Georgia Department of Audits and Accounts
Performance Audit Division
Greg S. Griffin, State Auditor
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Rural Hospital Tax Credit

Requested Information on the Rural Hospital Tax Credit

Why we did this review

The House Appropriations Committee requested this special examination of the Rural Hospital Tax Credit (RHTC). Based on the request, we reviewed: (1) if the funds are reaching the intended and most needy hospitals; (2) if third-party vendors retain a reasonable administrative fee and direct contributions according to the intent and greatest public benefit of the law; and (3) if there are additional transparency and accountability measures that should be considered to improve the integrity of the RHTC.

About the Rural Hospital Tax Credit

The Rural Hospital Tax Credit (RHTC) was established in 2017 and allows taxpayers to donate to eligible rural hospitals and reduce their state income tax liability by the amounts they donate. Taxpayers may choose a specific hospital, or if one is not designated, donations will be allocated based on a ranking of need.

The Department of Revenue (DOR) administers portions of the RHTC related to taxpayer eligibility criteria. The Department of Community Health (DCH) administers portions related to hospital eligibility criteria. In addition, a third-party vendor acts as a pass-through entity from the taxpayer to the rural hospital for some donations but is under contract with hospitals, not the state, for these services.

What we found

In 2018, donations to eligible rural hospitals did not necessarily go to the most financially needy because of the design of the RHTC. As a result, the General Assembly made changes to add a financial eligibility requirement for rural hospitals and to direct undesignated contributions to the most needy eligible rural hospital. However, the change in eligibility requirements had minimal impact since only one previously eligible rural hospital out of 58 became ineligible. Also, the total amount allocated has significantly decreased likely due to a recent change to IRS regulations.

Due to recent IRS regulations finalized in August 2019, taxpayers are no longer able to use the RHTC contribution as a charitable deduction on their federal taxes. This change significantly reduces previous financial benefits to the taxpayer for using the RHTC and will likely decrease the amount of funds available through the RHTC. From January-November 2018 to January-November 2019 donations eligible for the credit declined from $59 million to $31 million, a decline of approximately 50%.

In 2018 Georgia HEART, a third-party vendor who assists some taxpayers and rural hospitals with the RHTC, received the statutorily allowed maximum fee of 3% (approximately $1.8 million) for its services. However, Georgia HEART reported its cost to administer its program at approximately $770,000. Also, it transferred approximately $890,000 of its fee income to an affiliated nonprofit rather than allocate it to eligible rural hospitals. We were unable to determine if Georgia HEART's costs were reasonable and appropriate because its leadership was unwilling to allow DOAA access to its complete accounting, financial, or other business records. The state has no legal authority to access

accounting, financial, and other documents from private entities that do not have a contractual relationship with the state.

While the General Assembly has attempted to add greater accountability and transparency provisions to the RHTC statute, transparency and accountability are still limited. The General Assembly could further address accountability and transparency limitations under the current design as a tax credit or move to a different funding structure. First, the state could continue the RHTC but require taxpayer RHTC contributions be made through a state-managed nonprofit entity. DCH estimated it would cost approximately $350,000 annually for additional staff to support the nonprofit and act as a pass-through for the RHTC contributions from taxpayers seeking the tax credit. The second option is to change the funding method from a tax credit to a state appropriation for a state grant program for rural hospitals. DCH estimated it would cost approximately $720,000 annually to manage a state grant program of this size.

With either option, there is a finite cost to the state. As a tax credit, the state is willing to forgo up to $60 million in tax revenue annually. Tax credits, also called tax expenditures, are an allocation of government resources in the form of taxes that could have been collected and appropriated by the General Assembly. As a grant program, the General Assembly and governor can control the exact amount to support rural hospitals by appropriating $60 million.

This report is intended to answer question posed by the House Appropriations Committee and to help inform policy decisions.

***DCH's Response**: The Department of Community Health is in agreement with the report.*

***DOR's Response**: The Department did not accept undesignated contributions initially because the Department's systems did not allow undesignated contributions. Beginning in November 2019, the Department's systems were updated, and now the Department accepts undesignated contributions. These undesignated contributions are allocated per statutory requirements to the most needy eligible rural hospital.*

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Purpose of the Special Examination

This review of the Rural Hospital Tax Credit (RHTC) was conducted at the request of the House Appropriations Committee. The Committee stated:

"House Bill 186 has extended and expanded the Rural Hospital Tax Credit; however, the members of the House feel that a retrospective audit of the program, which began in 2017 will be extremely advantageous to determining if the funds are reaching the intended and most needy hospitals, if third-party vendors retain a reasonable administrative fee and direct contributions according to the intent and greatest public benefit of the law, and if there are additional transparency and accountability measures that should be considered to improve the integrity of the next period of donations through 2024."

A description of the objectives, scope, and methodology used in this review is included in Appendix A. A draft of the report was provided to the Department of Community Health (DCH) and the Department of Revenue (DOR) for their review, and pertinent responses were incorporated into the report.

Background

The Rural Hospital Tax Credit *was established to provide financial support to* ***rural hospitals***

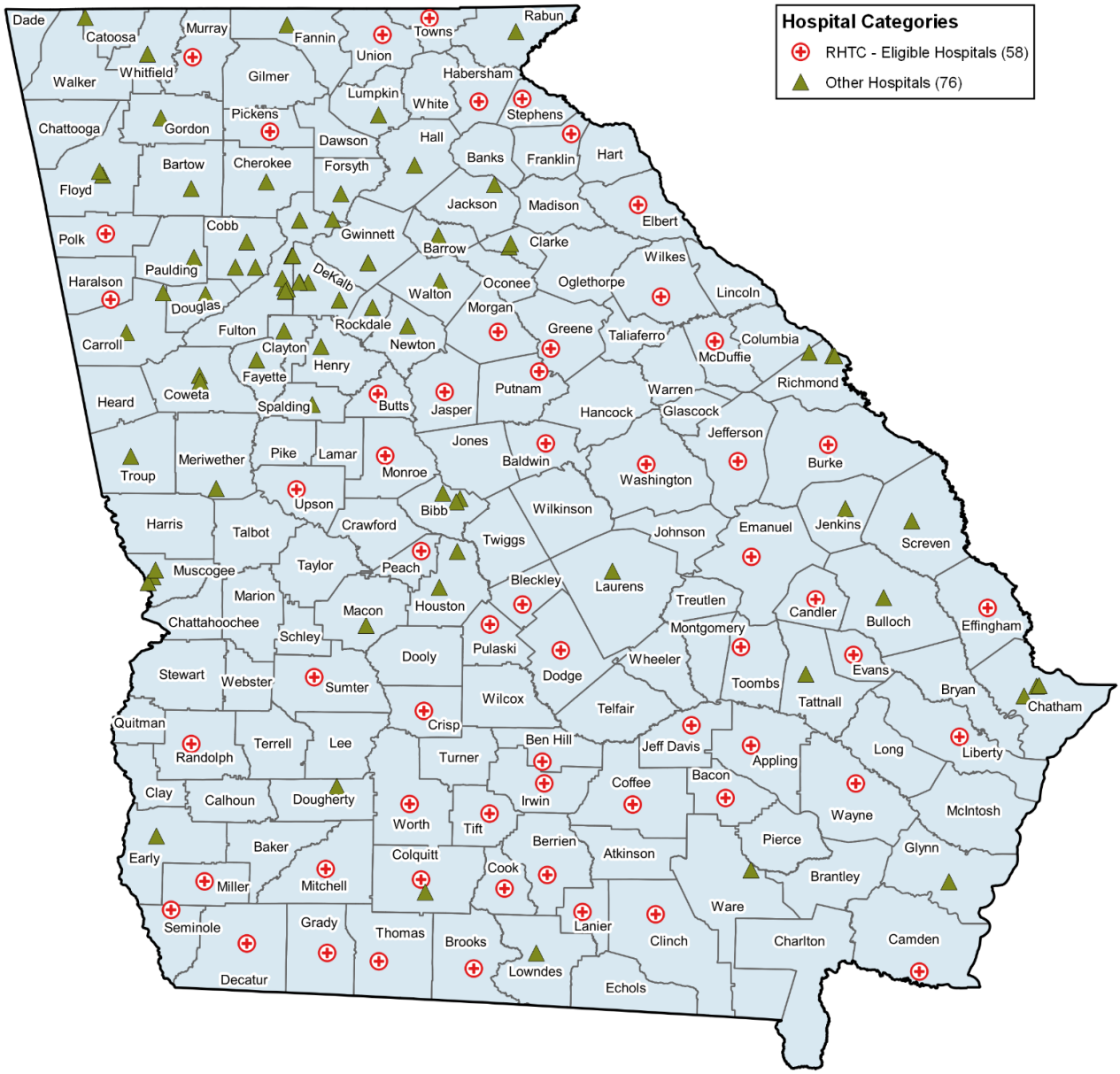
The Rural Hospital Tax Credit (RHTC) was established[1] to provide financial support to rural hospitals by allowing Georgia taxpayers to contribute to eligible rural hospitals and receive a tax credit. The RHTC became effective January 1, 2017. Rural hospitals in Georgia, similar to rural hospitals nationally, face financial challenges, with seven rural hospitals in Georgia closing since 2010.

There are a number of causes underlying the financial difficulties many rural hospitals face. Rural communities suffer from depopulation, resulting in fewer hospital patients. In addition, rural hospitals often have a high share of patients who either lack insurance or are on Medicaid/Medicare, which has lower reimbursement rates than most group insurance. According to the Government Accountability Office, "rural hospital closures were generally preceded and caused by financial distress. In particular, rural hospitals that closed typically had negative margins that made it difficult to cover their fixed costs."[2] **Exhibit 1** shows all hospitals in the state that provide acute, short-term care to patients, including RHTC-eligible hospitals.

[1] Established by O.C.G.A. § 48-7-29.20.

[2] GAO, *Rural Hospitals Closures*, GAO-18-634 (Washington, D.C.: April 2018)

Exhibit 1
Georgia Has 134 Acute, Short-Term Care Hospitals



Source: DCH Documents

Eligibility Criteria

Currently, there are 58 hospitals eligible to receive contributions through the RHTC. In order to qualify, a hospital must meet the following criteria:

- Reside in a county with a population of less than 50,000 or be designated as a Critical Access Hospital[3]

[3] Critical Access Hospital is a federal designation given by the Centers for Medicare and Medicaid Services (CMS). Critical Access Hospitals must adhere to certain guidelines, including having no more than 25 beds, an average duration of stay of under 96 hours, being more than 35 miles away from the next closest hospital, and providing 24/7 emergency care. Currently there are 24 Critical Access Hospitals.

- Be an acute care licensed hospital that provides inpatient hospital services that participates in Medicare and Medicaid
- Provide healthcare services to indigent patients
- Have at least 10% annual net revenue from indigent care, charity care, or bad debt
- Is operated by a county or municipal authority or is a tax-exempt 501(c)(3) organization
- Is current with all audits and reports required by law
- Beginning in 2020, have a three-year average patient margin, as percent of expense, less than one standard deviation above the statewide three-year average of other rural hospitals as calculated by DCH

The Department of Community Health (DCH) is required to annually rank all eligible rural hospitals by financial need. To rank rural hospitals by financial need, DCH utilizes three criteria each year:

1. Dun and Bradstreet Supplier Evaluation Risk (SER) Score from the Supplier Qualifier Reports that the hospitals submit with their 5-year plans. This supply risk metric helps management professionals evaluate long-term risks of doing business with various entities, including hospitals.

2. Low Income Utilization Rate (LIUR) from the Disproportionate Share Hospital (DSH) calculation. The LIUR is the percentage of revenue a hospital receives from Medicaid, state and local government cash subsidies, and uncompensated hospital services attributable to charity care.

3. Current Ratio calculated using annual financial data that hospitals submit to DCH. Current Ratio is a liquidity measure that measures an entity's ability to pay short-term obligations or those due within one year.

DCH calculates a rank for each eligible rural hospital for each criterion. It adds each of the three equally weighted ranks together to calculate a hospital's overall financial need ranking, which it posts onto its website. All eligible rural hospitals may receive RHTC contributions.

RHTC Limits

The RHTC has an annual aggregate limit of $60 million and each hospital has an annual individual limit of $4 million. Taxpayers who voluntarily participate in the RHTC may receive a state tax credit equal to 100% of their contribution to an eligible rural hospital. The maximum contribution between January 1 and June 30 is $5,000 for individuals and $10,000 for married couples filing jointly and for owners of pass-through entities[4] (including S-corporations and partnerships). Unlimited contributions for individuals are allowed after July 1 of the tax year if the $60 million aggregate limit has not been met. For C-corporations, it is also a 100% tax credit, equal

[4] For pass-through entities, the maximum credit "…shall be allowed only for the portion of the income on which such tax was actually paid by such individual"

to the actual contribution amount or 75% of the corporation's income tax liability, whichever is less.

Taxpayers do not have to designate a rural hospital when contributing to the RHTC; some contributions are undesignated (approximately $19 million in 2018). Taxpayers can make an undesignated contribution through a third-party vendor, who then directs the contributions to eligible rural hospitals. For 2019, undesignated contributions are required to be directed to the neediest eligible rural hospital, as ranked by the DCH, that has not reached the individual hospital limit.

The General Assembly made changes to the RHTC every year since its creation in 2017. As shown in **Exhibit 2**, both the value of the tax credit and tax credit limit have increased. In addition, the General Assembly changed aspects of the RHTC, including to allow owners of pass-through entities to be eligible, to require certain documents to be publicly posted by participating rural hospitals, to establish how undesignated contributions are directed, and to require an annual audit by the Department of Audits and Accounts.

Exhibit 2
Legislative Changes to the RHTC

	2017	2018	2019
State Tax Credit			
Individual[1]	90% (initially 70%)	90%	100%
C-Corporate	90% (initially 70%) or 75% of the corporation's tax liability, whichever is less	90% or 75% of the corporation's tax liability, whichever is less	100% or 75% of the corporation's tax liability, whichever is less
Jan 1 to June 30 Credit Limit			
Individual[1]	$5,000 individual $10,000 married (initially $2,500 and $5,000)	$5,000 individual $10,000 married	$5,000 individual $10,000 married
C-Corporate	90% (initially 70%) of the amount expended or 75% of the corporation's tax liability, whichever is less	90% of the amount expended or 75% of the corporation's tax liability, whichever is less	100% of the amount expended or 75% of the corporation's tax liability, whichever is less
July 1 to December 31 Credit Limit[2] [3]			
Individual[1]	Unlimited	Unlimited	Unlimited

[1] Owners of pass-through entities have the same limits and credit amounts as married couples filing jointly, provided that the maximum credit "…shall be allowed only for the portion of the income on which such tax was actually paid by such individual"

[2] If annual cap has not been met

[3] C-Corporations have the same limits throughout the entire year

Source: O.C.G.A.

The total amount contributed to rural hospitals through the RHTC increased from approximately $8.4 million in 2017 to $59.1 in 2018. The tax credit increased during this period from 90% of the contribution to 100% of the contribution.

Roles and Responsibilities

DCH and the Department of Revenue (DOR) are the two state agencies responsible for administering the RHTC. DCH enforces statutory requirements of rural hospitals, and DOR enforces statutory requirements related to taxpayer credit claims. In addition, a private third-party vendor acts as a pass-through for some taxpayer contributions to the hospitals under contract.

DCH Requirements

O.C.G.A. §§ 31-7-22 and 31-8-9.1 require DCH to

- finalize the list of rural hospitals eligible for participation in the RHTC for the upcoming calendar year;
- maintain an operations manual containing the current ranking of rural hospitals in order of financial need, the criteria and formula used to calculate financial neediness of rural hospitals, rural hospitals deadlines for submitting required information to DCH, and materials required for rural hospitals to submit;
- collect five-year plans from rural hospitals each year;
- prepare an annual report containing information from the operations manual for members of the General Assembly and the Governor; and
- post on its website a list of eligible rural hospitals in order of financial need, the annual report prepared for the General Assembly, amounts retained by third-party vendors participating in soliciting, administering, or managing contributions, and a link to DOR's website containing RHTC tax credit information.

DOR Requirements

O.C.G.A. § 48-7-29.20 requires DOR to

- track and enforce contribution limits for the RHTC;
- notify taxpayers of preapproval or denial for contributing to the RHTC within 30 days;
- post timelines and deadlines related to the RHTC on its website;
- post the ranking of rural hospitals eligible to receive RHTC contributions; and
- maintain a monthly progress report of total preapproved contributions to date to rural hospitals, total contributions received to date by rural hospitals, total aggregate amount of preapproved contributions, aggregate amount of tax credits available, and a list of preapproved contributions made to undesignated rural hospitals, as well as which rural hospitals have received undesignated contributions.

Third-Party Vendor

Portage Charity Advisors established itself as a third-party vendor prior to O.C.G.A. § 48-7-29.20 coming into effect. Portage created the Georgia HEART Hospital Program to assist rural hospitals in obtaining contributions through the RHTC. In April 2018, Portage was converted into Georgia HEART and 100% of interest in Georgia HEART was contributed to the Georgia Community Foundation.[5] The leadership remained the same.

Initially, Portage charged rural hospitals utilizing its services an administrative fee of 6% of all contributions. In 2017, the General Assembly passed a state law establishing a cap on administrative fees of 3%. In 2018, 52 eligible rural hospitals contracted with Georgia HEART. In 2019, all 58 rural hospitals contracted[6] with Georgia HEART. For 2018, Georgia HEART[7] received approximately $1.8 million in administrative fees.

According to Georgia HEART, its activities include the following:

- Marketing the RHTC to individuals and businesses
- Submitting and tracking pre-approval taxpayers' preapproval requests to DOR
- Managing an online dashboard for rural hospitals to view contributions in real-time
- Assisting with preparing documents rural hospitals must submit to DCH and DOR
- Providing RHTC-related customer service to rural hospitals

Contribution Process

As shown in **Exhibit 3**, taxpayers may contribute to the RHTC through DOR's online Georgia Tax Center or through Georgia HEART.

DOR Contribution Process

A taxpayer can submit a request to DOR for preapproval to contribute to a specified rural hospital. DOR then sends notification of preapproval or denial within 30 days based on the aggregate, taxpayer, and rural hospital limits of the RHTC.

According to DOR's response to this report, beginning in November 2019, DOR's systems were updated and now allow undesignated contributions. This process is not included in **Exhibit 3** because this system update was not in place during the review period.

[5] According to the transparency and accountability narrative posted on Georgia HEART's website.

[6] According to Georgia HEART's contracts with rural hospitals, the 3% administrative fee was applied to total RHTC donations, including donations that were not received through Georgia HEART.

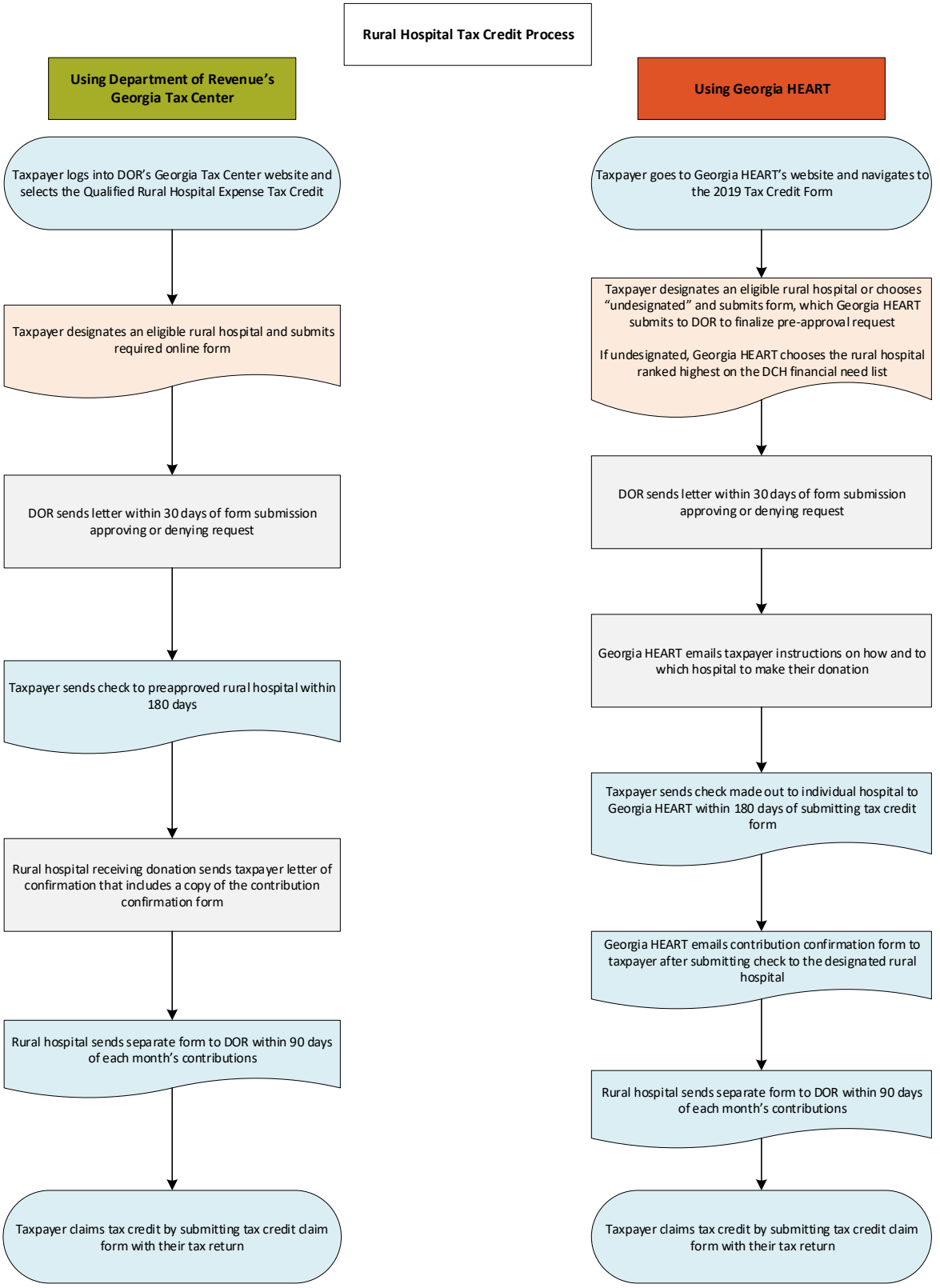
[7] This includes administrative fees from the RHTC collected by Portage.

Georgia HEART Contribution Process

Taxpayers may contribute to the RHTC through Georgia HEART by completing a form on its website, which Georgia HEART submits to DOR on behalf of taxpayers. Taxpayers are also able to contribute without specifying a rural hospital by using Georgia HEART's contribution method. According to Georgia HEART, taxpayers send checks made out to the hospital and Georgia HEART deposits the checks on behalf of the hospital. If a taxpayer chooses to make an undesignated contribution, Georgia HEART tells them which hospital to make the check out to.

Taxpayers have 180 days to submit their preapproved contributions to their designated rural hospital to claim the credit on their state income taxes. After submitting their check, the taxpayer's designated rural hospital confirms with the taxpayer that it received their contribution and submits required documentation to DOR on a rolling basis.

Exhibit 3
Taxpayers Can Contribute to Hospitals Through DOR or Georgia HEART



Source: DOR and Georgia HEART Documents

Requested Information

Finding 1: The donations received by rural hospitals in 2018 did not correspond with financial need.

In 2018, contributions to eligible rural hospitals did not necessarily go to the most financially needy because of the design of the RHTC. The eligibility criteria in 2018 did not measure hospitals' profitability, financial distress, or risk of closure. In addition, although statute directed DCH to rank all eligible rural hospitals according to financial need, the ranking was solely informational because taxpayers may choose which hospital receives their contribution. As a result, there was little correlation between level of support and level of need. The problem was further compounded by the statute's failure to direct undesignated donations to the most financially needy hospitals based on DCH's financial need list.

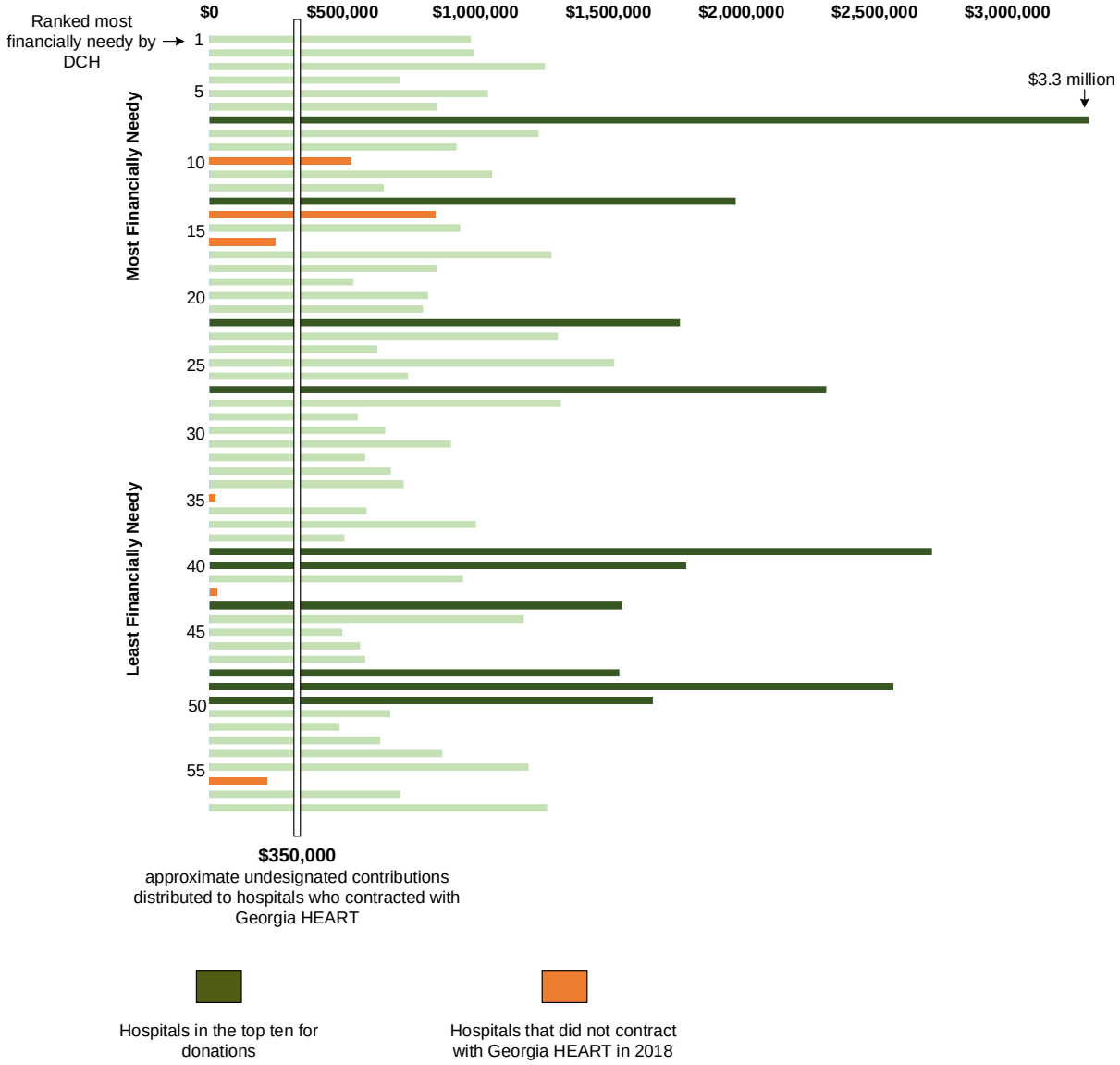
As shown in **Exhibit 4**, less needy rural hospitals, as ranked by DCH, can and did receive more donations than more needy rural hospitals. Six of the ten rural hospitals ranked most financially needy by DCH received less than the average donated amount in 2018. The top ten hospitals ranked by the amount of RHTC donations received represent 17% of rural hospitals but received 36% of RHTC donations. Also, six of these top ten RHTC donation recipients were ranked lower on DCH's financial need list. The total donations received by each rural hospital in 2018 is shown in **Appendix B**.

According to Georgia HEART, in 2018, taxpayers made approximately $19 million in undesignated contributions, representing approximately 32% of all RHTC contributions. Prior to 2019, there were no requirements for how undesignated contributions were to be allocated to rural hospitals. A third-party vendor, Georgia HEART, created the undesignated contribution as a mechanism for taxpayers who did not designate which rural hospital received their contribution, allowing Georgia HEART to allocate the contributions. For 2018, Georgia Heart reports it distributed undesignated contributions in approximately equal increments to the rural hospitals that had signed contracts with Georgia HEART. As shown in **Exhibit 4,** we estimated that each rural hospital that had contracted with Georgia HEART received approximately $350,000 in undesignated contributions.

O.C.G.A. § 48-7-29.20 was amended in 2019 to direct undesignated contributions to the most needy rural hospitals[8], as ranked by DCH. Nevertheless, taxpayer choice and eligibility criteria will continue to limit the extent to which the rural hospitals most in financial need receive the most support.

[8] This change is discussed in more detail in a subsequent finding on page 11.

Exhibit 4
The Donations Received by Eligible Rural Hospitals in 2018 Did Not Correspond with Financial Need



Source: DCH and Georgia HEART

Finding 2: Recent changes to state law will direct all undesignated contributions to the most needy rural hospitals and will make certain currently eligible rural hospitals ineligible from participating in the RHTC.

The General Assembly amended O.C.G.A. § 48-7-29.20 to direct all undesignated contributions to the neediest rural hospital on DCH's financial need list that has not yet reached its $4 million annual cap, regardless of whether or not the eligible rural hospital has a contract with a third-party vendor. This change only applies to undesignated contributions; taxpayers continue to have the ability to designate contributions to eligible rural hospitals of their choice. In addition, the General Assembly amended O.C.G.A. § 31-8-9.1 to revise eligibility requirements effective January 2020. As a result, rural hospitals with average three-year patient margins significantly above the average[9] of all RHTC-eligible rural hospitals will be ineligible from participating in the tax credit for that tax year.

Distribution of Undesignated Contributions

The recently amended O.C.G.A. § 48-7-29.20 directs all undesignated contributions to the most needy eligible rural hospital that has not yet reached its $4 million annual cap. Previously, state law did not dictate a distribution method of undesignated contributions, and Georgia HEART personnel reported it distributed undesignated contributions in $10,000 allotments from highest to lowest on DCH's financial need list for rural hospitals under contract with Georgia HEART. Georgia HEART stated it repeated this process until all undesignated contributions were exhausted or distributed. Based on Georgia HEART documents, we estimate that every rural hospital that contracted with it received approximately $350,000 in undesignated contributions in 2018. Rural hospitals that did not contract with Portage/Georgia HEART received no undesignated contributions in 2017 or 2018.

Exhibit 5 shows an example of how $8 million of undesignated contributions would be distributed within a given year among four rural hospitals under the new 2019 distribution process for undesignated contributions.

Exhibit 5
Hypothetical Distribution of $8 Million in Undesignated Contributions Using 2019 Rules

	Designated	Undesignated	Total
Hospital 1	**$500,000**	**$3.5 million**	**$4 million[1]**
Hospital 2	**$200,000**	**$3.8 million**	**$4 million**
Hospital 3	**$1 million**	**$700,000[2]**	**$1.7 million**
Hospital 4	**$300,000**	**$0[2]**	**$300,000**

[1]$4 million is a hospital's annual individual cap for donations.

[2]Hospital 3 exhausted the remaining undesignated contributions, so Hospital 4 receives no undesignated donations.

Source: O.C.G.A. § 48-7-29.20

[9] A three-year average patient margin, as percent of expense, more than one standard deviation above the statewide three-year average of other rural hospitals as calculated by DCH.

Based on undesignated contributions received from April 25 to November 30, 2019,[10] Georgia HEART's website indicates the neediest rural hospital on the DCH financial need list, Dorminy Medical Center, has received all undesignated donations for this time period, approximately $510,000. No other rural hospital will receive any undesignated donations unless Dorminy Medical Center reaches its $4 million cap.

As shown in **Exhibit 6**, if the current requirements for undesignated contributions had been in effect in 2018, six rural hospitals would have received between approximately $1.4 million and $3.6 million in undesignated contributions. All other rural hospitals would have received no undesignated funds.

Exhibit 6
If 2019 Rules Were Applied to 2018 RHTC Donations, Only Six Rural Hospitals Would Have Received Undesignated Contributions

Hospital	Estimated 2018 Undesignated Funds	Estimated Undesignated Funds[3] Using 2019 Rules
Burke County Hospital Authority	$350,000	$3.6 million
Irwin County Hospital	$350,000	$3.4 million
Dorminy Medical Center	$350,000	$3.4 million
Elbert Memorial Hospital	$350,000	$3.3 million
Candler County Hospital	$350,000	$3.1 million
Memorial Hospital and Manor	$350,000	$1.4 million
46 Other Hospitals[1]	$16.1 million	$0
6 Other Hospitals[2]	$0	$0

[1]Those that contracted with the vendor
[2]Those that did not contract with the vendor
[3]This is undesignated funds only, not total funds

Source: O.C.G.A, DCH, and Georgia HEART documents

Patient Margin Criterion

O.C.G.A. § 31-8-9.1 establishes an additional patient margin[11] criterion that rural hospitals must meet to be eligible for participation in the RHTC. Beginning in 2020, rural hospitals with average three-year patient margins, as a percent of expenses, more than one standard deviation above the statewide average of all RHTC-eligible rural hospitals will be ineligible to participate in the RHTC.

O.C.G.A. § 31-8-9.1 establishes a formula for DCH to calculate rural hospitals' patient margins but does not state if DCH should use a weighted or simple average when determining the average rural hospital's patient margins. According to the Cecil G. Sheps Center for Health Services Research, the method used to calculate average margins makes a significant difference because the gap between hospitals' simple average margins and weighted average margins can be substantial. DCH is using a weighted average and estimates that one previously eligible rural hospital will no

[10] According to the Georgia HEART's website, $510,000 in undesignated contributions were received from April 25, 2019 to November 30, 2019. We do not have access to any records on undesignated contributions made through Georgia Heart from January 1, 2019 to April 24, 2019.

[11] O.C.G.A. § 31-8-9.1 defines patient margin as "gross patient revenues less contractual adjustments, bad debt, indigent and charity care, other compensated care, and total expenses."

longer be eligible to participate in the RHTC in 2020. If instead a simple average were used, 11 rural hospitals would become ineligible.

Finding 3: Recent changes to IRS regulations make the RHTC less financially advantageous for taxpayers, which will likely decrease the amount of RHTC donations to eligible rural hospitals, including the most needy.

According to recent IRS regulations finalized in August 2019, taxpayers are no longer able to use the RHTC contribution as a charitable deduction on their federal taxes. This change in regulations significantly reduces and, in many cases, eliminates the financial benefits to the taxpayer using the RHTC. This reduction or elimination of financial benefits will likely decrease the amount of funds contributed to hospitals through the RHTC. From January-November 2018 to January-November 2019 the use of the credit declined by approximately $28 million, or approximately 50%.

Change in the IRS Code

New IRS regulations, effective August 27, 2018, prevent taxpayers from claiming both a 100% state tax credit and a federal charitable deduction for these contributions. The federal Tax Cuts and Jobs Act of 2017 capped the State and Local Tax (SALT) itemized deduction at $10,000. The SALT deduction allows federal taxpayers who itemize to deduct state and local taxes, such as state income and local property taxes. To circumvent the $10,000 SALT deduction cap, states established state tax credits in the form of charities. Taxpayers could contribute to these charities and receive a 100% state tax credit and also use the contribution as a charitable deduction on their federal taxes.

Prior to the new IRS regulations, RHTC donors could use the RHTC as both a 100% state tax credit and a federal charitable deduction. As shown in **Exhibit 7**, a household making $800,000 (approximate average household income for a RHTC donor) and contributing $20,000 through the RHTC could potentially receive a return of 137%[12] of their contribution, or a total reduction in state and federal taxes of $27,400. With the new IRS rules, they would receive only the 100% state tax credit, making the credit less financially advantageous.

Exhibit 7
The Tax Benefit of RHTC Donations Declined from 2018 to 2019

	RHTC Contribution	State Tax Credit	Federal Charitable Contribution	Net Tax Savings[1]
2018	$20,000	$20,000	$20,000	**$7,400**
2019	$20,000	$20,000	$0	**$0**

[1] Assuming deduction applies to income in the top tax rate of 37%

Source: IRS

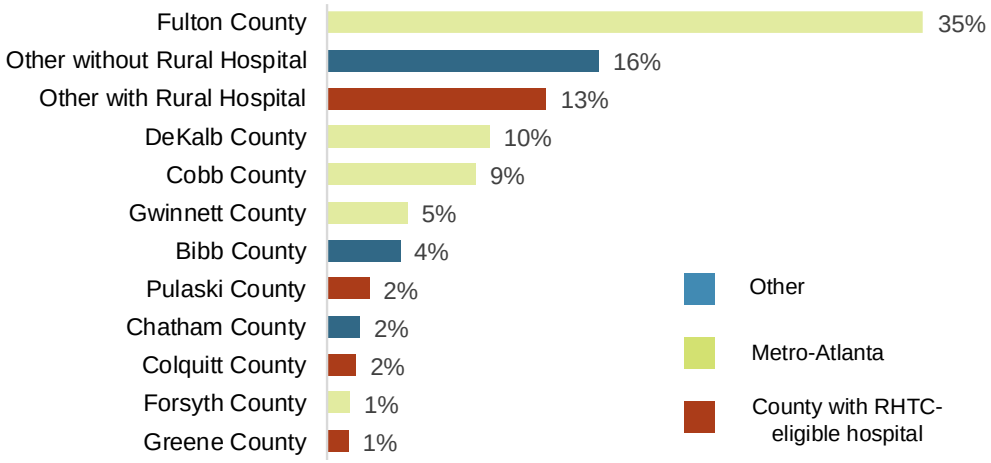
[12] Taxpayer would receive a 100% state tax credit and an additional federal charitable deduction which would be up to 37% of the contribution, depending on the taxpayer's income tax bracket.

RHTC Donors

Based on our analysis, it appears that a number of taxpayers contributed to rural hospitals through the RHTC for tax planning purposes. As shown in **Exhibit 8**, 2018 RHTC contributions primarily came from nonrural areas, primarily metro-Atlanta, where there are no eligible rural hospitals. In 2018, approximately 77% of contributions came from taxpayers residing in nonrural counties. Likewise, according to Georgia HEART, 87% of the approximately $19 million in 2018 undesignated contributions came from metro-Atlanta.

Conversely, approximately 16% of RHTC contributions are from taxpayers residing in the same county as the rural hospital receiving the donation. Eight percent of contributions are from taxpayers residing in adjacent counties. These may be taxpayers contributing to the closest rural hospital.

Exhibit 8
RHTC Contributions are Primarily from Urban Areas in Georgia, Including Metro-Atlanta, 2018

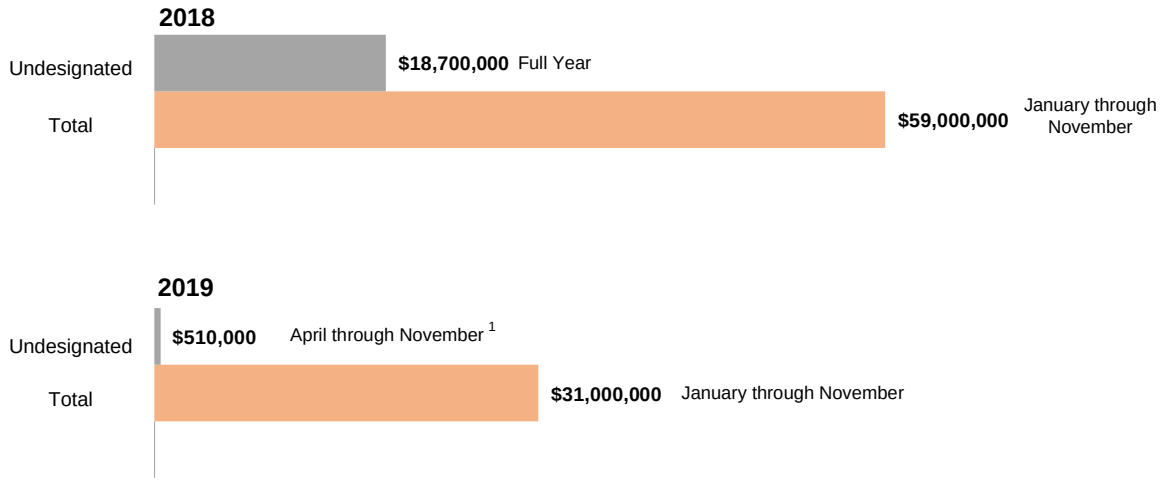


Source: DOR

Changes in RHTC Donations

As shown in **Exhibit 9**, RHTC donations are significantly lower in 2019 than they were over the same period in 2018 (January through November). Approximately $28 million less has been contributed in 2019. The decrease in contributions has resulted in reducing donations that can be directed to the most needy eligible hospitals. Since the final IRS rules were not published until August 2019, the full impact of the tax changes will be more evident in 2020.

Exhibit 9[13]
RHTC Donations are Significantly Lower in 2019



[1] According to Georgia HEART's website. This is the only time period for which Georgia HEART lists 2019 undesignated contributions.

Source: DOR and Georgia HEART

[13] For 2019, these are the most up-to-date figures available to DOAA. Beginning on April 25, 2019, statute requires undesignated contributions to be directed to the most needy eligible rural hospital. Georgia HEART began posting information on its website showing both the amount and recipient of all undesignated contributions it processed after that date. We do not have any access to data on 2019 undesignated contributions, other than what Georgia HEART publicly posted on its website.

Finding 4: There are alternative measures and approaches that could be utilized to create a more comprehensive need ranking of rural hospitals.

The rural hospital ranking created by DCH may not fully capture each rural hospital's financial need due to the limited number of financial measures used. Also, DCH's financial ranking does not consider non-financial measures of need.[14] For example, the geographic location and populations served may make some rural hospitals more essential than others. In addition, the ordinal ranking system (i.e., ranking 1-10) may not be the most appropriate manner to rank hospitals due to the difficulty of precisely measuring financial need. The inclusion of additional criteria and a categorical ranking system (i.e., "high need" or "low need") could provide a more appropriate ranking system.

Methods to Measure Hospital Need

Currently, DCH uses the following three criteria to rank hospitals' financial need: the current ratio of assets to liabilities, the Dun and Bradstreet Supplier Evaluation Rating (SER), and the Low-Income Utilization Ratio (LIUR).[15] Each of these is equally weighted to establish the ordinal hospital ranking.

Researchers have extensively studied how to measure rural hospital need. According to the North Carolina Rural Health Research Program, "[f]inancial indicators are the strongest drivers of financial distress, particularly total margin, benchmark performance and retained earnings, while hospital size and market poverty rates are the most influential non-financial factors." The Cecil G. Sheps Center for Health Services Research at the University of North Carolina established a Financial Distress Index for rural hospitals nationwide. The index uses 15 criteria based on research of rural hospitals that have closed which include financial performance, government reimbursement, organizational characteristics, and market conditions.

Methods to Rank Hospital Need

Currently, DCH uses an ordinal ranking system to rank eligible rural hospitals' financial need. Ordinal ranking is where hospitals are ranked a specific number denoting their order in the series of all hospitals, i.e. 1, 2, 3, 4, and so on. Due to the difficulty of precisely measuring hospital financial need, categorical rankings can provide a more appropriate assessment. In a categorical ranking system, hospitals are ranked as part of a group, such as high financial need or medium financial need. Since there could be slight differences between the hospital ranked the most financially needy or the fifth most financially needy, it is more reasonable to compile them into broader categories. For example, Irwin County Hospital has a current ratio of assets to liabilities of 0.60, while WellStar Sylvan Grove Hospital has a current ratio of 0.65, and four other rural hospitals have a current ratio of less than 1.0. The Cecil G. Sheps Center for Health Services Research at the University of North Carolina created a categorical ranking for rural hospitals, from a low risk of closure to a high risk of closure.

To demonstrate the impact of including one additional measure, DOAA recalculated DCH's financial need list including patient margin (rural health researchers use a similar measure)[16]. As shown in **Exhibit 10**, including patient margin does make an

[14] RHTC eligibility criteria consider non-financial need measures.

[15] These criteria are discussed in detail on page 3.

[16] Beginning 2020, O.C.G.A. § 31-8-9.1 requires DCH to use patient margin to determine eligibility.

impact on how the rural hospitals would be ranked. One of the rural hospitals currently ranked in the top ten most needy rural hospitals would drop out of the top ten, with two dropping at least five ranking spots. The top rural hospital also changed, with Candler County Hospital ranked the most needy when including patient margin.

A revised ranking system with additional variables could better inform taxpayers that contribute to the RHTC of a hospital's financial need and improve the distribution of undesignated contributions to the neediest hospitals. For example, as of November 2019, there have been approximately $510,000 in undesignated contributions, which is required to be directed to Dorminy Medical Center. The inclusion of patient margin would direct those dollars to Candler County Hospital.

Exhibit 10
The Inclusion of Patient Margin as an Additional Criterion Impacts the Financial Need Rank of Rural Hospitals

Hospital	2019 DCH Rank	2019 Rank with Patient Margin[1]	Change in Rank
Dorminy Medical Center	1	3	-2
Candler County Hospital	2	1	+1
Irwin County Hospital	3	2	+1
Memorial Hospital of Bainbridge	4	9	-5
Liberty Regional Medical Center	5	6	-1
Elbert Memorial Hospital	6	8	-2
Emanuel Medical Center	7	4	+3
Taylor Regional Hospital	8	5	+3
Stephens County Hospital	9	7	+2
WellStar Sylvan Grove Hospital	10	18	-8

[1]Patient margin as a percent of expenses.

Source: DCH

Finding 5: While the current design of the RHTC limits transparency and accountability of the RHTC expenditures and contributions, alternative funding structures would increase accountability and transparency of distributing taxpayer dollars to rural hospitals.

While the General Assembly has attempted to add greater accountability and transparency provisions to the RHTC statute, transparency and accountability are still limited due to RHTC's design. The General Assembly could further address accountability and transparency limitations under the current design as a tax credit or move to a different funding structure. First, the state could continue the RHTC but require taxpayer RHTC contributions be made through a state-managed nonprofit entity. The second option is to change the funding method from a tax credit to a state appropriation to a state grant program for rural hospitals.

Accountability – *"being answerable for decisions and having meaningful mechanisms in place to ensure adherence to all applicable laws, regulations and standards."*

Transparency – *"government's obligation to share information with citizens that is needed to make informed decisions and hold officials accountable for the conduct of the people's business."*

While there are some transparency requirements built into the RHTC statute, the requirements are not sufficient. We noted state agencies mostly comply with O.C.G.A §§ 31-8-9.1 and 48-7-29.20 by providing required documents. These include the monthly Qualified Rural Hospital Organization Expense Tax Credit Report, the list of eligible hospitals ranked by financial need, and the annual report on RHTC donation expenditures.[17] In addition, the General Assembly added a requirement for DOAA to conduct an annual audit of the tax credit. Nevertheless, the RHTC is limited in the following ways:

- The RHTC lacks legislative intent or policy goals established in statute. The current intent is limited to providing a mechanism to direct tax expenditures to a group of hospitals. Based on public comments made by various legislators, the intent may be to allow taxpayers to divert their tax dollars to their local rural hospital, increase funds for the most needy rural hospitals, or to prevent the closure of rural hospitals.

- There is limited ability to significantly direct the tax expenditures. The state has largely abdicated the decision-making authority over the total amount given to rural hospitals and how contributions are allocated to taxpayers, providing direction only for undesignated contributions to go to the neediest hospitals.

O.C.G.A § 31-8-9.1 requires that donations are utilized for "the provision of health care-related services for residents of a rural county or for residents of the area serviced by a critical access hospital."

- The state lacks the ability to ensure that RHTC contributions have a long-term impact on the fiscal sustainability of participating rural hospitals. While helpful, donations can fluctuate year to year, making it difficult for hospitals to properly plan without a stable funding source. In addition, rural hospitals have broad discretion on how they spend their RHTC donations. The RHTC

[17] However, DOR does not provide in the monthly report a list of preapproved contributions made to unspecified/undesignated rural hospitals and which ones received those donations as is required by O.C.G.A § 48-7-29.20 since its systems did not accept undesignated contributions. DOR does provide a link to Georgia Heart's website for information on Georgia Heart's undesignated contributions. Beginning in November of 2019, DOR systems were updated and DOR has indicated that it will post information regarding undesignated contributions it receives as required by the 2019 changes to O.C.G.A § 48-7-29.20

is structured to ensure that rural hospitals have the flexibility to expend donations in the manner they believe is best for their hospital.

- The current state provisions do not provide the state, including auditors, with access to the data and contracts of all entities involved in the administration of the RHTC. The limited or lack of access to data from private entities, hospitals, and third-party vendors limits the effectiveness of the annual audit requirement. For example, in response to a data request and series of questions from DOAA for this review, the third-party vendor, Georgia HEART, posted a narrative on its website and provided the following statements in an email to DOAA:

  "By cooperating with your office in this manner, Georgia HEART intends to facilitate and expedite the Special Examination, while at the same time reserving its right to object to the DAA's jurisdiction in connection with seeking confidential and other business records and information from a private, nongovernmental agency or organization.

  Although the Narrative contains most of the information you seek with respect to the Special Examination, please know that…the Narrative does not contain the detail of specific donor contribution information, as, in the Hospital Participation Agreements, Georgia HEART specifically agrees to treat that information as confidential, respecting the fact that the donors contribute to the rural hospitals, not Georgia HEART, and that, prior to the contributions being made, neither Georgia HEART nor the rural hospitals informed the donors that their taxpayer information might be subject to Special Examination by the DAA or any other state agency."

Requiring contributions be made through a state-managed nonprofit entity or alternatively, establishing a state grant program would ensure that a state entity would have oversight authority of the tax credit and that all information related to the tax credit be publicly available or available confidentially to auditors. With either option, there is a finite cost to the state. As a tax credit, the state is willing to forgo up to $60 million in tax revenue annually. Tax credits, also called tax expenditures, are an allocation of government resources in the form of taxes that could have been collected and appropriated by the General Assembly. As a grant program, the General Assembly and governor can control the exact amount to support rural hospitals by appropriating $60 million.

The option to require contributions be made through a state-managed nonprofit entity or to establish a state grant program are discussed below.

Option 1: State Nonprofit – Tax Credit

The state could statutorily create a nonprofit and attach it to DCH, similar to other state operated nonprofits[18] and require all RHTC contributions to be made through this new entity. The RHTC could continue to operate as a tax credit. As shown in **Exhibit 15**, this could increase oversight, transparency, and accountability in several ways, including the following:

[18] Examples include the Georgia Foundation for Public Education and the DNR Foundation.

- Requiring the nonprofit to be subject to all laws relating to open meetings and the inspection of records
- Requiring the nonprofit to make public reports on its activities
- Ensuring undesignated contributions are distributed in the legislatively-required manner
- Allowing the state to have full control over all data related to the RHTC and allow state auditors access to confidential data

DCH estimated it would cost approximately $350,000 annually for additional staff to support the nonprofit and act as a pass-through for the RHTC contributions from taxpayers seeking the tax credit.

Option 2: State Grant Program – State Appropriation

State appropriations inherently provide a higher level of transparency and accountability than tax expenditures. Through the appropriations process, the state annually determines the appropriate level of state funding for programs, such as providing funding to needy rural hospitals. State appropriations are discussed and reviewed annually as part of the budgetary process.

Rather than operate as a tax credit, a state grant program would provide the highest level of accountability, transparency, and oversight, as shown in **Exhibit 11**. The General Assembly could appropriate a desired amount of funds annually for DCH to disburse to eligible rural hospitals through a grant program. In addition, this ensures one state entity, DCH, would have oversight of the program, and the ability to design, implement, and oversee an internal control system to evaluate the grant program and ensure the program is achieving its objectives.

DCH estimated it would cost approximately $720,000 annually to manage a state grant program of this size.

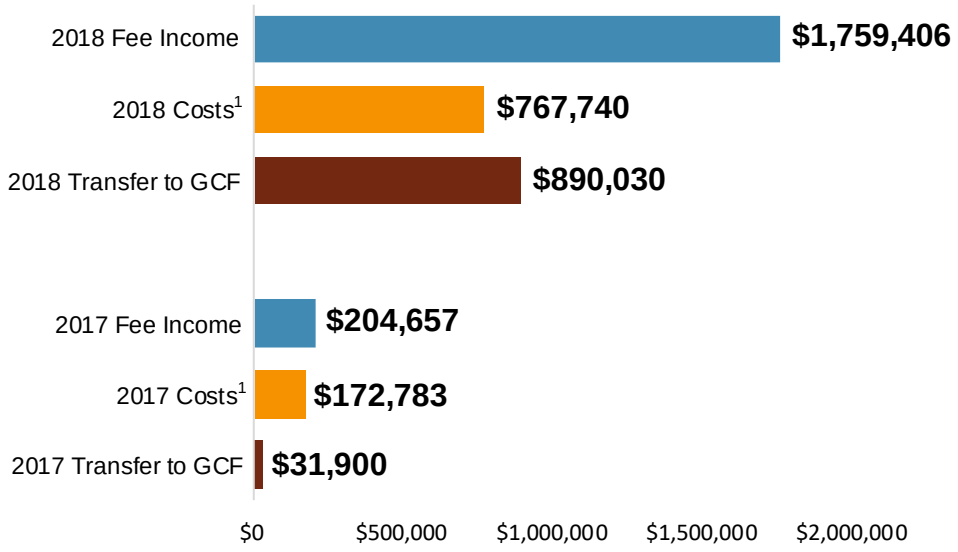
Exhibit 11
Increased State Involvement Would Could Increase Oversight, Transparency, and Accountability of the RHTC

	Current	State-managed Tax Credit	State Grant Program
Accountability	**Medium** Accountability requirements are established related to donation limits	**Medium** Accountability requirements could be established related to donation limits	**High** State could ensure funds go to the neediest hospitals
Transparency	**Medium** Some RHTC data is publicly posted including broad expenditure reports	**High** All RHTC data and management decisions could be publicly posted	**High** All data and management decisions could be publicly posted
Oversight	**Low** No state entity has oversight of the RHTC nor can any have full oversight as currently structured	**Medium** Oversight could be assigned for some aspects of the RHTC	**High** A state entity would have oversight of all aspects of the program

Finding 6: Although within statutory limits, the third-party vendor charged an administrative fee that exceeded its stated expenses in 2017 and 2018.

O.C.G.A. § 31-8-9.1 allows third-parties to collect a maximum of 3% of donations to "solicit, administer, or manage the donations received." In 2018, Georgia HEART charged the maximum 3% fee[19] and, in 2017, Portage (Georgia HEART's predecessor) also charged the maximum 3% fee.[20] As shown in **Exhibit 12**, in each of these years, the administrative fee revenues exceeded the entities' reported costs. Portage and Georgia HEART transferred the excess fee amounts to the Georgia Community Foundation (GCF), a 501(c)(3). Rather than allocate it to rural hospitals through the RHTC, Georgia HEART stated that GCF has used the transferred excess amounts to donate to other entities for the benefit of rural health. According to Georgia HEART, as of June 30, 2019, approximately $530,000 of the transferred amount had not yet been spent.

Exhibit 12
Georgia HEART's 2018 Administrative Fee Income Exceeded Its Stated Costs by Approximately $1 Million[1]



[1]2018 costs are based on Georgia HEART's audited financial statements and 2017 costs are based on Portage's unaudited financial statements.

Source: Georgia HEART documentation

Georgia Community Foundation's mission *is to promote and support charitable and educational activities in Georgia and to provide philanthropic advice and charitable giving services to donors.*

Georgia GOAL's mission *is to provide greater opportunities for access to learning for all Georgia children.*

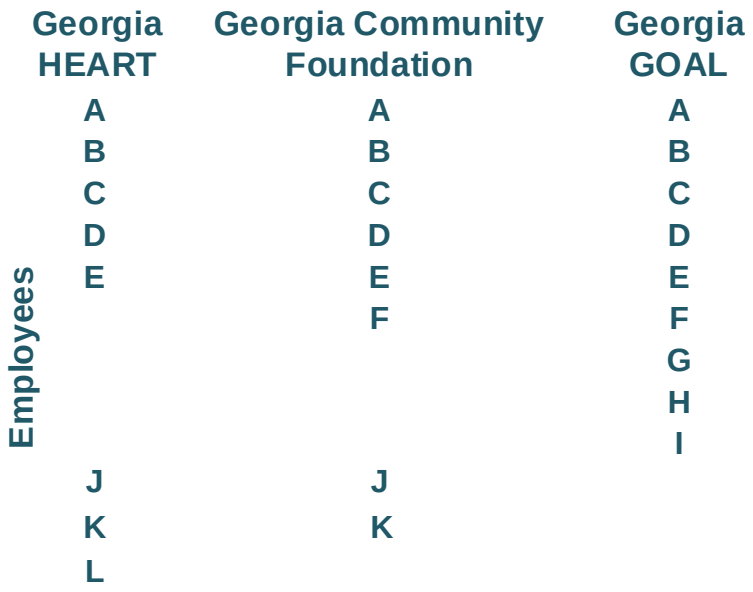
We were unable to determine if Georgia HEART's costs were reasonable and appropriate because it is not legally required to allow, and its leadership would not permit, DOAA access to its accounting, financial, or other business records. A complicating factor in determining the reasonableness of costs is how Georgia

[19] According to Georgia HEART's contracts with rural hospitals, the 3% administrative fee was applied to total RHTC donations, including donations that were not received through Georgia HEART.

[20] According to the transparency and accountability narrative posted on Georgia HEART's website, effective April 18, 2018, Portage converted from a corporation to a limited liability company under the name Georgia HEART Hospital Program, LLC.

HEART allocated its resources among two nonprofits. Georgia HEART is associated with Georgia GOAL and GCF through shared leadership and staff. As shown in **Exhibit 13**, as of August 2019, Georgia HEART, GCF, and Georgia GOAL all shared five employees while Georgia HEART and GCF each shared seven employees. The three entities also share office space. Without access to the entities' records, we were unable to evaluate how costs such as salaries, rent, and employees' time were allocated among the entities. In addition, because we did not have complete access to any of the entities' financial records, we were unable to confirm exact costs associated with administering the RHTC.

Exhibit 13
Georgia HEART and Associated Entities Share Employees[1]



[1]This is based on a review of the entities' websites as of August 2019

Source: Georgia HEART, GCF, and Georgia GOAL websites

As a point of comparison, we asked DCH to estimate how much it would cost to act as a pass-through for RHTC donations and distribute taxpayer contributions to designated rural hospitals. DCH estimated it would cost approximately $350,000 annually to act as a pass-through for RHTC donations. While DCH would not provide certain services to rural hospitals and would provide no services to taxpayers that Georgia HEART states it provides, DCH stated staff are available to address rural hospitals' questions. In addition, DOR staff are available to address taxpayer questions related to the RHTC. As of November 2019, DOR began accepting undesignated contributions which had previously been accepted solely by Georgia HEART.

Appendix A: Objectives, Scope, and Methodology

Objectives

This report examines the Rural Hospital Tax Credit (RHTC). Specifically, our examination set out to determine the following:

1. Determine if the funds are reaching the intended and most needy hospitals;
2. Determine if third-party vendors retain a reasonable administrative fee and direct contributions according to the intent and greatest public benefit of the law; and
3. Determine if there are additional transparency and accountability measures that should be considered to improve the integrity of the next period of donations through 2024.

Scope

This special examination generally covered activity related to the Rural Hospital Tax Credit that occurred since its establishment in 2017, with consideration of earlier periods when relevant. Information used in this report was obtained by reviewing relevant laws, rules, and regulations, interviewing agency officials and staff from the Department of Community Health (DCH) and the Department of Revenue (DOR), analyzing data and reports by DCH and DOR, and reviewing studies by the Government Accountability Office (GAO), Deloitte, and Navigant Consulting.

DOAA obtained DOR data on taxpayers who have contributed to the RHTC since its creation in 2017. This included data on all taxpayer contribution amounts to the RHTC, the dates taxpayers contributed, credits claimed and unclaimed by taxpayers, taxpayers' federal adjusted gross income, and taxpayers' county of residence. We assessed the data used for this examination and determined the data used were sufficiently reliable for our analyses.

DOAA obtained DCH data on Georgia hospitals' finances. This included data on revenues, expenses, and RHTC donations received. We assessed the data used for this examination and determined the data used were sufficiently reliable for our analyses.

Government auditing standards require that we also report the scope of our work on internal control that is significant within the context of the audit objectives. We reviewed internal controls as part of our work on Objectives 2 and 3. Specific information related to the scope of our internal control work is described by objective in the methodology section below.

Methodology

To determine if the funds are reaching the intended and most needy hospitals, we used DCH data to compare donations received by RHTC-eligible hospitals in 2018 to their financial need ranking. We reviewed reports on rural hospitals financial distress and closure from the GAO, UNC's Rural Health Research Program (which is funded by the Federal Office of Rural Health Policy), and Navigant Consulting. We interviewed a UNC professor with the Rural Health Research Program on how to measure and rank rural hospital financial distress. We used additional financial criteria and evaluated the impact of its inclusion on the ranking of rural hospitals. We reviewed state law and documents on Georgia HEART's website regarding the

direction of undesignated contributions to RHTC-eligible hospitals made since April 2019. Finally, we used DCH data to determine which rural hospitals would be ineligible from participating in the RHTC in 2020 due to an update to state law.

We evaluated the impact of federal IRS regulation changes on the amount of funds contributed through the RHTC by reviewing IRS regulation updates on state and local tax deductions and the federal 2017 Tax and Jobs Act. In addition, we analyzed individual taxpayer data to determine the geographic area contributions were coming from, common tax credits and deductions taken by these taxpayers, and household income. To determine the county of residence for each individual taxpayer, each address was geocoded using ArcGIS. For the geographic analysis of 2018 contributions, the analysis accounted for approximately $50 million of the $55 million in individual contributions made. Some contributions could not be analyzed due to inaccurate or blank addresses, or the use of a P.O. Box, which did not return a county in ArcGIS.

To determine if third-party vendors retain a reasonable administrative fee and direct contributions according to the intent and greatest public benefit of the law, we reviewed Portage Charity Advisors Inc. and Georgia HEART's audited financials and transparency narrative to compare their expenses in administering the RHTC to their administrative fee incomes on RHTC contributions. We also analyzed possible cost sharing between Georgia HEART and its associated nonprofits by comparing shared resources, such as the number of staff employed with Georgia HEART who are also employed in its associated nonprofits. We interviewed Georgia HEART and DOR staff and requested documentation from Georgia HEART to determine if undesignated contributions were directed according to the intent of the law, but were unable to access Georgia HEART's data on undesignated contributions to confirm if this occurred. Finally, we requested DCH to estimate state costs for DCH to act as a pass-through entity for taxpayer contributions or to change the structure of the RHTC to a DCH-managed state grant program

To determine if there are additional transparency and accountability measures that should be considered to improve the integrity of the next period of donations through 2024, we reviewed O.C.G.A §§ 31-8-9.1 and 48-7-29.20 to determine what transparency and accountability measures are required by state law and compared these requirements to the internal control standards set forth in the GAO Green Book. We also utilized the GAO Internal Control Management and Evaluation Tool to determine what internal controls were not in existence for the RHTC.

The third-party vendor, Georgia HEART, was an external impairment for this special examination because we were unable to obtain all information requested from them and their involvement with the administration of the RHTC to determine if they charge a reasonable fee. We do not have legal authority to compel private entities with no contractual relationship with the state to provide information or review their business and financial records. The information contained in this report regarding Georgia HEART is based on publicly available information, primarily from Georgia HEART's website.

We conducted this special examination in accordance with generally accepted government auditing standards (GAGAS). Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that

the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix B: 2018 RHTC-Eligible Hospitals and Contributions

Hospital	Rank	County	Donations
Irwin County Hospital	1	Irwin	$982,957
Dorminy Medical Center	2	Ben Hill	$992,170
Candler County Hospital	3	Candler	$1,261,378
Burke County Hospital	4	Burke	$714,312
Elbert Memorial Hospital	5	Elbert	$1,047,263
Memorial Hospital & Manor	6	Decatur	$854,490
Taylor Regional Hospital	7	Pulaski	$3,307,596
Wellstar Sylvan Grove	8	Butts	$1,237,139
Emanuel Medical Center	9	Emanuel	$929,941
Stephens County Hospital	10	Stephens	$535,184
Navicent Health Baldwin	11	Baldwin	$1,062,133
Washington County	12	Washington	$655,176
Coffee Regional Medical Center	13	Coffee	$1,979,910
Evans Memorial Hospital	14	Evans	$852,096
Wills Memorial Hospital	15	Wilkes	$942,322
Habersham Medical Center	16	Habersham	$854,634
Monroe County Hospital	16	Monroe	$1,285,237
Piedmont Mountainside	16	Pickens	$246,903
Jeff Davis Hospital	19	Jeff Davis	$540,141
Liberty Regional Medical	20	Liberty	$822,254
Dodge County Hospital	21	Dodge	$1,768,963
Wayne Memorial Hospital	21	Wayne	$803,726
St. Mary's Sacred Heart	23	Franklin	$1,309,699
Appling Health Care System	24	Appling	$631,610
Colquitt Regional Medical	25	Colquitt	$2,319,139
Cook Medical Center	25	Cook	$746,452
Putnam General Hospital	25	Putnam	$1,521,584
Tift Regional Medical	28	Tift	$1,321,456
Bleckley Memorial Hospital	29	Bleckley	$558,783

Rank	Rank	County	Donations
Bacon County Hospital	30	Bacon	$660,417
Phoebe Sumter Medical Center	31	Sumter	$906,381
University Hospital McDuffie	32	McDuffie	$584,225
Jefferson Hospital	33	Jefferson	$681,807
Southeast GA Health System	34	Camden	$22,222
Southwest GA Regional	34	Randolph	$730,130
Donalsonville Hospital, Inc	36	Seminole	$590,675
Upson Regional Medical Center	37	Upson	$1,001,512
Clinch Memorial Hospital	38	Clinch	$507,391
St. Mary's Good Samaritan	39	Greene	$2,716,930
Higgins General Hospital	40	Haralson	$1,789,595
Morgan Medical Center	41	Morgan	$952,974
Meadows Regional Medical	42	Toombs	$1,550,753
Miller County Hospital	42	Miller	$27,449
Crisp Regional Hospital	44	Crisp	$1,181,561
Brooks County Hospital	45	Brooks	$498,549
Polk Medical Center	46	Polk	$565,260
SGMC Berrien Campus	47	Berrien	$585,283
Grady General Hospital	48	Grady	$1,541,352
Phoebe Worth Medical Center	49	Worth	$2,571,953
Effingham Health System	50	Effingham	$677,925
John D. Archbold Memorial	50	Thomas	$1,667,645
Mitchell County Hospital	52	Mitchell	$487,562
SGMC Lanier Campus	53	Lanier	$640,501
Medical Center - Peach County	54	Peach	$875,100
Chatuge Regional Hospital	55	Towns	$1,201,222
Jasper Memorial Hospital	56	Jasper	$716,172
Murray Medical Center	56	Murray	$218,220
Union General Hospital	58	Union	$1,270,855

Source: DCH

The Performance Audit Division was established in 1971 to conduct in-depth reviews of state-funded programs. Our reviews determine if programs are meeting goals and objectives; measure program results and effectiveness; identify alternate methods to meet goals; evaluate efficiency of resource allocation; assess compliance with laws and regulations; and provide credible management information to decision makers. For more information, contact us at (404)656-2180 or visit our website at www.audits.ga.gov.