) for expenses		X
<b>q</b> Reimbursement paid by related organization(s) for expenses		X
<b>r</b> Other transfer of cash or property to related organization(s)		X
<b>s</b> Other transfer of cash or property from related organization(s)		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) URMC Health Foundation	c	45,160	Cash value
(2) URMC Health Foundation	l		Indeterminable value
(3) URMC Health Foundation	m		Indeterminable value
(4) URMC Health Foundation	n		Indeterminable value
(5) URMC Health Foundation	o		Indeterminable value
(6)			

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

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

(a) Name, address, and EIN of entity	(b) Primary activity	(c) Legal domicile (state or foreign country)	(d) Predominant income (related, unrelated, excluded from tax under sections 512-514)	(e) Are all partners section 501(c)(3) organizations?		(f) Share of total income	(g) Share of end-of-year assets	(h) Disproportionate allocations?		(i) Code V—UBI amount in box 20 of Schedule K-1 (Form 1065)	(j) General or managing partner?		(k) Percentage ownership
				Yes	No			Yes	No		Yes	No	
(1) .....													
(2) .....													
(3) .....													
(4) .....													
(5) .....													
(6) .....													
(7) .....													
(8) .....													
(9) .....													
(10) .....													
(11) .....													



## Part A : General Information

### 1. Identification

UID:HOSP523

**Facility Name:** Upson Regional Medical Center

**County:** Upson

**Street Address:** PO Drawer 1059

**City:** Thomaston

**Zip:** 30286-0013

**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, 2020 through December 31, 2020.  
***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](mailto: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	4/23/1947

#### 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 County Hospital, Inc	Not for Profit	8/12/1986

#### D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A	NA	

#### E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Health Tech Management Services	For Profit	2/4/2002

#### 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:

City: State:

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(PHO)

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preferred Provider Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indemnity Fee-for-Service Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Another Insurance Product Not Listed Above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 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. Do not include newborn and neonatal services. Do not include long-term care units, 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	379	1,995	379	1,995
Pediatrics (Non ICU)	2	15	29	15	29
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	7	15	38	15	38
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	28	1,496	5,995	1,496	5,995
Intensive Care	8	212	1,580	212	1,580
Psychiatry	18	412	4,657	412	4,657
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	18	1,037	4,596	1,037	4,596
	0	0	0	0	0
	0	0	0	0	0
<b>Total</b>	<b>88</b>	<b>3,566</b>	<b>18,890</b>	<b>3,566</b>	<b>18,890</b>

## **2. Race/Ethnicity**

Please report admissions and inpatient days for the hospital by the following race and ethnicity categories. Exclude newborn and neonatal.

<b>Race/Ethnicity</b>	<b>Admissions</b>	<b>Inpatient Days</b>
American Indian/Alaska Native	1	8
Asian	4	368
Black/African American	1,127	5,916
Hispanic/Latino	16	73
Pacific Islander/Hawaiian	4	19
White	2,350	11,682
Multi-Racial	64	716
<b>Total</b>	<b>3,566</b>	<b>18,782</b>

## **3. Gender**

Please report admissions and inpatient days by gender. Exclude newborn and neonatal.

<b>Gender</b>	<b>Admissions</b>	<b>Inpatient Days</b>
Male	1,594	9,314
Female	1,972	9,468
<b>Total</b>	<b>3,566</b>	<b>18,782</b>

## **4. Payment Source**

Please report admissions and inpatient days by primary payment source. Exclude newborn and neonatal.

<b>Primary Payment Source</b>	<b>Admissions</b>	<b>Inpatient Days</b>
Medicare	2,044	2,326
Medicaid	665	1,669
Peachare	0	0
Third-Party	531	11,090
Self-Pay	276	885
Other	50	2,812

## **5. Discharges to Death**

Report the total number of inpatient admissions discharged during the reporting period due to death.

192

## **6. Charges for Selected Services**

Please report the hospital's average charges as of 12-31-2020 (to the nearest whole dollar).

<b>Service</b>	<b>Charge</b>
Private Room Rate	1,122
Semi-Private Room Rate	1,098
Operating Room: Average Charge for the First Hour	10,691
Average Total Charge for an Inpatient Day	3,531



## Part E : Emergency Department and Outpatient Services

### **1. Emergency Visits**

Please report the number of emergency visits only.

22,488

### **2. Inpatient Admissions from ER**

Please report inpatient admissions to the Hospital from the ER for emergency cases ONLY.

2,356

### **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	22,488
	0	0
	0	0
	0	0
	0	0

### **5. Transfers**

Please provide the number of Transfers to another institution from the Emergency Department.

271

### **6. Non-Emergency Visits**

Please provide the number of Outpatient/Clinic/All Other Non-Emergency visits to the hospital.

55,683

### **7. Observation Visits/Cases**

Please provide the total number of Observation visits/cases for the entire report period.

839

### **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.

328

## 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
Podiatric Services	1	1
Renal Dialysis	2	1
ESWL	2	1
Biliary Lithotripter	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, Diagnostic	1	1
Positron Emission Tomography (PET)	1	1
Radioisotope, Therapeutic	2	1
Magnetic Resonance Imaging (MRI)	3	4
Chemotherapy	1	1
Respiratory Therapy	1	1
Occupational Therapy	2	1
Physical Therapy	2	1
Speech Pathology Therapy	2	1
Gamma Ray Knife	2	1
Audiology Services	3	4
HIV/AIDS Diagnostic Treatment/Services	3	4
Ambulance Services	3	4
Hospice	3	4
Respite Care Services	2	1
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.

<b>Category</b>	<b>Total</b>
Number of Podiatric Patients	45
Number of Dialysis Treatments	251
Number of ESWL Patients	82
Number of ESWL Procedures	82
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	19,438
Number of CTS Units (machines)	2
Number of CTS Procedures	8,114
Number of Diagnostic Radioisotope Procedures	1,513
Number of PET Units (machines)	1
Number of PET Procedures	43
Number of Therapeutic Radioisotope Procedures	0
Number of Number of MRI Units	1
Number of Number of MRI Procedures	1,509
Number of Chemotherapy Treatments	112
Number of Respiratory Therapy Treatments	50,363
Number of Occupational Therapy Treatments	1
Number of Physical Therapy Treatments	46,340
Number of Speech Pathology Patients	407
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	114
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	2
Number of Ultrasound/Medical Sonography Procedures	3,537
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	

## Part G : Facility Workforce Information

### 1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2020. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2020.

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*)	130.15	14.00	3.00
Licensed Practical Nurses (LPNs)	14.10	0.00	0.00
Pharmacists	4.90	0.00	0.00
Other Health Services Professionals*	144.95	15.00	1.00
Administration and Support	7.00	1.00	0.00
All Other Hospital Personnel (not included above)	206.55	7.00	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	Not Applicable
Registered Nurses (RNs-Advance Practice)	More than 90 Days
Licensed Practical Nurses (LPNs)	30 Days or Less
Pharmacists	Not Applicable
Other Health Services Professionals	61-90 Days
All Other Hospital Personnel (not included above)	61-90 Days

### 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	0
Asian	7
Black/African American	7
Hispanic/Latino	0
Pacific Islander/Hawaiian	0
White	29
Multi-Racial	1

### 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	11	<input checked="" type="checkbox"/>	0	0
General Internal Medicine	11	<input type="checkbox"/>	0	0
Pediatricians	3	<input checked="" type="checkbox"/>	0	0
Other Medical Specialties	0	<input type="checkbox"/>	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	4	<input type="checkbox"/>	0	0
Non-OB Physicians Providing OB Services	0	<input type="checkbox"/>	0	0
Gynecology	5	<input type="checkbox"/>	0	0
Ophthalmology Surgery	1	<input type="checkbox"/>	0	0
Orthopedic Surgery	2	<input type="checkbox"/>	0	0
Plastic Surgery	0	<input type="checkbox"/>	0	0
General Surgery	2	<input type="checkbox"/>	0	0
Thoracic Surgery	0	<input type="checkbox"/>	0	0
Other Surgical Specialties	2	<input type="checkbox"/>	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	5	<input checked="" type="checkbox"/>	0	0
Dermatology	0	<input type="checkbox"/>	0	0
Emergency Medicine	1	<input checked="" type="checkbox"/>	0	0
Nuclear Medicine	0	<input type="checkbox"/>	0	0
Pathology	1	<input checked="" type="checkbox"/>	0	0
Psychiatry	3	<input type="checkbox"/>	0	0
Radiology	3	<input checked="" type="checkbox"/>	0	0
	0	<input type="checkbox"/>	0	0
	0	<input type="checkbox"/>	0	0
	0	<input type="checkbox"/>	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 surgeons) with Admitting Privileges	0
Podiatrists	2
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	35

**5b. Name of Other Professions**

Please provide the names of professions classified as "Other Staff Affiliates with Clinical Privileges" above.

Nurse Practitioner, PA ,CRNA's , and Midwife

**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
Alabama	18	3	0	10	0	0	0	0	0	0	0	0	0
Barrow	10	0	0	0	0	0	0	0	0	0	0	0	0
Bartow	10	2	0	11	0	0	0	0	0	0	0	0	0
Bibb	28	2	1	15	0	0	0	0	0	0	0	0	0
Butts	14	10	8	1	0	0	0	0	0	0	0	0	0
Carroll	19	3	0	19	0	0	0	0	0	0	0	0	0
Catoosa	1	0	0	1	0	0	0	0	0	0	0	0	0
Chatham	3	0	0	3	0	0	0	0	0	0	0	0	0
Chattooga	7	0	0	9	0	0	0	0	0	0	0	0	0
Cherokee	4	1	1	2	0	0	0	0	0	0	0	0	0
Clarke	7	0	0	7	0	0	0	0	0	0	0	0	0
Clayton	6	4	3	3	0	0	0	0	0	0	0	0	0
Cobb	7	2	0	6	0	0	0	0	0	0	0	0	0
Coffee	0	2	0	0	0	0	0	0	0	0	0	0	0
Colquitt	1	0	0	1	0	0	0	0	0	0	0	0	0
Columbia	5	3	0	2	0	0	0	0	0	0	0	0	0
Coweta	21	6	1	13	0	0	0	0	0	0	0	0	0
Crawford	22	9	2	1	0	0	0	0	0	0	0	0	0
Crisp	3	0	0	1	0	0	0	0	0	0	0	0	0
DeKalb	8	0	0	5	0	0	0	0	0	0	0	0	0
Dougherty	9	0	0	1	0	0	0	0	0	0	0	0	0
Douglas	12	0	0	3	0	0	0	0	0	0	0	0	0
Evans	0	1	0	0	0	0	0	0	0	0	0	0	0
Fayette	10	3	1	5	0	0	0	0	0	0	0	0	0
Florida	5	0	0	0	0	0	0	0	0	0	0	0	0
Floyd	14	0	0	13	0	0	0	0	0	0	0	0	0
Forsyth	1	0	0	1	0	0	0	0	0	0	0	0	0



Fulton	10	2	0	6	0	0	0	0	0	0	0	0	0
Gilmer	1	0	0	1	0	0	0	0	0	0	0	0	0
Gordon	2	0	0	2	0	0	0	0	0	0	0	0	0
Gwinnett	9	0	0	10	0	0	0	0	0	0	0	0	0
Haralson	4	0	0	4	0	0	0	0	0	0	0	0	0
Harris	12	10	1	3	0	0	0	0	0	0	0	0	0
Henry	20	12	1	6	0	0	0	0	0	0	0	0	0
Houston	6	2	0	4	0	0	0	0	0	0	0	0	0
Jackson	2	0	0	1	0	0	0	0	0	0	0	0	0
Jasper	2	2	0	0	0	0	0	0	0	0	0	0	0
Jones	1	0	1	0	0	0	0	0	0	0	0	0	0
Lamar	394	278	51	21	0	0	0	0	0	0	0	0	0
Laurens	2	0	0	2	0	0	0	0	0	0	0	0	0
Lee	2	0	0	0	0	0	0	0	0	0	0	0	0
Lowndes	1	0	0	0	0	0	0	0	0	0	0	0	0
Macon	1	1	0	0	0	0	0	0	0	0	0	0	0
Madison	1	0	0	1	0	0	0	0	0	0	0	0	0
Marion	4	4	1	0	0	0	0	0	0	0	0	0	0
Meriwether	252	107	17	26	0	0	0	0	0	0	0	0	0
Monroe	46	46	8	3	0	0	0	0	0	0	0	0	0
Morgan	2	0	0	0	0	0	0	0	0	0	0	0	0
Muscogee	37	6	2	35	0	0	0	0	0	0	0	0	0
Newton	1	0	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	21	3	0	6	0	0	0	0	0	0	0	0	0
Paulding	3	1	0	1	0	0	0	0	0	0	0	0	0
Peach	7	2	1	1	0	0	0	0	0	0	0	0	0
Pike	315	121	24	12	0	0	0	0	0	0	0	0	0
Polk	11	0	0	12	0	0	0	0	0	0	0	0	0
Pulaski	1	0	0	1	0	0	0	0	0	0	0	0	0
Quitman	1	0	0	0	0	0	0	0	0	0	0	0	0
Randolph	1	0	0	0	0	0	0	0	0	0	0	0	0
Richmond	20	0	0	18	0	0	0	0	0	0	0	0	0
Rockdale	2	0	1	1	0	0	0	0	0	0	0	0	0
Schley	1	1	0	0	0	0	0	0	0	0	0	0	0
Spalding	54	85	10	10	0	0	0	0	0	0	0	0	0
Stephens	1	0	0	0	0	0	0	0	0	0	0	0	0
Stewart	1	0	0	0	0	0	0	0	0	0	0	0	0
Sumter	2	0	0	0	0	0	0	0	0	0	0	0	0
Talbot	66	30	5	1	0	0	0	0	0	0	0	0	0
Taylor	129	69	14	8	0	0	0	0	0	0	0	0	0
Terrell	1	0	0	1	0	0	0	0	0	0	0	0	0
Tift	1	0	0	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	16	1	0	9	0	0	0	0	0	0	0	0	0

Turner	1	0	0	1	0	0	0	0	0	0	0	0	0
Twiggs	1	0	0	1	0	0	0	0	0	0	0	0	0
Upson	1,845	1,535	179	65	0	0	0	0	0	0	0	0	0
Walker	1	0	0	1	0	0	0	0	0	0	0	0	0
Walton	3	0	0	1	0	0	0	0	0	0	0	0	0
Washington	1	0	0	1	0	0	0	0	0	0	0	0	0
White	1	0	0	0	0	0	0	0	0	0	0	0	0
Wilkes	1	0	0	1	0	0	0	0	0	0	0	0	0
Worth	1	0	0	0	0	0	0	0	0	0	0	0	0
<b>Total</b>	<b>3,566</b>	<b>2,370</b>	<b>333</b>	<b>411</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

## 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	2
	0	0	0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>7</b>

#### 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	506	1,705
Cystoscopy	0	0	46	151
Endoscopy	0	0	220	514
	0	0	0	0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>772</b>	<b>2,370</b>

#### 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	506	1,705
Cystoscopy	0	0	46	151
Endoscopy	0	0	220	514
	0	0	0	0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>772</b>	<b>2,370</b>

### 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	1
Black/African American	628
Hispanic/Latino	15
Pacific Islander/Hawaiian	0
White	1,702
Multi-Racial	20
<b>Total</b>	<b>2,370</b>

## **2. Age Grouping**

Please report the total number of ambulatory patients by age grouping.

Age of Patient	Number of Ambulatory Patients
Ages 0-14	131
Ages 15-64	1,480
Ages 65-74	453
Ages 75-85	256
Ages 85 and Up	50
<b>Total</b>	<b>2,370</b>

## **3. Gender**

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	1,005
Female	1,365
<b>Total</b>	<b>2,370</b>

## **4. Payment Source**

Please report the total number of ambulatory patients by payment source.

Primary Payment Source	Number of Patients
Medicare	1,017
Medicaid	443
Third-Party	794
Self-Pay	116

## **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 the hospital or anywhere on its grounds.

#### **1. Number of Delivery Rooms: 0**

2. Number of Birthing Rooms: 5
3. Number of LDR Rooms: 1
4. Number of LDRP Rooms: 0
5. Number of Cesarean Sections: 135
6. Total Live Births: 333
7. Total Births (Live and Late Fetal Deaths): 333
8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 333

## 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)	5	322	753	0
Specialty Care (Intermediate Neonatal Care)	2	11	51	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	0	320
Asian	4	14
Black/African American	122	152
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	192	333
Multi-Racial	15	40
<b>Total</b>	<b>333</b>	<b>859</b>

## **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	0	0
Ages 15-44	333	859
Ages 45 and Up	0	0
<b>Total</b>	<b>333</b>	<b>859</b>

## **3. Average Charge for an Uncomplicated Delivery**

Please report the average hospital charge for an uncomplicated delivery(CPT 59400)

\$4,641.00

## **4. Average Charge for a Premature Delivery**

Please report the average hospital charge for a premature delivery.

\$5,960.00

## **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: 0**

**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
<b>Total</b>	<b>0</b>	<b>0</b>

## **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
<b>Total</b>	<b>0</b>	<b>0</b>

## **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
<b>Total</b>	<b>0</b>	<b>0</b>

## **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	411	4,657	411	2,650	2,358	<input checked="" type="checkbox"/>
General Acute Psychiatric Adolescents 13-17	0	0	0	0	0	<input type="checkbox"/>
General Acute Psychiatric Children 12 and Under	0	0	0	0	0	<input type="checkbox"/>
Acute Substance Abuse Adults 18 and over	0	0	0	0	0	<input type="checkbox"/>
Acute Substance Abuse Adolescents 13-17	0	0	0	0	0	<input type="checkbox"/>
Extended Care Adults 18 and over	0	0	0	0	0	<input type="checkbox"/>
Extended Care Adolescents 13-17	0	0	0	0	0	<input type="checkbox"/>
Extended Care Adolescents 0-12	0	0	0	0	0	<input type="checkbox"/>



## 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	1	8
Asian	1	19
Black/African American	117	1,424
Hispanic/Latino	1	5
Pacific Islander/Hawaiian	0	0
White	258	2,785
Multi-Racial	33	311
<b>Total</b>	<b>411</b>	<b>4,552</b>

### 2. Gender

Please provide the number of admissions and inpatient days by the following gender classifications.

Gender of Patient	Admissions	Inpatient Days
Male	182	1,811
Female	229	2,741
<b>Total</b>	<b>411</b>	<b>4,552</b>

### 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	328	3,880
Medicaid	63	484
Third Party	20	188
Self-Pay	0	0
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? 0 (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 Interpreter

Telephone Interpreter Service

Refer Patient to Outside Agency

Other (please describe):

We also have a web-based video service for patients that are deaf and need ASL.

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	53	233	0
Spanish	0.5	0	0	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?

We provide diversity training and language interpretation services on orientation and annually.

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?

Upson Family Medical Center - Southside RHC

CareConnect Convenient Care Thomaston, Ga

Yourtown Health Barnesville, Ga

Yourtown Health Milby Medical Center Zebulon, Ga

# 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 inpatient 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 inaccurate 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:** Jeffrey S Tarrant

**Date:** 3/5/2021

**Title:** CEO

**Comments:**



March 10, 2021

Teresa Harper  
Clerk of Superior Court  
P.O. Box 469  
Courthouse Annex  
Thomaston, GA 30286

RE: 2020 Indigent and Charity Care

Dear Ms. Harper:

This report is provided in compliance with the requirements of OCGA 31-7-90.1(a) and OCGA 14-3-305(d), and is being provided by Upson County Hospital, Inc., a corporation of the type referred to in OCGA 14-3-305(d). The Hospital Authority of Upson County does not itself directly provide the care required to be reported. Such care is provided by Upson County Hospital, Inc., d/b/a Upson Regional Medical Center.

Respectfully,

A handwritten signature in blue ink, appearing to read 'John Williams', is written over a faint blue line.

John Williams  
CFO/COO

Enclosure

cc: Norman Allen, Chairman, Upson County Board of Commissioners

**UPSON REGIONAL MEDICAL CENTER  
 GEORGIA INDIGENT CARE TRUST FUND  
 PART I: TOTAL INDIGENT CARE BY COUNTY**

2020YTD

Col A	Col B	Col C	Col D	Col E	Col F	Col G	Col H	Col I				
County	Indigent (Col B-E required)				Charity (Col F-I required)				YTD Total	YTD Total	% of Total	% of Total
	Inpatients		Outpatients		Inpatients		Outpatients		Admiss	\$	Adm By Cty	\$ By Cty
	# Admiss	\$ Indigent	# Admiss	\$ Indigent	# Admiss	\$ Charity	# Admiss	\$ Charity	By Cty	By Cty	Adm By Cty	\$ By Cty
Upson	138	\$ 2,712,200.39	2,323	\$ 6,153,590.86	78	\$ 447,414.39	1,170	\$ 1,688,728.05	3,709	\$ 11,001,933.69	61.07%	55.25%
Pike	41	\$ 607,878.86	562	\$ 1,226,646.64	20	\$ 83,661.83	232	\$ 273,186.41	855	\$ 2,191,373.74	14.08%	11.01%
Lamar	28	\$ 1,194,234.90	462	\$ 1,542,490.90	15	\$ 199,538.77	187	\$ 283,403.23	692	\$ 3,219,667.80	11.39%	16.17%
Taylor	11	\$216,284.70	115	\$ 375,531.29	5	\$ 70,221.73	56	\$ 60,410.75	187	\$ 722,448.47	3.08%	3.63%
Spalding	16	\$ 485,186.96	63	\$ 236,202.87	1	\$ 2,041.01	12	\$ 43,797.86	92	\$ 767,228.70	1.51%	3.85%
Meriwether	16	\$244,348.88	122	\$ 309,606.26	3	\$ 6,070.63	71	\$ 147,301.36	212	\$ 707,327.13	3.49%	3.55%
Crawford	2	\$ 13,785.94	56	\$ 109,984.03	0	\$ -	6	\$ 7,072.10	64	\$ 130,842.07	1.05%	0.66%
Monroe	2	\$ 14,026.03	62	\$ 225,978.44	0	\$ -	3	\$ 9,810.11	67	\$ 249,814.58	1.10%	1.25%
Talbot	2	\$ 80,017.81	43	\$ 85,468.17	0	\$ -	23	\$ 44,838.37	68	\$ 210,324.35	1.12%	1.06%
Coweta	0	\$ -	2	\$ 1,241.70	0	\$ -	0	\$ -	2	\$ 1,241.70	0.03%	0.01%
Peach	0	\$ -	0	\$ -	1	\$ 21,743.89	0	\$ -	1	\$ 21,743.89	0.02%	0.11%
Troup	1	\$ 116,613.85	3	\$ 19,804.97	0	\$ -	1	\$ 733.28	5	\$ 137,152.10	0.08%	0.69%
Clayton	2	\$ 92,750.90	5	\$ 20,658.15	0	\$ -	3	\$ 447.85	10	\$ 113,856.90	0.16%	0.57%
Other Ctys	1	\$ 53,333.65	59	\$ 175,019.07	2	\$ 1,294.01	16	\$ 70,213.55	78	\$ 299,860.28	1.28%	1.51%
Outside GA	5	\$ 7,980.36	21	\$ 99,531.36	2	\$ 18,830.34	3	\$ 10,505.36	31	\$ 136,847.42	0.51%	0.69%
<b>Totals</b>	<b>265</b>	<b>\$5,838,643.23</b>	<b>3,898</b>	<b>\$ 10,581,754.71</b>	<b>127</b>	<b>\$ 850,816.60</b>	<b>1,783</b>	<b>\$ 2,640,448.28</b>	<b>6073</b>	<b>\$ 19,911,662.82</b>	<b>100.00%</b>	<b>100.00%</b>

% by Type	4.36%	29.32%	64.19%	53.14%	2.09%	4.27%	29.36%	13.26%	100.00%	100.00%
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**A. General DSH Year Information**

1. DSH Year: 

Begin	End
07/01/2018	06/30/2019

2. Select Your Facility from the Drop-Down Menu Provided:

Identification of cost reports needed to cover the DSH Year:

- 3. Cost Report Year 1
- 4. Cost Report Year 2 (if applicable)
- 5. Cost Report Year 3 (if applicable)

Cost Report Begin Date(s)	Cost Report End Date(s)
01/01/2019	12/31/2019

Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES

- 6. Medicaid Provider Number:
- 7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):
- 8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):
- 9. Medicare Provider Number:

Data	
000001988A	
0	
0	
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:

- 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.)
- 2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?
- 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?

DSH Examination Year (07/01/18 - 06/30/19)

3a. Was the hospital open as of December 22, 1987?

3b. What date did the hospital open?

**C. Disclosure of Other Medicaid Payments Received:**

1. Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2018 - 06/30/2019 \$ 1,209,281  
 (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)
  
2. Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2018 - 06/30/2019    
 (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.  
 NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.
  
3. Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services 07/01/2018 - 06/30/2019 \$ 1,209,281

**Certification:**

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.

**Answer**  
 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  
 John Williams  
 \_\_\_\_\_  
 Hospital CEO or CFO Printed Name

\_\_\_\_\_  
 CFO  
 Title  
 706-647-8111  
 \_\_\_\_\_  
 Hospital CEO or CFO Telephone Number

10/29/20  
 \_\_\_\_\_  
 Date  
 jhwilliams@urmc.org  
 \_\_\_\_\_  
 Hospital CEO or CFO E-Mail

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	Jim Creamer, CPA
Title	Partner
Firm Name	Draffin & Tucker, LLP
Telephone Number	229-883-7878
E-Mail Address	jcream@draffin-tucker.com

**D. General Cost Report Year Information** 1/1/2019 - 12/31/2019

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:

2. Select Cost Report Year Covered by this Survey (enter "X"):  

1/1/2019 through 12/31/2019	X		
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3. Status of Cost Report Used for this Survey (Should be audited if available):

3a. Date CMS processed the HCRIS file into the HCRIS database:

	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	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
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		
14. State Name & Number		
15. State Name & Number		

*(List additional states on a separate attachment)*

**E. Disclosure of Medicaid / Uninsured Payments Received: (01/01/2019 - 12/31/2019)**

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)	\$ 54,338	\$ 367,204	\$421,542
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$ 458,816	\$ 2,971,414	\$3,430,230
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)	\$513,154	\$3,338,618	\$3,851,772
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	10.59%	11.00%	10.94%

*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 (01/01/2019 - 12/31/2019)**

**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)

17,568

(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
- 8. Outpatient Hospital Charity Care Charges
- 9. Non-Hospital Charity Care Charges
- 10. Total Charity Care Charges

6,442,825  
 16,080,417  
 22,523,242

**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)			
11. Hospital	\$25,530,515.00			\$ 18,737,626	\$ -	\$ -	\$ 6,792,889
12. Subprovider I (Psych or Rehab)	\$7,287,571.00			\$ 5,348,571	\$ -	\$ -	\$ 1,939,000
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	\$76,232,020.00	\$164,250,992.00		\$ 55,949,011	\$ 120,548,827	\$ -	\$ 63,985,174
20. Outpatient Services		\$46,861,644.00			\$ 34,393,194	\$ -	\$ 12,468,450
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	\$0.00	\$0.00	\$21,957,333.00	\$ -	\$ -	\$ 16,115,158	\$ -
27. Total	\$ 109,050,106	\$ 211,112,636	\$ 21,957,333	\$ 80,035,208	\$ 154,942,021	\$ 16,115,158	\$ 85,185,513

- 29. Total Per Cost Report Total Patient Revenues (G-3 Line 1)
- 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
- 36. Unreconciled Difference

342,120,075

Total Contractual Adj. (G-3 Line 2)

251,092,387

+  
+  
+  
-  
-

251,092,387

Unreconciled Difference (Should be \$0)

\$ -

Unreconciled Difference (Should be \$0)

\$ -

**G. Cost Report - Cost / Days / Charges**

Cost Report Year (01/01/2019-12/31/2019) 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
		<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern &amp; Resident Offset ONLY)*</i>	<i>Cost Report Worksheet C, Part I, Col.2 and Col. 4</i>	<i>Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26</i>	<i>Calculated</i>	<i>Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults &amp; Peds; W/S D-1, Pt. 2, Lines 42-47 for others</i>	<i>Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)</i>	<i>Calculated Per Diem</i>

**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.

**Routine Cost Centers (list below):**

1	03000	ADULTS & PEDIATRICS	\$ 13,761,462	\$ -	\$ -	\$ 0.00	\$ 13,761,462	13,241	\$18,042,771.00	\$ 1,039.31
2	03100	INTENSIVE CARE UNIT	\$ 4,923,779	\$ -	\$ -	\$ -	\$ 4,923,779	4,229	\$8,553,180.00	\$ 1,164.29
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	\$ 974,620	\$ -	\$ -	\$ -	\$ 974,620	1,284	\$1,238,114.00	\$ 759.05
11			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
12			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
13			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
14			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
15			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
16			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
17			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
18		Total Routine	\$ 19,659,861	\$ -	\$ -	\$ -	\$ 19,659,861	18,754	\$ 27,834,065	
19		Weighted Average								\$ 1,048.30

Observation Data (Non-Distinct)

20	09200	Observation (Non-Distinct)		1,186	-	-	\$ 1,232,622	\$297,125.00	\$4,686,896.00	\$ 4,984,021	0.247315
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		<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern &amp; Resident Offset ONLY)*</i>	<i>Cost Report Worksheet C, Part I, Col.2 and Col. 4</i>	<i>Calculated</i>	<i>Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6</i>	<i>Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7</i>	<i>Total Charges - Cost Report Worksheet C, Pt. I, Col. 8</i>	<i>Medicaid Calculated Cost-to-Charge Ratio</i>
--	--	---	--	--	-------------------	---	--	---	---

**Ancillary Cost Centers (from W/S C excluding Observation) (list below)**

21	50	OPERATING ROOM	\$6,289,628.00	\$ -	\$0.00	\$ 6,289,628	\$19,159,265.00	\$24,663,104.00	\$ 43,822,369	0.143526
22	51	RECOVERY ROOM	\$2,110,158.00	\$ -	\$0.00	\$ 2,110,158	\$2,981,522.00	\$6,315,633.00	\$ 9,297,155	0.226968
23	52	DELIVERY ROOM & LABOR ROOM	\$2,216,271.00	\$ -	\$0.00	\$ 2,216,271	\$1,981,788.00	\$581,669.00	\$ 2,563,457	0.864563
24	53	ANESTHESIOLOGY	\$194,561.00	\$ -	\$0.00	\$ 194,561	\$1,076,078.00	\$1,989,642.00	\$ 3,065,720	0.063463
25	54	RADIOLOGY-DIAGNOSTIC	\$3,883,585.00	\$ -	\$0.00	\$ 3,883,585	\$2,228,024.00	\$14,704,590.00	\$ 16,932,614	0.229355
26	56	RAIIOISOTOPE	\$560,062.00	\$ -	\$0.00	\$ 560,062	\$325,222.00	\$3,314,657.00	\$ 3,639,879	0.153868
27	57	CT SCAN	\$838,454.00	\$ -	\$0.00	\$ 838,454	\$4,762,199.00	\$38,867,661.00	\$ 43,629,860	0.019217
28	58	MRI	\$253,947.00	\$ -	\$0.00	\$ 253,947	\$912,879.00	\$3,265,257.00	\$ 4,178,136	0.060780
29	59	CARDIAC CATH	\$1,082,635.00	\$ -	\$0.00	\$ 1,082,635	\$1,451,035.00	\$4,156,916.00	\$ 5,607,951	0.193054

**G. Cost Report - Cost / Days / Charges**

Cost Report Year (01/01/2019-12/31/2019) 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	60 LABORATORY	\$5,046,190.00	\$ -	\$0.00	\$ 5,046,190	\$6,593,451.00	\$23,653,226.00	\$ 30,246,677	0.166835
31	62 WHOLE BLOOD STORAGE	\$201,501.00	\$ -	\$0.00	\$ 201,501	\$1,294,861.00	\$618,339.00	\$ 1,913,200	0.105321
32	65 RESPIRATORY THERAPY	\$1,490,672.00	\$ -	\$0.00	\$ 1,490,672	\$8,013,267.00	\$2,344,439.00	\$ 10,357,706	0.143919
33	66 PHYSICAL THERAPY	\$2,739,155.00	\$ -	\$0.00	\$ 2,739,155	\$2,428,629.00	\$7,095,042.00	\$ 9,523,671	0.287615
34	69 ELECTROCARDIOLOGY	\$1,242,167.00	\$ -	\$0.00	\$ 1,242,167	\$1,942,945.00	\$8,145,240.00	\$ 10,088,185	0.123131
35	71 MEDICAL SUPPLIES CHARGED TO PATIENT	\$4,258,715.00	\$ -	\$0.00	\$ 4,258,715	\$3,131,015.00	\$2,635,277.00	\$ 5,766,292	0.738553
36	72 IMPL. DEV. CHARGED TO PATIENTS	\$1,973,430.00	\$ -	\$0.00	\$ 1,973,430	\$4,819,539.00	\$4,051,457.00	\$ 8,870,996	0.222459
37	73 DRUGS CHARGED TO PATIENTS	\$4,838,829.00	\$ -	\$0.00	\$ 4,838,829	\$12,185,712.00	\$17,093,278.00	\$ 29,278,990	0.165266
38	74 RENAL DIALYSIS	\$283,873.00	\$ -	\$0.00	\$ 283,873	\$719,840.00	\$44,990.00	\$ 764,830	0.371158
39	76 WOUND CARE CENTER	\$932,304.00	\$ -	\$0.00	\$ 932,304	\$224,749.00	\$710,575.00	\$ 935,324	0.996771
40	91 EMERGENCY	\$6,901,628.00	\$ -	\$0.00	\$ 6,901,628	\$5,344,046.00	\$41,517,598.00	\$ 46,861,644	0.147277
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 (01/01/2019-12/31/2019) 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	<b>Total Ancillary</b>	\$ 47,337,765	\$ -	\$ -	\$ 47,337,765	\$ 81,873,191	\$ 210,455,486	\$ 292,328,677	
127	<b>Weighted Average</b>								0.166150
128	<b>Sub Totals</b>	\$ 66,997,626	\$ -	\$ -	\$ 66,997,626	\$ 109,707,256	\$ 210,455,486	\$ 320,162,742	
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 Payers (Hospital must calculate. Submit support for calculation of cost.)								
131.01	Other Cost Adjustments (support must be submitted)								
132	<b>Grand Total</b>				\$ 66,997,626				
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 (01/01/2019-12/31/2019) 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-Over (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 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				
<b>Routine Cost Centers (from Section G):</b>				<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>			
1	03000 ADULTS & PEDIATRICS	\$ 1,039.31		1,205		809		1,301		1,111		574		4,426		42.30%	
2	03100 INTENSIVE CARE UNIT	\$ 1,164.29		708		59		689		421		265		1,877		50.70%	
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	\$ 759.05		91		772				107		10		970		76.32%	
11	\$ -																
12	\$ -																
13	\$ -																
14	\$ -																
15	\$ -																
16	\$ -																
17	\$ -																
18			<b>Total Days</b>	<b>2,004</b>		<b>1,640</b>		<b>1,990</b>		<b>1,639</b>		<b>849</b>		<b>7,273</b>		<b>43.85%</b>	
19	Total Days per PS&R or Exhibit Detail																
20	Unreconciled Days (Explain Variance)																
21			<b>Routine Charges</b>		<b>Routine Charges</b>		<b>Routine Charges</b>		<b>Routine Charges</b>		<b>Routine Charges</b>		<b>Routine Charges</b>		<b>Routine Charges</b>		<b>42.37%</b>
21.01	Routine Charges		\$ 2,988,557		\$ 1,877,815		\$ 3,253,170		\$ 2,457,082		\$ 1,260,574		\$ 10,376,024		\$ 10,376,024		
	Calculated Routine Charge Per Diem		\$ 1,491.30		\$ 1,023.06		\$ 1,634.76		\$ 1,499.13		\$ 1,484.78		\$ 1,426.73		\$ 1,426.73		
<b>Ancillary Cost Centers (from W/S C) (from Section G):</b>				<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	
22	09200 Observation (Non-Distinct)		0.247315	34,149	302,405	13,368	310,356	28,688	412,450	37,083	288,441	13,272	454,183	113,288	1,313,652	38.06%	
23	50 OPERATING ROOM		0.143526	1,596,603	1,979,056	1,739,741	3,326,380	1,561,851	2,340,887	1,645,007	1,652,537	1,285,837	1,947,314	6,543,202	9,296,860	43.58%	
24	51 RECOVERY ROOM		0.228968	238,400	286,780	391,975	788,665	224,395	288,920	298,460	279,870	212,470	344,210	1,153,230	1,644,235	36.15%	
25	52 DELIVERY ROOM & LABOR ROOM		0.864563	66,385	17,463	1,033,924	255,262	23,106	10,854	231,468	64,281	4,572	1,354,883	347,860	347,860	66.85%	
26	53 ANESTHESIOLOGY		0.063463	102,431	138,312	112,136	202,001	107,472	145,170	115,930	109,731	84,446	124,487	437,969	595,214	40.58%	
27	54 RADIOLOGY-DIAGNOSTIC		0.229355	406,305	875,804	125,952	1,388,972	472,705	816,817	347,624	843,789	236,762	1,505,227	1,352,586	3,925,382	41.59%	
28	56 RADIOISOTOPE		0.153868	29,573	112,891	2,247	84,188	17,250	229,545	20,254	236,219	54,773	138,935	69,324	662,843	25.44%	
29	57 CT SCAN		0.019217	974,111	2,113,387	268,436	2,569,810	1,033,179	1,908,919	837,493	2,016,581	1,018,433	6,400,082	3,113,219	8,608,697	44.00%	
30	58 MRI		0.060760	120,268	229,982	29,269	254,615	114,719	219,825	82,852	200,199	116,921	162,788	347,108	904,621	36.70%	
31	59 CARDIAC CATH		0.193054	-	-	-	-	-	-	-	-	-	-	-	-	0.00%	
32	60 LABORATORY		0.166835	1,330,477	1,829,789	716,680	2,488,034	1,279,116	1,279,116	1,018,874	1,258,165	749,502	3,202,430	4,354,006	6,855,104	30.32%	
33	62 WHOLE BLOOD STORAGE		0.105321	143,609	29,838	68,196	41,660	131,942	34,805	93,947	20,312	64,622	38,616	437,594	126,615	34.89%	
34	65 RESPIRATORY THERAPY		0.143919	1,108,841	52,138	150,835	191,615	1,241,296	163,811	782,663	121,940	343,772	102,423	3,283,635	529,504	41.20%	
35	66 PHYSICAL THERAPY		0.287615	193,603	494,875	20,450	250,221	270,461	367,798	223,629	395,471	65,320	189,255	708,143	1,508,365	26.05%	
36	69 ELECTROCARDIOLOGY		0.123131	375,791	620,202	46,374	328,544	426,787	565,660	300,214	511,744	320,211	883,437	1,149,166	2,026,150	43.56%	
37	71 MEDICAL SUPPLIES CHARGED TO PATIENT		0.738553	323,087	169,126	215,766	262,189	406,746	176,904	333,000	91,417	156,658	200,078	1,278,599	699,637	40.54%	
38	72 IMPL. DEV. CHARGED TO PATIENTS		0.222459	518,882	128,557	110,283	257,464	420,789	277,573	644,882	134,122	325,513	305,013	1,694,636	797,716	35.20%	
39	73 DRUGS CHARGED TO PATIENTS		0.165286	1,749,403	978,411	708,887	1,531,352	1,682,200	847,804	1,132,111	1,128,101	915,326	2,087,302	5,270,601	4,485,667	43.73%	
40	74 RENAL DIALYSIS		0.371158	126,790	-	-	-	165,645	20,450	73,620	-	-	-	366,055	20,450	62.94%	
41	76 WOUND CARE CENTER		0.996771	-	-	-	-	76,727	-	35,308	-	-	2,037	76,727	12,200	12.20%	
42	91 EMERGENCY		0.147277	863,724	3,691,855	116,064	6,113,220	894,274	2,252,121	562,766	2,464,287	517,946	9,055,577	2,436,828	14,521,483	56.86%	
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**H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:**

Cost Report Year (01/01/2019-12/31/2019) 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		%
61															
62															
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127															
			\$ 10,302,131	\$ 14,050,872	\$ 5,868,584	\$ 20,644,548	\$ 10,511,481	\$ 12,436,156	\$ 8,781,876	\$ 11,817,207	\$ 6,523,472	\$ 27,147,966			

**H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:**

Cost Report Year (01/01/2019-12/31/2019) 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		%
<b>Totals / Payments</b>													
128 <b>Total Charges (includes organ acquisition from Section J)</b>	\$ 13,290,688	\$ 14,050,872	\$ 7,546,399	\$ 20,644,548	\$ 13,764,651	\$ 12,436,156	\$ 11,238,958	\$ 11,817,207	\$ 7,784,046	\$ 27,147,966	\$ 45,840,696	\$ 58,948,782	43.81%
									(Agrees to Exhibit A)	(Agrees to Exhibit A)			
129 Total Charges per PS&R or Exhibit Detail	\$ 13,290,688	\$ 14,050,872	\$ 7,546,399	\$ 20,644,548	\$ 13,764,651	\$ 12,436,156	\$ 11,238,958	\$ 11,817,207	\$ 7,784,046	\$ 27,147,966			
130 Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131 <b>Total Calculated Cost (includes organ acquisition from Section J)</b>	\$ 3,941,138	\$ 2,114,182	\$ 3,252,487	\$ 3,326,880	\$ 4,004,195	\$ 1,959,208	\$ 3,431,030	\$ 1,768,445	\$ 1,939,433	\$ 3,593,874	\$ 14,628,850	\$ 9,168,715	44.03%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 3,689,853	\$ 2,053,774	\$ -	\$ 438	\$ 267,617	\$ 133,967	\$ 91,869	\$ 106,690			\$ 4,049,339	\$ 2,294,869	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ 2,167,667	\$ 2,820,724			\$ 51,745	\$ 62,761			\$ 2,219,412	\$ 2,883,485	
134 Private Insurance (including primary and third party liability)	\$ 37,624	\$ 859	\$ 3,100	\$ -	\$ 17,630	\$ 1,998	\$ 2,404,819	\$ 1,584,132			\$ 2,463,173	\$ 1,586,989	
135 Self-Pay (including Co-Pay and Spend-Down)	\$ -	\$ 6,423	\$ 57	\$ 308	\$ 2,832	\$ 7,107	\$ -	\$ 2,027			\$ 2,889	\$ 15,865	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 3,727,477	\$ 2,061,056	\$ 2,170,824	\$ 2,821,470									
137 Medicaid Cost Settlement Payments (See Note B)		\$ (228,488)										\$ (228,488)	
138 Other Medicaid Payments Reported on Cost Report Year (See Note C)													
139 Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					\$ 4,086,763	\$ 1,461,925	\$ 12,739	\$ 999			\$ 4,099,502	\$ 1,462,924	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							\$ 835,145	\$ 256,860			\$ 835,145	\$ 256,860	
141 Medicare Cross-Over Bad Debt Payments					\$ 151,689	\$ 111,948					\$ 151,689	\$ 111,948	
142 Other Medicare Cross-Over Payments (See Note D)					\$ 40,792	\$ 596					\$ 40,792	\$ 596	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									\$ 54,338	\$ 367,204			
144 Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)									\$ -	\$ -			
145 <b>Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)</b>	\$ 213,661	\$ 281,614	\$ 1,081,663	\$ 505,410	\$ (563,128)	\$ 241,667	\$ 34,713	\$ (245,024)	\$ 1,885,095	\$ 3,226,670	\$ 766,909	\$ 783,667	
146 <b>Calculated Payments as a Percentage of Cost</b>	95%	87%	67%	85%	114%	88%	99%	114%	3%	10%	95%	91%	
147 <b>Total Medicare Days from WIS S-3 of the Cost Report Excluding Swing-Bed (C/R, WIS S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 &amp; 6)</b>					10,260								
148 <b>Percent of cross-over days to total Medicare days from the cost report</b>					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 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 Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

**I. Out-of-State Medicaid Data:**

Cost Report Year (01/01/2019-12/31/2019) 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 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 PS&R Summary (Note A)	From PS&R Summary (Note A)
		From Section G	From Section G										
<b>Routine Cost Centers (list below):</b>				<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>
1	03000 ADULTS & PEDIATRICS	\$ 1,039.31		19						80		99	
2	03100 INTENSIVE CARE UNIT	\$ 1,164.29								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	\$ 759.05											
11		\$ -											
12		\$ -											
13		\$ -											
14		\$ -											
15		\$ -											
16		\$ -											
17		\$ -											
18		\$ -											
			<b>Total Days</b>	19						82		101	
19	Total Days per PS&R or Exhibit Detail			19						82			
20	Unreconciled Days (Explain Variance)												
			<b>Routine Charges</b>		<b>Routine Charges</b>		<b>Routine Charges</b>		<b>Routine Charges</b>		<b>Routine Charges</b>		<b>Routine Charges</b>
21	Routine Charges		\$ 19,926		\$ -		\$ -		\$ 137,155		\$ 157,081		\$ -
21.01	Calculated Routine Charge Per Diem		\$ 1,048.74		\$ -		\$ -		\$ 1,672.62		\$ 1,555.26		\$ -
<b>Ancillary Cost Centers (from W/S C) (list below):</b>				<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>
22	09200 Observation (Non-Distinct)		0.247315	-	1,440					840		-	2,280
23	50 OPERATING ROOM		0.143526	23,924	-					-		23,924	-
24	51 RECOVERY ROOM		0.226968	6,850	-					-		6,850	-
25	52 DELIVERY ROOM & LABOR ROOM		0.864563	-	-					-		-	-
26	53 ANESTHESIOLOGY		0.063463	1,423	469					-		1,423	469
27	54 RADIOLOGY-DIAGNOSTIC		0.229355	2,894	12,565				1,004	5,900		3,898	18,465
28	56 REAIOISOTOPE		0.153868	-	-					-		-	-
29	57 CT SCAN		0.019217	16,416	14,810				1,699	23,120		18,115	37,930
30	58 MRI		0.060780	-	-					1,800		-	1,800
31	59 CARDIAC CATH		0.193054	-	-					-		-	-
32	60 LABORATORY		0.166835	5,749	22,329				14,748	15,433		20,497	37,762
33	62 WHOLE BLOOD STORAGE		0.105321	-	-					-		-	-
34	65 RESPIRATORY THERAPY		0.143919	3,822	2,507				530	768		4,352	3,275
35	66 PHYSICAL THERAPY		0.287615	3,872	-				4,344	1,455		8,216	1,455
36	69 ELECTROCARDIOLOGY		0.123131	553	4,977				4,977	4,699		5,530	9,676
37	71 MEDICAL SUPPLIES CHARGED TO PATIENT		0.738553	1,543	284				771	92		2,314	376
38	72 IMPL. DEV. CHARGED TO PATIENTS		0.222459	-	-					-		-	-
39	73 DRUGS CHARGED TO PATIENTS		0.165266	13,560	12,036				11,645	7,186		25,205	19,222
40	74 RENAL DIALYSIS		0.371158	-	-				18,405	-		18,405	-
41	76 WOUND CARE CENTER		0.996771	-	-				-	-		-	-
42	91 EMERGENCY		0.147277	6,345	71,683				4,230	30,680		10,575	102,363
43			-	-	-							-	-
44			-	-	-							-	-
45			-	-	-							-	-
46			-	-	-							-	-
47			-	-	-							-	-



**I. Out-of-State Medicaid Data:**

Cost Report Year (01/01/2019-12/31/2019) 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			
									\$	\$		
110												
111												
112												
113												
114												
115												
116												
117												
118												
119												
120												
121												
122												
123												
124												
125												
126												
127												
	\$	86,951	\$	143,101	\$	-	\$	-	\$	62,353	\$	91,972

**Totals / Payments**

128	<b>Total Charges (Includes organ acquisition from Section K)</b>	\$ 106,877	\$ 143,101	\$ -	\$ -	\$ -	\$ -	\$ 199,508	\$ 91,972	\$ 306,385	\$ 235,073
129	Total Charges per PS&R or Exhibit Detail	\$ 106,877	\$ 143,101	\$ -	\$ -	\$ -	\$ -	\$ 199,508	\$ 91,972		
130	Unreconciled Charges (Explain Variance)										
131	<b>Total Calculated Cost (includes organ acquisition from Section K)</b>	\$ 32,811	\$ 21,008	\$ -	\$ -	\$ -	\$ -	\$ 100,083	\$ 11,571	\$ 132,894	\$ 32,579
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 6,476	\$ 6,444					\$ 545		\$ 6,476	\$ 6,989
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	\$ 1,838	\$ 1,289							\$ 1,838	\$ 1,289
134	Private Insurance (including primary and third party liability)		\$ 84					\$ 11,473	\$ 1,175	\$ 11,473	\$ 1,259
135	Self-Pay (including Co-Pay and Spend-Down)									\$ -	\$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 8,314	\$ 7,817	\$ -	\$ -						
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)							\$ 52,801	\$ 8,277	\$ 52,801	\$ 8,277
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)								\$ 894	\$ -	\$ 894
141	Medicare Cross-Over Bad Debt Payments									\$ -	\$ -
142	Other Medicare Cross-Over Payments (See Note D)									\$ -	\$ -
143	<b>Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)</b>	\$ 24,497	\$ 13,191	\$ -	\$ -	\$ -	\$ -	\$ 35,809	\$ 680	\$ 60,306	\$ 13,871
144	<b>Calculated Payments as a Percentage of Cost</b>	25%	37%	0%	0%	0%	0%	64%	94%	55%	57%

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.

**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 (01/01/2019-12/31/2019) 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)*	\$ 972,024	
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)	\$ 972,024	5.00 (Where is the cost included on w/s A?)
3 Difference (Explain Here ----->)	\$ -	
<b>Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)</b>		
4 Reclassification Code		(Reclassified to / (from))
5 Reclassification Code		(Reclassified to / (from))
6 Reclassification Code		(Reclassified to / (from))
7 Reclassification Code		(Reclassified to / (from))
<b>DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)</b>		
8 Reason for adjustment		(Adjusted to / (from))
9 Reason for adjustment		(Adjusted to / (from))
10 Reason for adjustment		(Adjusted to / (from))
11 Reason for adjustment		(Adjusted to / (from))
<b>DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)</b>		
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	\$ 972,024	

**DSH UCC Provider Tax Assessment Adjustment:**

17 Gross Allowable Assessment Not Included in the Cost Report	\$ -
<b>Apportionment of Provider Tax Assessment Adjustment to Medicaid &amp; Uninsured:</b>	
18 Medicaid Hospital Charges Sec. G	105,330,936
19 Uninsured Hospital Charges Sec. G	34,932,012
20 Total Hospital Charges Sec. G	320,162,742
21 Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	32.90%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	10.91%
23 Medicaid Provider Tax Assessment Adjustment to DSH UCC	\$ -
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ -
25 Provider Tax Assessment Adjustment to DSH UCC	\$ -

\* Assessment must exclude any non-hospital assessment such as Nursing Facility.

\*\* The Gross Allowable Assessment Not Included in the Cost Report (line 17, above) will be apportioned to Medicaid and uninsured based on charges sec. g unless the hospital provides a revised cost report to include the amount in the cost-to-charge ratios and per diems used in the survey.

**Real Property Holdings Owned by the Hospital Authority of Upson County and Upson County Hospital, Inc. (HB 321)**

Location <sup>1</sup>	Tax Parcel ID Number	Estimated Size	Purchase Price <sup>2</sup>	Current HealthCare Purpose? <sup>3</sup>		Improvements? <sup>4</sup>		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 2 <sup>nd</sup> 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

<sup>1</sup> Location may be the county, address, or site identification/description.

<sup>2</sup> Purchase price to be listed as of the date of acquisition of the property by the hospital, if known. If unknown, state "UNK".

<sup>3</sup> 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.

<sup>4</sup> Improvement means the permanent addition or construction of a building or structure.

Location <sup>1</sup>	Tax Parcel ID Number	Estimated Size	Purchase Price <sup>2</sup>	Current HealthCare Purpose? <sup>3</sup>		Improvements? <sup>4</sup>		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
Date: 07/23/2021 Revised:								

<sup>1</sup> Location may be the county, address, or site identification/description.

<sup>2</sup> Purchase price to be listed as of the date of acquisition of the property by the hospital, if known. If unknown, state "UNK".

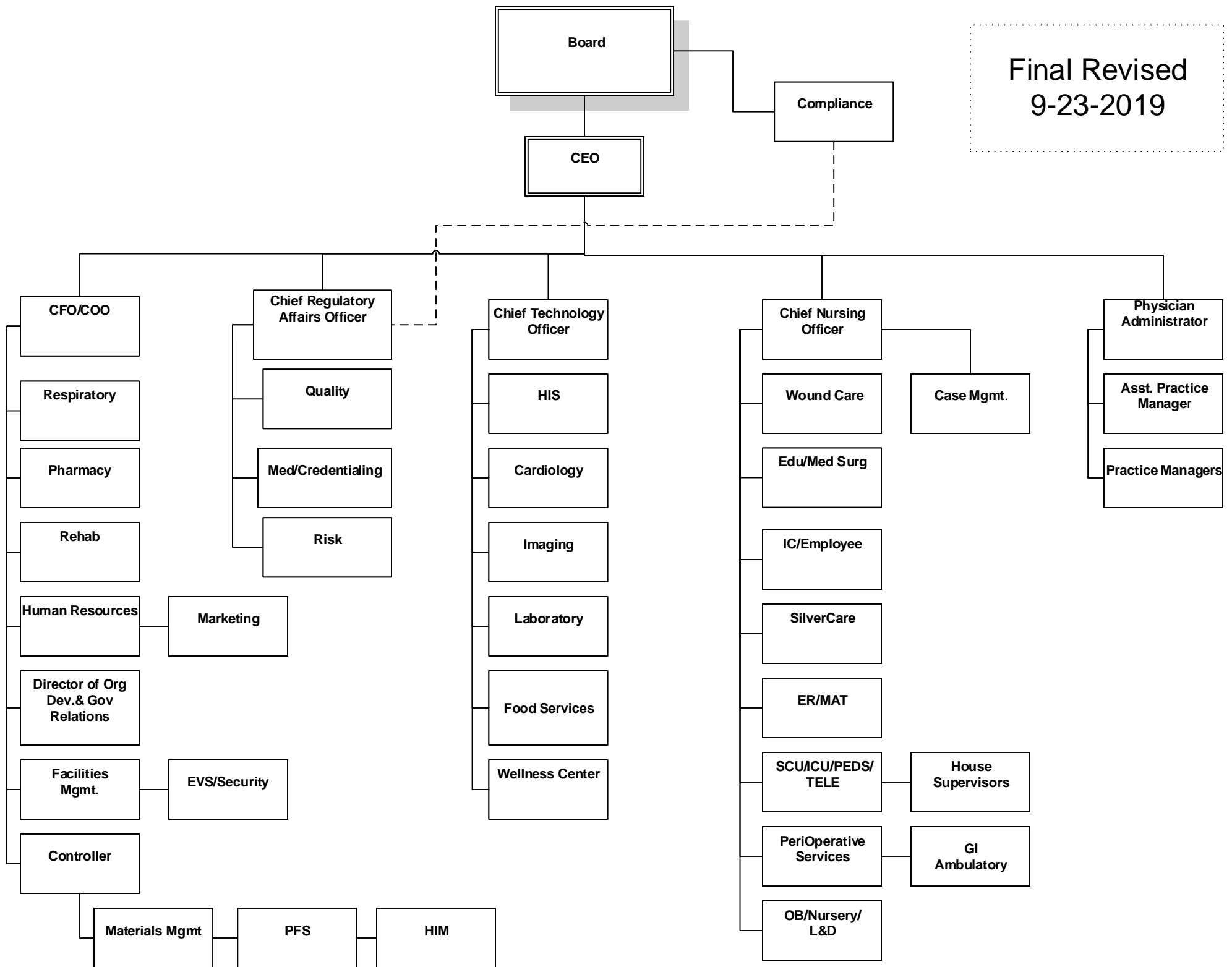
<sup>3</sup> Health care purpose includes the provision of patient care; the provision or delivery of healthcare services, including supportive administrative services; the training and education of physicians, nurses, and other healthcare personnel; and community education and outreach relating to health care or wellness.

<sup>4</sup> Improvement means the permanent addition or construction of a building or structure.





Final Revised  
9-23-2019



**TITLE/DESCRIPTION:** Financial Assistance Policy  
**FILING NUMBER** 4834  
**EFFECTIVE DATE:** 09/01/2015  
**DATE OF LAST REVIEW:** 11/17/2020  
**DATE OF LAST REVISION:** 11/17/2020  
**APPROVED BY:** CFO/COO, Controller

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### **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 February 1, 2020 through January 31, 2021 is twenty eight percent (28%).
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:

<b>Household Income</b>	<b>Maximum Amount Individual is Responsible for Paying</b>
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 UPMC 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 UPMC's Financial Assistance Application. The Application must be completed in its entirety and all required supporting documentation must be attached to the Application.

1. UPMC 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.upmc.org](http://www.upmc.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. UPMC 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 UPMC 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, UPMC 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 UPMC will accept and process a Financial Assistance Application ends on the 240<sup>th</sup> day after UPMC 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](mailto: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:

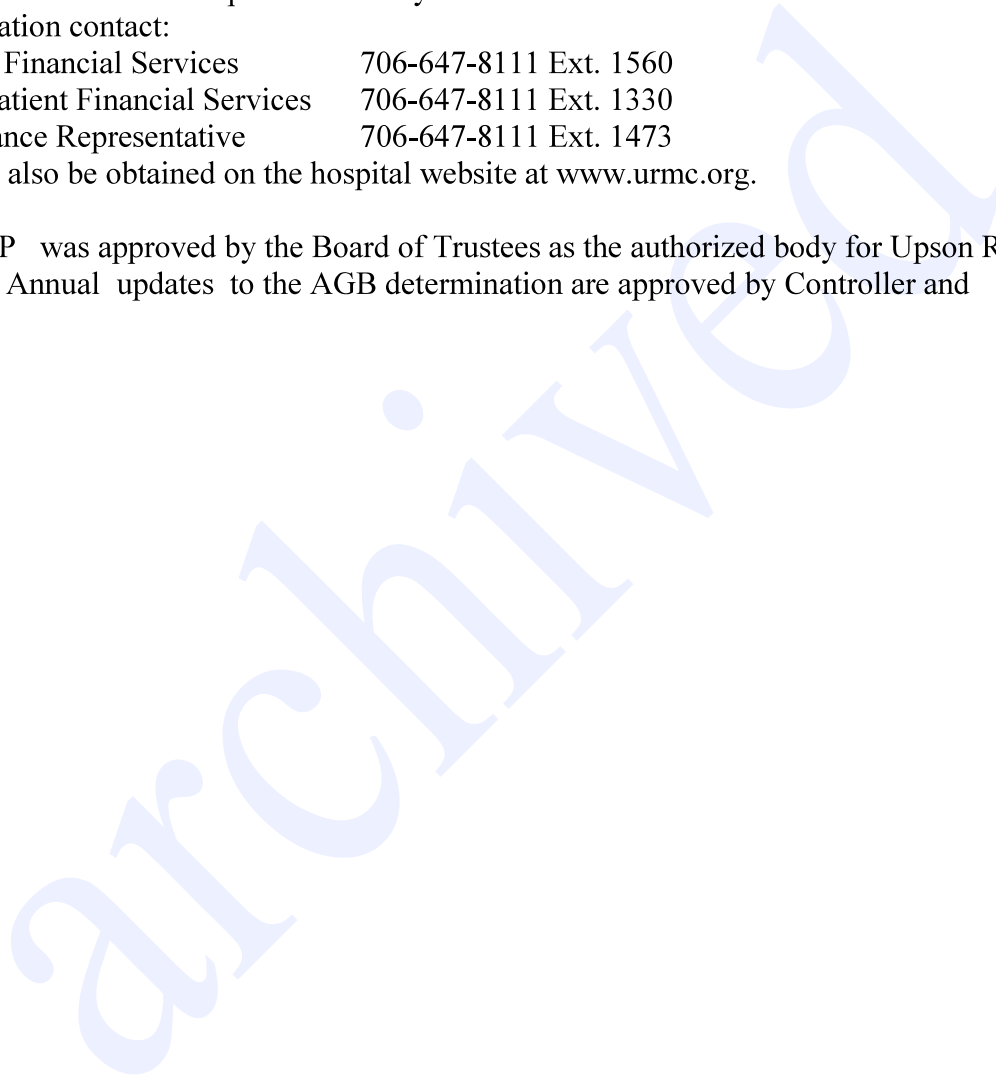
Director, Patient Financial Services           706-647-8111 Ext. 1560

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](http://www.urmc.org).

The original FAP was approved by the Board of Trustees as the authorized body for Upson Regional Medical Center. Annual updates to the AGB determination are approved by Controller and CFO/COO.





## 2019 Hospital Financial 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 calendar year 2019 only.

***Do not use a different report period.***

**Please indicate your hospital fiscal year.**

From: 1/1/2019 To:12/31/2019

**Please indicate your cost report year.**

From: 01/01/2019 To:12/31/2019

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](mailto: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	105,416,487
Total Inpatient Admissions accounting for Inpatient Revenue	4,054
Outpatient Gross Patient Revenue	216,151,604
Total Outpatient Visits accounting for Outpatient Revenue	67,291
Medicare Contractual Adjustments	116,194,495
Medicaid Contractual Adjustments	53,328,642
Other Contractual Adjustments:	32,488,533
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	15,058,424
Gross Indigent Care:	18,407,031
Gross Charity Care:	4,116,211
Uncompensated Indigent Care (net):	18,407,031
Uncompensated Charity Care (net ):	4,116,211
Other Free Care:	1,289,287
Other Revenue/Gains:	1,161,201
Total Expenses:	77,761,015

### 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	1,253,809
Admin Discounts	32,139
Employee Discounts	3,339
	0
<b>Total</b>	<b>1,289,287</b>

## 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 2019? (Check box if yes.)

### 2. Effective Date

What was the effective date of the policy or policies in effect during 2019?

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.?

**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 2019? (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	5,418,720	1,024,105	6,442,825
Outpatient	12,988,311	3,092,106	16,080,417
<b>Total</b>	<b>18,407,031</b>	<b>4,116,211</b>	<b>22,523,242</b>

#### 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
<b>Total</b>	<b>0</b>

#### 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	5,418,720	1,024,105	6,442,825
Outpatient	12,988,311	3,092,106	16,080,417
<b>Total</b>	<b>18,407,031</b>	<b>4,116,211</b>	<b>22,523,242</b>

## 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
Bibb	0	0	5	32,791	0	0	2	1,389
Bleckley	0	0	0	0	0	0	12	19,778
Butts	0	0	21	53,511	0	0	3	6,654
Clayton	0	0	1	1,040	0	0	0	0
Coffee	0	0	5	7,057	0	0	0	0
Coweta	0	0	2	6,432	0	0	1	3,249
Crawford	0	0	11	13,372	0	0	10	20,613
DeKalb	0	0	7	18,230	0	0	0	0
Fulton	0	0	1	2,852	1	7,407	0	0
Harris	2	130,478	9	7,194	0	0	1	472
Henry	0	0	4	6,281	0	0	0	0
Houston	2	9,063	0	0	0	0	0	0
Johnson	1	87,417	6	4,629	0	0	0	0
Lamar	42	650,787	585	1,604,831	11	128,403	241	423,946
Meriwether	16	241,145	174	525,256	4	23,468	104	123,763
Monroe	9	269,050	124	262,495	0	0	45	50,214
Murray	0	0	0	0	0	0	1	858
Other Out of State	2	7,454	26	58,925	0	0	2	136
Peach	0	0	0	0	0	0	0	0
Pike	46	720,462	528	1,646,044	24	95,675	247	377,315
Polk	0	0	0	0	1	734	6	2,787
Pulaski	1	906	0	0	0	0	0	0
Putnam	0	0	1	6,080	0	0	0	0
Spalding	5	159,437	57	264,170	1	44,524	30	55,293
Sumter	1	400	0	0	0	0	0	0
Talbot	5	58,557	67	131,921	5	6,645	46	27,197
Taylor	12	41,480	217	526,459	1	23,365	58	80,049
Troup	3	78,638	9	13,363	0	0	4	3,371
Twiggs	0	0	2	1,037	0	0	0	0
Upson	178	2,963,446	3,390	7,794,342	96	693,884	1,541	1,893,241
Wilkinson	0	0	0	0	0	0	1	1,780
<b>Total</b>	<b>325</b>	<b>5,418,720</b>	<b>5,252</b>	<b>12,988,312</b>	<b>144</b>	<b>1,024,105</b>	<b>2,355</b>	<b>3,092,105</b>

## 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 2019?  
(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 2019.

Patient Category	SFY 2018	SFY2019	SFY2019
	7/1/17-6/30/18	7/1/18-6/30/19	7/1/19-6/30/20
A. Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	0	7,832,380	10,574,651
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.	0	1,847,714	2,262,497
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 2018	SFY2019	SFY2019
7/1/17-6/30/18	7/1/18-6/30/19	7/1/19-6/30/20
0	3,106	4,970

## Reconciliation Addendum

This section is printed in landscape format on a separate PDF file.

## Nurse Employment Addendum

This section is printed 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 inaccurate 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:** Jeff Tarrant

**Date:** 6/29/2020

**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 Williams

**Date:** 6/29/2020

**Title:** CFO/COO

**Comments:**

**2019 Hospital Financial Survey Hospital Financial Statements Reconciliation Addendum  
HOSP523- Upson Regional Medical Center**

Section 1: Hospital Only Data from Hospital Financial Survey (HFS):											
HFS Source:	Contractual Adj's, Hill Burton, Bad Debt, Gross Indigent and Charity Care, and Other Free Care									Total Deductions of All Types (Sum Col 2-9)	Net Patient Revenue (Col 1 - 10)
	Part C, 1	Part C, 1	Part C, 1	Part C, 1	Part C, 1	Part C, 1	Part E, 1	Part E, 1	Part C, 1		
	Gross Patient Charges	Medicare Contractual Adjs	Medicaid Contractual Adjs	Other Contractual Adjs	Hill Burton Obligations	Bad Debt	Gross Indigent Care (IP & OP)	Gross Charity Care (IP & OP)	Other Free Care		
	1	2	3	4	5	6	7	8	9	10	11
Inpatient Gross Patient Revenue	105,416,487										
Outpatient Gross Patient Revenue	216,151,604										
Per Part C, 1. Financial Table		116,194,495	53,328,642	32,488,533	0	15,058,424			1,289,287		
Per Part E, 1. Indigent and Charity Care							18,407,031	4,116,211			
<b>Totals per HFS</b>	<b>321,568,091</b>	<b>116,194,495</b>	<b>53,328,642</b>	<b>32,488,533</b>	<b>0</b>	<b>15,058,424</b>	<b>18,407,031</b>	<b>4,116,211</b>	<b>1,289,287</b>	<b>240,882,623</b>	<b>80,685,468</b>
<b>Section 2: Reconciling Items to Financial Statements:</b>										<b>(B)</b>	<b>(B)</b>
<b>Non-Hospital Services:</b>											
> Professional Fees	20551982.0									10,209,765	
> Home Health Agency	0									0	
> SNF/NF Swing Bed Services	0									0	
> Nursing Home	0									0	
> Hospice	0									0	
> Freestanding Ambulatory Surg. Centers	0									0	
> n/a	0									0	
> n/a	0.0									0	
> n/a	0.0									0	
> n/a	0.0									0.0	
> n/a	0									0	
> n/a	0									0	
Bad Debt (Expense per Financials) (A)										0	
Indigent Care Trust Fund Income										0	
<b>Other Reconciling Items:</b>											
> ICTF Income	1266618.0									0.0	
> Other Income	0									0	
> Audit Variance	12,084									-8,446	
> n/a	0									0	
<b>Total Reconciling Items</b>	<b>21,830,684</b>									<b>10,201,319</b>	<b>11,629,365</b>
<b>Total Per Form</b>	<b>343,398,775</b>									<b>251,083,942</b>	<b>92,314,833</b>
<b>Total Per Financial Statements</b>	<b>343398775.0</b>										<b>92,314,833</b>
<b>Unreconciled Difference (Must be Zero)</b>	<b>0</b>										<b>0</b>
<b>(A) Due to specific differences in the presentation of data on the HFS, Bad Debt per Financials may differ from the amount reported on the HFS-proper (Part C).</b>											
<b>(B) Taxable Net Patient Revenue will equal Net Patient Revenue in Section 1 column 11, plus Other Free Care in Section 1 column 9.</b>											



**2019 Hospital Financial Survey Nurse Employment Addendum**

**HOSP523**

Did your facility employ one or more nurses holding a multistate license pursuant to O.C.G.A. § 43-26-60 et seq. for 30 days or more in 2019 (January 1, 2019 through December 31, 2019)? (Check the box, if yes.)

If yes, please list each nurse below:

Full Name	Address	Duration
Pamela Roberts	PO Box 907 Williamson, GA 30292	09/26/18 - present
Ronnie G. Ammerita	500 Pleasant Valley Road Molena, GA 30258	11/12/18 - present