Singing River Health System (A Component Unit of Jackson County, Mississippi)

Financial Statements and Supplementary Information

Year Ended September 30, 2015

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DIXON HUGHES GOODMAN LLP

Independent Auditor's Report

Board of Trustees
Singing River Health System
Gautier, Mississippi

Report on the Financial Statements

We have audited the accompanying financial statements of Singing River Health System (the "Health System"), a component unit of Jackson County, Mississippi, which comprise the statement of net position as of September 30, 2015 and the related statement of revenues, expenses and changes in net position and cash flows for the year then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Governmental Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

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

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

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Health System as of September 30, 2015, and the results of their operations and cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

DIXON HUGHES GOODMAN LLP

Emphasis of Matter

As discussed in Note 2 to the financial statements, during the year ended September 30, 2015, the Health System implemented new accounting guidance for pension accounting and reporting that requires retroactive adjustments to amounts previously reported as of and for the year ended September 30, 2014. Our opinion is not modified with respect to this matter.

Other Matters

Required Supplementary Information

Management's Discussion and Analysis and the Schedule of Changes in Net Pension Liability and Related Ratios are not a required part of the financial statements, but is supplementary information required by the Governmental Accounting Standards Board ("GASB"). We have applied certain limited procedures, which consisted primarily of inquiries of management regarding the methods of measurement and presentation of the supplementary information. However, we did not audit the information and express no opinion on it.

Other Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the financial statements taken as a whole. The Schedule of Surety Bonds for Officers and Employees on page 44 is presented for purposes of additional analysis and is not a required part of the basic financial statements.

The Schedule of Surety Bonds for Officers and Employees has not been subjected to the auditing procedures applied in the audit of basic financial statements, and accordingly, we do not express an opinion or provide any assurance on it.

Other Reporting Required by Governmental Auditing Standards

In accordance with *Governmental Auditing Standards*, we have also issued our report dated December 30, 2015, on our consideration of the Health System's internal control over financial reporting and our tests of its compliance with certain provisions of laws, regulations, contracts, grants and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion of the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Health System's internal control over financial reporting and compliance.

Dixon Hughes Goodman LLP

Birmingham, Alabama
December 30, 2015

Management's Discussion and Analysis

Overview of the Financial Statements

This annual report consists of the financial statements and notes to the financial statements of Singing River Health System. The Health System is a governmental entity organized and existing pursuant to the applicable statutes of the State of Mississippi, an instrumentality of the County, which operates on a not-for-profit basis and is organized as a county hospital under provisions of the statutes of the State of Mississippi. The Health System is exempt from federal and state income taxes.

While the County may appropriate money from its general fund and levy property taxes to support the operations of the Health System, the Health System has been self-supporting and receives no County appropriations for its operations, nor has it received any such financial support from the County in over twenty-six years. The legally available mills have been pledged as additional security for the 2009 and 2011 Revenue Bonds, but have not been levied to support these or any other bonds.

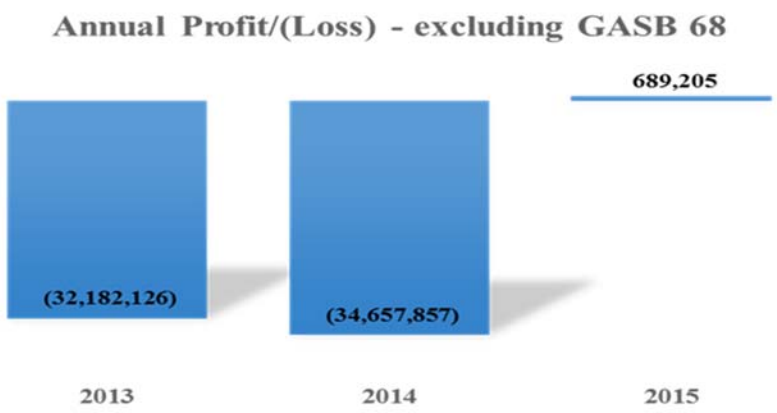
The Board of Trustees, appointed by the County Board of Supervisors, is charged with the maintenance, operations, and management of the Health System, its finances and staff. The Health System's primary mission is to provide healthcare services to the citizens of its service area, which includes the County and the surrounding areas, through its acute, primary, and specialty care facilities.

The financial statements include the accounts and transactions of Singing River Health System which includes Singing River Hospital, Ocean Springs Hospital and various outpatient facilities, and its blended component units Anesthesia Services, LLC and SRHS Ambulatory Services, Inc. SRHS Ambulatory Services, Inc. is comprised of its blended component units, including Mississippi Coast Endoscopy and Ambulatory Surgical Center, LLC, Ocean Springs Surgical and Endoscopy Center, LLC, and other outpatient healthcare service entities. The blended component units of Ambulatory Services are majority owned joint ventures with local physicians. These ventures were developed as part of the Health System's strategic goal of providing important medical services to the community in a delivery mode that is convenient and efficient for the patients.

Financial Highlights

Excluding the GASB 68 pension standards implementation and related pension expense as discussed in more detail below, the increase in net position would have been a positive $689,205, versus ($34,657,857) for 2014 and ($32,182,126) for 2013. In spite of innumerable challenges, the prior year operating loss trend of losing nearly $3 million per month has been reversed. Had the turnaround plan not been implemented when it was, the Health System certainly would have been bankrupt by this point in time.

For fiscal year 2015, when including GASB 68 and pension expense, the Health System reported an increase in net position of approximately $60.7 million. When excluding the pension entries, there was an increase of approximately $689 thousand as noted above. For fiscal year 2014, the Health System reported a decrease in net position of approximately $34.7 million. For fiscal year 2013, the Health System reported a decrease in net position of approximately $32.2 million. The 2013 financial statements include a restatement adjustment to the net position as of September 30, 2012 to reflect a correction in the Health System's net realizable value of patient accounts receivable. As a result of a new management team's review of its methodology to estimate the net realization of patient accounts receivable, it was determined that valuation allowances did not correctly apply historical collections against certain patient charges. The net realizable value of the Health System's patient accounts receivable was cumulatively overstated by approximately $88 million for years 2013 and prior.



While the pension plan continues to be the most significant issue the Health System faces, as further punctuated by the current impact of pension litigation expense, maintaining volume in the midst of cutting costs is a primary operating challenge. Increasing volume or further expense reduction initiatives will be necessary in order to do better than just break-even, which the Health System must do in order to fund the pension, fund raises to front line personnel when necessary, and fund necessary capital and technological improvements needed to remain competitive. To help overcome the challenges faced, the Health System will continue to market its proven high clinical quality as a differentiation, focusing always on the mission and the patients served.

The largest of many threats to cash flow are multi-million dollar DSH (Disproportionate Share Hospitals) Medicaid program reductions, reimbursement reductions from Medicare, Medicaid and private payors, as well as the future negative impact of deferred maintenance. As is already known and as was corroborated by the Laporte consultants hired by the County, the future of Healthcare reimbursement in America is concerning. The Health System staved off a significant reduction in reimbursement from Blue Cross regarding their plans including the State and School Employees plan, but continued pressure to reduce rates will persist. Medicare continues to increase the VBP (Value Based Purchasing Program) payment reductions and readmission penalties, implement RAC (Recovery Audit Contractor) and two midnight rule related reductions, and force bundled payment initiatives to reduce payments, Employers have shifted the burden of payment to employees, also resulting in less income to Health Systems. Further, the DSH program continues to be reduced in accordance with the Affordable Care Act, and Mississippi has not expanded Medicaid and does not plan to.

There are four general items that will be reflected on the financial statements for the year that are anomalous related to the pension and applications of GASB 68. First is the recognition of the full net pension liability of approximately $304 million as an adjustment to the statement of net position liability and net position beginning balances. Second is an approximate $ 77.6 million reduction in the long-term pension liability primarily related to the plan freeze that occurred during the current fiscal year; other changes such as changes in mortality rates affect the long term liability, but the plan freeze was the largest assumption change. Third is amortization of the approximate $7.5 million unfavorable variance between the actual return of 1.6% on the plan assets and the target rate of return of 6.5%, which is required to be amortized over five years beginning this year, at approximately $1.5 million per year. Fourth is amortization of approximately $22.1 million from an unfavorable reduction in the tax exempt municipal bond rate for 4.26% to 3.93%, which is required to be amortized over 3.9 years beginning this year, at approximately $5.7 million per year. The net impact of the last three items, which flow through the income statement this year under GASB 68, is a net increase of approximately $70.4 million.

The gross total pension liability as of September 30, 2015 was approximately $441 million, and after subtracting the assets of approximately $137 million, the net liability was approximately $304 million. In laymen's terms, recording the GASB 68 accounting policy resulted in a non-cash accounting entry which reflects the full net liability on the books of approximately $304 million, after the liability was reduced by approximately $77.6 million for the plan freeze that occurred during the fiscal year. The approximate $77.6 million was a gain on the books because the liability was frozen and reduced, but the cash impact of the freeze will occur over the next 35 years.

In fiscal years 2015 and 2014, the net pension liability was approximately $304 million and approximately $342 million after audit adjustment, respectively. These liabilities represent the liability as determined by an actuary. The Health System's pension cost and actuarial outlook have been negatively impacted by lack of employer funding and inability to fund due to negative cash flow from operations, below industry required employee contributions (e.g., 3 percent versus 9 percent required in the Mississippi State plan), plan design, increased life expectancy, future discount rates, reduced inflow due to a freeze in the plan to new employees, etc.

The Health System adopted GASB No. 68, *Accounting and Financial Reporting for Pension*, in fiscal year 2015. This statement requires governmental entities providing defined benefit pensions to recognize their long-term obligation for pension benefits as a liability and to more comprehensively and comparably measure the annual costs of pension benefits. The adoption of GASB 68 resulted in a significant increase in the stated liability. Refer to Note 10 and 15 in the accompanying financial statements for additional information regarding the adoption of this GASB Statement.

On November 20, 2014, the Health System's Board of Trustees resolved to amend the Plan to, among other things, freeze the Plan so that no further contributions will be made by the employees and that no further benefits shall accrue. The Resolution also directed that the Plan be terminated and that assets of the Plan be allocated and benefits funded in accordance with applicable provisions of the Plan. Additionally, the Resolution directed that a new plan be established with modified benefits. Subsequently, that resolution was rescinded and an alternate partial funding plan amendment was developed. Currently there are nine state court actions pending in the Chancery Court, fifteen actions in Circuit Court, and three Federal Court actions pending pertaining to the Health System and the Plan. Six of the state cases aim to prevent the Health System from terminating the Plan via a permanent injunction while the other two state court actions allege violations of the Mississippi Uniform Trust Act, among other allegations. In addition three putative class action lawsuits have been filed in Federal Court against the Health System and others alleging Breach of Contract and Fiduciary Allegations.

The complaints seek monetary relief and in some instances injunctive relief which could prevent amendment of the Plan. The ultimate resolutions of the actions pending against the Health System and the Plan cannot be reasonably determined but could have a material adverse effect on the Health System's financial condition, results of operations and its long-term viability.

Total cash, cash equivalents and funds designated by the Board for capital improvements increased approximately $17.4 million from September 30, 2014 to September 30, 2015, while it decreased by approximately $30.8 million from September 30, 2013 to September 30, 2014 Net days revenue in patient accounts receivable were 37 days at September 30, 2015 compared to 46 days at September 30, 2014.

There is still significant work to be done to restore the Health System to a consistent and safe positive operating margin and a stronger balance sheet. Overall, the Health System's current difficult financial situations is due to:

- Overestimation of Accounts Receivable by approximately $88 million between 2006 and 2013
- Significantly reduced income from both private and government payors
- High levels of uncompensated care
- No public tax dollars to compensate for indigent care
- Enormous capital expenditures and bond indebtedness in the past
- Unsustainable expenses which if not addressed could have bankrupted the Health System
- Lowest growth in consumer healthcare spend in 53 years
- Affordable Care Act and related compliance expense (e.g., Electronic Health Records)
- Lack of Medicaid Expansion combined with fewer privately insured patients and less State funding

The Health System will overcome the financial hurdles its faces by leveraging its differentiators, such as:

- Above average scores in clinical and service quality as noted by The Joint Commission, CMS, Blue Cross/Blue Shield, American Heart Association and others
- Centers of Excellence in Ortho (Joints), Cardiology (Heart), Neurology (Stroke) and Bariatrics
- Board certified physicians in every specialty, serving both hospitals
- The only Joint Commission accredited Hospice program in South Mississippi
- Highly trained and committed teams of caregivers at all levels
- Highest HCAPS scores in state in many areas
- Patient satisfaction ratings among the highest in the region

Assets, Liabilities And Net Position (Statement Of Net Position)

Total unrestricted consolidated cash and investments at September 30, 2015 is approximately $45 million which equates to 51 days of consolidated cash on hand at September 30, 2015.

Net accounts receivable at September 30, 2015 was the lowest this year at approximately $33.7 million, as a result of aggressive collection efforts and as execution of the Revenue Cycle initiatives continue.

Debt continues to be paid down on schedule, with bonds payable at $94.4 at year end.

Total net position remains negative at approximately ($143.7 million). This is down from the positive approximately $83.7 million at the beginning of the year due primarily to the adjustment for the required reflection of the GASB 68 full pension liability. In accordance with GASB 68 the balance sheet reflects the total net pension liability of approximately $304 million. The negative net position balance is a significant issue, and the organization must work harder than ever to adopt a plan for the pension plan that both ensures a benefit to participants and works toward curing the deficit.

The following table provides a summary of the Health System's total assets, total liabilities, and total net position at September 30, 2015 and 2014.

	2015 (in millions)	2014 (in millions)
ASSETS		
Current assets	$ 91.9	$ 75.4
Designated funds and funds held by trustees	13.0	19.7
Other assets	1.2	1.3
Capital assets	185.7	202.2
Total assets	291.8	298.6
DEFERRED OUTFLOWS OF RESOURCES		
Deferred loss on debt refunding	25.4	3.7
Total assets and deferred outflows of resources	$ 317.2	$ 302.3
LIABILITIES		
Current liabilities	43.3	$ 46.4
Long-term debt, less current installments	87.8	94.4
Capital lease obligations, less current installments	1.1	1.3
Other long-term liabilities	328.7	76.5
Total liabilities	460.9	218.6

NET POSITION		
Invested in capital assets, net of related debt	88.9	99.4
Restricted – expendable for debt service	13.2	13.1
Restricted – nonexpendable for minority interest	0.9	0.9
Unrestricted (deficit)	(246.7)	(29.7)
Total net position	(143.7)	83.7
Total liabilities and net position	$ 317.2	$ 302.3

The following is a summary of the Health System's cash and cash equivalents, funds designated by Board for capital improvements and funds held by trustees as of September 30, 2015 and 2014:

	2015 (in millions)	2014 (in millions)
Cash and cash equivalents	$ 45.0	$ 19.7
Funds designated by Board	0.0	7.9
Held by for debt service and self-insurance funding	15.8	14.5
Total	$ 60.8	$ 42.1

On September 30, 2015 and 2014, the Health System held cash and cash equivalents sufficient to cover approximately 51 (or 63 after GASB 68 pension adjustment) days and 28 days respectively, of non-depreciation expenses, including interest expense.

Acquiring additional cash reserves continues to be an important consideration for the Health System due to the importance placed on cash on hand by credit agencies and bond insurers. Options for accessing capital in the marketplace will continue to be restricted until additional cash reserves are acquired. This will be a particular challenge for the Health System, due to its long-standing efforts to maintain a charge structure that is low relative to the other hospital providers on the Mississippi Gulf Coast. This strategy has been in place for many years in recognition of its role as a community hospital that did not historically place a high strategic priority in the accumulation of cash reserves. The need to maintain state of the art facilities in a high-tech (and high-cost) industry, and pressures to increase wages to remain competitive in the face of national shortages in many healthcare professions, including nursing, have made it particularly challenging to significantly improve the Health System's cash position.

Capital Assets

During fiscal year 2015, net capital assets decreased from approximately $202.2 million to approximately $185.7 million. During fiscal year 2014, net capital assets decreased from approximately $203.7 million to approximately $202.2 million.

The Health System contracted with Epic Systems Corporation as a clinical development partner and vendor for acquisition and further development of an information and decision support system in 2012. This includes a comprehensive electronic health record, on-line clinical orders and documentation, physician order entry, and other applications. The installation and maintenance of these products was accomplished on July 1, 2012 with other applications scheduled to go live through 2016.

Debt Administration

On April 2, 2009, the Health System issued $35,000,000 of Special Obligation Bonds (the Series 2009A bonds) through the Mississippi Development Bank (the "MDB"). The purpose of the bonds was to provide funding for constructing, remodeling, adding to, equipping and furnishing an addition to and expansion of the Health System, funding a debt service reserve fund for the Series 2009A bonds and paying cost of issuance on the Series 2009A

bonds. The bonds consist of $6,455,000 Serial Bonds and $28,545,000 Term Bonds and are at fixed rates ranging from 3.0 percent to 5.625 percent.

On October 27, 2009 the Health System refunded the Series 2008A bonds, outstanding in the amount of $44,000,000, with the Series 2009 B-1 and 2009 B-2 bonds. The Series 2009 B-1 and 2009 B-2 bonds are fixed rate bonds secured by a bond insurance policy provided by Assured Guaranty and a five mill pledge of the assessed real and personal property by Jackson County.

The Series 2009 B-1 and B-2 bonds were issued by the MDB and pay interest semiannually (January 1 and July 1) and principal annually (July 1 with the exception of the 2023 payment which is March 1). The Series 2009 B-1 bonds of $48,340,000 mature on March 1, 2023 and the Series 2009 B-2 bonds of $2,395,000 matured on July 1, 2012.

On July 27, 2011, the Health System issued $36,610,000 of Special Obligation Bonds (the Series 2011 bonds). The purpose of the 2011 bonds is to provide funding for an electronic medical record system, constructing, remodeling, adding to, equipping and furnishing an addition to and expansion of the Health System, funding a debt service reserve fund, paying capitalized interest and paying costs of issuance on the Series 2011 bonds were issued by the MDB and pay interest semiannually (January 1 and July 1) and principal annually (July 1). The bonds consist of $28,255,000 Serial Bonds maturing on July 1, 2023, $4,490,000 of Term Bonds maturing on July 1, 2031 and $3,865,000 of Term Bonds maturing on July 1, 2036 and are at fixed rates ranging from 3.0 percent to 4.375 percent.

The loan agreements between the MDB and the Health System discussed above set certain financial tests including cash availability, debt service coverage and additional indebtedness. These covenants are consistent with other credit providers to the Health System as well as with those of hospital credits of comparable size and financial strength. Certain of these covenants were not met in 2015 and 2014. On July 15, 2014, the loan agreements were amended to state that a failure to comply with the financial covenants set forth in the bond agreements are not events of default. Rather, the amendments provide that the Bond Insurer may determine, at their sole discretion, whether a financial covenant violation constitutes an event of default. Management obtained waivers from the Bond Insurer for these respective violations. In connection with the 2013 waiver, the Bond Insurer required the Health System to engage a consultant to assist in developing a plan to improve the organization and operation of the Health System. The consultant completed this and management began implementing this plan during 2014.

Based upon current forecasted results, management believes the Health System will still not meet these financial covenant requirements at the next measurement dates in fiscal year 2016. Because management does not believe it is probable the Bond Insurer will consider the expected future covenant violations through September 30, 2016 events of default, the principal balances outstanding are classified in the accompanying statements of net position based upon their contractual maturities.

Revenues, Expenses And Changes In Net Position (Statement Of Revenues, Expenses And Changes In Net Position)

Excess margin after interest and depreciation expense for the year when including the pension entries was $61m. As noted above, this is skewed by the recognition of non-cash pension entries related to GASB 68. Excess margin when excluding the pension entries was a gain of approximately $689 thousand.

As strategically planned, Clinics and Behavioral Health have downward trending volume yet upward trending net income. Although the Cardiac division net income dipped slightly in the last quarter due to payor mix, volume continues a general upward trend in that division. The Ocean Springs Cardiac Cath Lab is leading net income favorable trends at approximately $7.4 million, 6% higher than prior year, followed by the Ocean Springs Chemistry Lab at approximately $7.3 million, 10% higher than prior year.

Volumes overall have been on a slight downward trend. Total Patient Service revenue was slightly down in the current fiscal year. Part of the revenue decrease is offset by a more than favorable reduction in expenses, as the Health System renegotiated the Emergency Department contract whereby the Emergency Department physicians bill and collect their own fees instead of the Health System doing the billing and compensation for the physician

group. In spite of volume decreases in some of the better paying service lines, revenue initiatives in the areas of Managed Care have helped bring payments from private payers up. This is negatively offset by the fact that large commercial employers continue to cut benefits, raise deductibles and cover less, putting more of the burden on workers who end up unable to pay. Governmental payments which are our largest payer segment (and now up from 66% to 67% of total discharges) are being reduced by governmental agencies such as Medicare and Medicaid.

While the goal has not been met for the "days cash on hand" bond covenant, for the first time in recent history the bond covenant requirement called "maximum annual debt services" has been met. This metric is calculated as net income available for debt service divided by the maximum annual debt service requirement. The bond covenant requirement is 1.2, and while it has been unfavorably below the requirement for some time, it is finally at a level in compliance with that covenant, at 2.39.

Revenues and Expense

The table below shows revenues, expenses and the changes in net position for fiscal years 2015 and 2014:

	2015	2014
Operating revenues:		
Net patient service revenue	$ 336.7	$ 334.3
Other revenue	15.2	14.7
Total operating revenues	351.9	349.0
Operating expenses:		
Salaries and benefits	97.4	187.4
Professional fees	11.0	17.0
Supplies and other	71.4	73.1
Purchased service	44.1	46.7
Other expenses	37.3	31.2
Depreciation and amortization	24.5	24.4
Total operating expenses	285.7	379.8
Operating income (loss)	66.2	(30.8)
Nonoperating revenues (expenses):		
Investment income	0.3	0.3
Interest expense	(4.9)	(3.5)
Nonoperating expenses, net	(4.6)	(3.0)
Distributions to minority interest	(0.9)	(0.7)
Decrease in net position	$ 60.6	$ (34.7)

The table below shows revenue, expenses and the changes in net positions for fiscal years 2015 and 2014 excluding GASB 68:

	2015	2014
Operating revenues:		
Net patient service revenue	$ 336.7	$ 334.3
Other revenue	15.2	14.7
Total operating revenues	351.9	349.0
Operating expenses:		
Salaries and benefits	157.4	187.4
Professional fees	11.0	17.0
Supplies and other	71.4	73.1
Purchased service	44.1	46.7
Other expenses	37.3	31.2
Depreciation and amortization	24.5	24.4
Total operating expenses	345.7	379.8

Operating income (loss)	6.2	(30.8)
Nonoperating revenues (expenses):		
Investment income	0.3	0.3
Interest expense	(4.9)	(3.5)
Nonoperating expenses, net	(4.6)	(3.0)
Distributions to minority interest	(0.9)	(0.7)
Decrease in net position	$ 0.7	$ (34.7)

Net Patient Service Revenue

Net Patient Service Revenue for the Health System was approximately $336 million in fiscal year 2015, and approximately $334 million in fiscal year 2014.

Effective April 1, 2001, the Division of Medicaid ("DOM") implemented the Upper Payment Limit ("UPL") program. Through participation in the UPL program, the Health System has received gross reimbursement of approximately $16.7 million during 2015 and approximately $17.9 million during 2014. This reimbursement was used to provide services to an increasing number of Medicaid and indigent patients; however, there can be no assurance that the program will not be discontinued. If so, audit will likely be materially modified in the future.

In addition to UPL payments, the Health System received Medicaid DSH payments of approximately $17.9 million and $18.1 million for fiscal years 2015 and 2014, respectively. DSH is designed to provide additional compensation to providers who meet the threshold, where inpatient Medicaid utilization is 75 percent of the state mean. This percentage is subject to change. This is an all or none program, which means that a hospital is either fully in the program or completely excluded based solely on the hospital's Medicaid utilization relative to the threshold. The amount of the reimbursement is calculated by the DOM based on a survey of Mississippi hospitals designed to provide the DOM with data it can use, along with its own information and formulas, to estimate the DSH allocation to each qualifying hospital. There is no guarantee of Health System eligibility in future years. The additional reimbursement received through the DSH program is designed to assist the hospitals in funding costs associated with providing healthcare to the indigent and underinsured.

The system paid an annual assessment of $12.5 million and $11.2 million for fiscal years 2015 and 2014, in order to participate in the Medicaid DSH and DOM UPL program.

The net impact of the above three paragraphs is $22.1 million in 2015 and $24.8 million in 2014, a decrease of $2.7 million.

During fiscal year 2015, payor class percentages were relatively stable; however, private insurance continued to decrease and government sponsored payors like Medicare continued to increase slightly.

Below is a chart comparing payor class percentages for fiscal years 2015 and 2014 based on volume of revenue:

	2015	2014
Medicare	48.9%	47.8%
Medicaid	12.2%	11.5%
Managed care	31.2%	32.0%
Self-pay	7.7%	8.7%
Total	100%	100%

Statistics

- Adult Admissions were flat.
- Emergency Room visits were slightly positive driven by Ocean Springs.
- Outpatient programs visits overall were slightly down.
- Inpatient surgeries were down 2%.
- Outpatient surgeries were down 8% particularly in Pascagoula.
- Deliveries were up 1%.

Inpatient days of care for the Health System decreased by 3 percent, while admissions increased 2 percent during fiscal year 2015 where average length of stay for acute care patients and behavioral health remained the same. During fiscal years 2015, outpatient observation bed days decreased 5.0 percent from fiscal year 2014.

Observation beds are inpatient beds utilized by certain patients for approximately two days or less and reimbursement by Medicare, Medicaid, and most insurance companies at a lower outpatient rate. Observation days were 4,573 and 4,822 for fiscal years 2015 and 2014, respectively.

A summary of inpatient days by service days follows:

	2015	2014
Medical	22,324	21,911
Surgical/orthopedic	14,397	17,610
Psychiatric	5,951	6,089
Maternal child health	10,764	10,280
Intensive and intermediate care	12,216	12,103
General acute care days	65,652	67,993
Rehab	6,352	6,156
Nursery	3,385	3,379
Total all inpatient days	75,389	77,528
Total admissions	17,104	16,817

The Medicare case mix for hospitals is a measure of Medicare inpatient acuity and has an effect on Medicare inpatient payments. Case mix levels have remained steady in fiscal years 2015 and 2014

A summary of Medicare case mix indices follows:

	2015	2014
Singing River Hospital	1.60	1.60
Ocean Springs Hospital	1.67	1.69

Deductions from Revenue

Contractual and other adjustments (excluding charity and bad debts) expressed as a percentage of gross revenues, were 73.6 percent and 73.4 percent for fiscal years 2015 and 2014, respectively.

Bad Debts

Bad debt expense was approximately $111.7 million and $114.3 million in fiscal years 2015 and 2014, respectively. Bad debt expense relates to patients with self-pay balances that do not qualify under the charity guidelines discussed previously and to those patients of which collection for services cannot be obtained.

Operating Expenses

Total operating expenses, including depreciation and amortization, decreased to approximately $285.7 million in fiscal year 2015 down from $379.8 million in fiscal year 2014. Total operating expenses per adjusted discharge decreased 27 percent and 6.4 percent in fiscal years 2015 and 2014, respectively.

Salaries and Wages

During fiscal year 2015, total Health System salaries and wages decreased 8.2 percent over prior year levels. Total full time equivalents (FTEs) decreased across the Health System by 124 FTEs during fiscal year 2015, from 2,407 in fiscal year 2014 to 2,283 in 2015. A significant portion of the benefit expense decrease in 2015 is the result of the $60.0 million contra pension expense recognized in 2015 under GASB 68.

Other Cost Factors

Supplies and pharmaceutical costs decreased approximately 2.3 percent during fiscal year 2015. The Health System participates in national and state group purchasing programs which assured that pricing for products is among the best available. During fiscal years 2015, drug costs benefitted from participation in the Federal 340B drug discount program and the M&D Cares drug replacement program, both of which serve indigent patients.

Labor costs (salaries and benefits) and supplies (including medical supplies, blood products, and pharmaceuticals) combine to account for over 59.0 percent of total operating costs for the fiscal year ending September 30, 2015

Interest expense increased from $3.5 million in 2014 to $4.9 million in 2015 due to a reduction in the amount of interest expense capitalized associated with qualified construction expenditures during 2015.

Cash Flow

While the revenue cycle improvements and optimization are outstanding, if volumes decrease, there will be less money available to collect. Net cash position increased by approximately $1.8 million for the last month of the year, but on the statement of net position and statement of revenues, expenses and changes in net position, it is important to note that some offsetting legal expense was accrued but is not yet paid. Year-to-date net cash provided by operating activities was approximately $36.3 million, versus a negative prior year amount of approximately ($1.5 million), an improvement year-to-date of approximately $37.8 million.

Year-to-date cash collections of $302,038,652 were $39,471 more than prior year in spite of volume in some of the higher paying services being down. Cash paid for labor continues to decrease substantially and is down favorably over approximately $12 million year-to-date. The net Medicaid DSH and UPL payment year-to-date of approximately $22.1 million is down approximately $2.7 million from prior year, and expected to continue to decrease more drastically in future years under the terms of the Affordable Care Act.

Capital expenditures were approximately $1.5 million for the hospitals, approximately $13.1 million or 90% less than prior year and remain at an all-time low, which is not a sustainable trend.

The ICD-10 coding standard has been implemented, which will reduce cash in the short term to all health care entities, but the execution of the conversion is going as successfully as possible. One other threat to the cash flow situation is the status of the 340b pharmacy discount program, which was at one point within two tenths of one percent of falling below the threshold for qualification. It is now at a safer range, but if it does fall out of range it will mean well over approximately $10 million in reduced cash annually.

General Industry Issues

Nationally, many critical issues are having a significant impact on the operations of health systems. The dynamics of provider alignment and the nature of payments are changing drastically. They include but are not limited to the following:

Value Model Risk – The Centers for Medicare and Medicaid Services ("CMS") continues to promulgate various rules and regulations to move traditional fee-for-service payments to alternative delivery models where higher percentages of payments would be based on value metrics. These value metrics include but are not limited to spending per beneficiary, outcome measures such as heart failure and pneumonia rates, patient experience of care measures such as HCAHPS surveys, and various process of care measures.

Lack of Medicaid Expansion – The expected addition of newly-insured Americans as the Patient Protection and Affordable Care Act (PPACAP) rolls out over the next decade might provide a benefit for some hospitals through an increased number of paying patients and a reduced amount of uncompensated care. However, a significant portion of these newly insured patients will be Medicaid recipients and since Mississippians elected not to expand its Medicaid, it will not fully benefit from the PPACA. In contrast to the situation in expansion states, thousands of Mississippians will be denied access to Medicaid coverage.

Medicaid DSH Reduction – The PPACA calls for reductions in Disproportionate Share Hospital (DSH) payments to states and the Health System could be negatively impacted by well over $20 million per year in the future by these reductions.

Shift of Burden of Employees – The emergence of new care payment models and new health plan designs will impact how health systems operate and are paid. The PPACA has increased the degree to which employers have shifted the burden to employees. Consumers are taking on more financial responsibility for their health coverage, both voluntarily and involuntarily through employer health plan structures. These "consumer driven health plans" and "high deductible health plans" will impact how health systems and providers are paid. Healthcare spending is significantly lower for families in high deductible plans compared with families in other types of plans. Families in these plans also cut back on preventive care such as immunizations and cancer screenings even though that care is not subject to a deductible. They initiate fewer episodes of care and spend less per episode. They also spend less on inpatient and outpatient care and prescription drugs, but not on emergency department care, which is both more expensive for them and generally unprofitable for health systems.

Exchange Reimbursements Negative Impact – Health Insurance Exchanges under the PPACA are not being utilized in the manner that was expected by the designers of the program. For those who do participate, the introduction of exchange-purchased plans is shifting more beneficiaries into lower-paying plans with plan reimbursement rates that are significantly lower than traditional employer-sponsored plans. As some Americans use these marketplaces to find coverage, an increasing number of healthcare services will be paid at lower reimbursement rates.

Readmission Penalties – The Readmissions Reduction Program established by the PPACA cut Medicare reimbursement by up to two percent for hospitals with readmission rates.

RAC Reduction – The Federal Recovery Audit Contract ("RAC") program has led to significant challenges for health systems and has resulted in reduced reimbursement each of the past four years. Hospitals and health systems are facing more audits of payment claims, which subject hospitals to additional administrative burden and costly payment denials, most of which are subjected to long, costly and cumbersome appeal processes that the government has sole control of administration.

Bundled Payments Reductions – Medicare has required certain payments to be "bundled" in order to reduce payments. For example, when lab costs are associated with other procedures in the overall encounter, no separate credit is given to the lab cost, the payment is simply bundled based on the overall procedure or diagnosis.

Sequestration Reductions – The Budget Control Act of 2011 established an enforcement mechanism called "sequestration" under which across-the-board spending reductions must be implemented over ten years beginning in 2013. The spending reductions are to be split evenly between defense and non-defense spending, although certain programs (including Medicaid and the CHIP program) are exempt from these automatic spending reductions, and Medicare expenditures were reduced two percent. Each year for the next nine years that the deficit thresholds are reached, similar across-the-board spending reductions could be implemented, and Medicare payments would be similarly reduced. Some private health insurance plans where payments are linked or related to Medicare payment amounts may seek to implement similar payment solutions.

Electronic Health Record Costs – The American Recovery and Reinvestment Act of 2009 provides for Medicare and Medicaid Electronic Health Record (EHR) incentive payments that began in calendar year 2011 for eligible hospitals and professionals that adopt and meaningfully use certified EHR technology. The financial impact of implementing EHR and the application of penalties for not being in compliance are significant. In addition to the cost of capital of these systems, the ongoing maintenance costs are substantial and in some cases exceed the incentives to implement them.

Technological Advancement Costs – The cost of physical medical technology remains very high. With almost every life-saving advance in medicine comes significant additional cost in the form of equipment and/or pharmaceuticals. With the recent national attention placed on patient safety, there is considerable pressure on hospitals to make significant investments in physical medical technology, clinical decision support systems, electronic medical records, and other related applications. Another consequence of this shift is a shortfall of IT talent needed to help healthcare organizations manage their operations, optimize EHRs and make sure of the data. Healthcare organization's IT staff will be forced to deal with things like preparing the organization for ICD-10, continuing work toward Meaningful Use Requirements and implementing IT tools required for risk-based payment and population health management.

ICD-10 Cash Flow Reduction – On October 1, 2015, the ICD-9 code sets used to report medical diagnoses and inpatient procedures were required to be replaced by ICD-10 code sets. One of the most important concerns in the transition from ICD-9 to ICD-10 codes is that there is no simple mapping or translation from the former to the latter. There is some one-to-one correspondence, but often there are one-to-many, many-to-one, many-to many, or no correspondence at all. This conversion will be a major endeavor and will result in some lag time in processing payments accurately by both payors and providers.

Indigent and Uninsured – The number of indigent and uninsured patients remains a significant problem, and the burden of providing this care often falls on hospitals and other providers. These patients are important and should be provided all necessary and appropriate healthcare services; however, the lack of an efficient integrated plan of care, coordinated at the national, state, and local levels, for these patients adds both inefficiency and cost to the healthcare delivery system.

Labor and Supply Cost Impact – Reimbursements from Medicare, Medicaid, and commercial insurers do not increase at the same rate as the cost of labor, supply, and pharmaceutical costs. Drug costs have continued to increase at near double-digit rates for the last several years, and a national shortage of certain healthcare workers coupled with increased demand is increasing wage rates.

Competition – Significant competition for the few remaining profitable areas in healthcare continues to grow. For-profit providers are competing with hospitals for outpatient surgery, laboratory, Magnetic Resonance Imaging (MRI), rehabilitation, and other areas, which historically were provided by hospitals. These competitors typically do not provide the same level of uncompensated care required for a community hospital, nor do they typically provide unprofitable services such as emergency care/trauma or psychiatric care.

Specialist Shortages – There are shortages of certain physician specialists both locally and nationally, and this shortage is expected to grow over the next several years. The issues outlined above, along with many others, result in more difficulties in attracting physicians to certain specialties and also make local recruiting a significant challenge. Most experts also anticipate that as the baby boomer generation continues to age, the demands on the national's healthcare providers will increase.

Malpractice Insurance – Due to a proliferation of malpractice suits across this country, malpractice insurance rates continue to be an issue for hospitals and physicians.

Trauma Cost – Maintaining a comprehensive trauma system continues to be a challenge, particularly in Mississippi, due principally to physician shortages in certain specialty areas such as neurosurgery, insufficient reimbursement for the high costs associated with maintaining a 7-day per week, 24-hour per day emergency department and significant regulatory requirements.

Behavioral Health – The Health System continues to operate a Behavioral Health program as a service to the community. This consists of an adult acute psychiatric unit, a geriatric psychiatric unit, several structured outpatient programs, a crisis intervention program, and physician office practices. The program accounts lose money on a fully-costed basis. A portion of the loss is due to a significant number of Chancery Court ordered commitments, most of which are uncompensated. During fiscal year 2015, the Program accounted for just under $3.3 million in losses with full overhead. This compares to losses of approximately $4.8 million in fiscal year 2014.

Capital Access – Access to capital remains a challenge for many hospitals in the country, particularly public hospitals. Meeting community expectations for high-quality services while maintaining a reasonable charge structure makes it difficult for community safety-net hospitals to generate surplus cash and operating results that meet the high expectations of capital markets.

There are numerous other factors that must be considered in evaluating the financial operations and strategic plan of any healthcare provider. However, it is important to evaluate the performance of any such provider within the context of the industry.

Plan of Operation

In order to improve operations, management implemented a plan to maximize net patient revenue and minimize operating expenses. During 2014, a consultant was engaged to develop a financial plan to reorganize the revenue cycle, including redesign of the patient access and financial services functions, initiation of a formal denials management process, implementation of an enhanced accounts receivable collection strategy, reduction of costs to collect, and process improvement for better charge capture. Another initiative to maximize revenue was launched to negotiate managed care contracts, where the Health System had some significant upside. With respect to operation expense, the management team has been restructured to a more efficient model and the Health System has operationalized a cost reduction plan focused on initiatives ranging from labor productivity, benefits redesign, reorganization of primary care clinic strategy, supply chain management enhancements and others. While all initiatives will be centered around clinical quality as the foundation, it is management's intent for these operational strategies to return the Health System to a positive margin.

Singing River Health System
Statement of Net Position
September 30, 2015

ASSETS AND DEFERRED OUTFLOWS	
Current assets:	
Cash and cash equivalents	$ 45,033,845
Trusteed bond funds - required for current liabilities	2,774,860
Patient accounts receivable, net of allowance for doubtful accounts of $60,150,060	33,713,001
Other receivables	2,014,681
Due from third-party payors	1,991,273
Inventories	4,795,052
Prepaid expenses	1,598,494
Total current assets	91,921,206
Trusteed bond funds	10,486,958
Held by trustee for self-insurance funding	2,510,332
Capital assets, net	185,705,100
Other assets	1,180,777
Total assets	291,804,373
Deferred outflows of resources:	
Pension deferrals	22,437,089
Deferred loss on debt refunding, net	2,961,005
Total deferred outflows of resources	25,398,094
Total assets and deferred outflows of resources	$ 317,202,467
LIABILITIES AND NET POSITION	
Current liabilities:	
Current installments of long-term debt	$ 6,550,000
Current installments of capital lease obligations	1,360,225
Current installments of other long-term liabilities	702,960
Accounts payable	14,695,131
Accrued payroll and employee benefits	18,832,229
Other accrued expenses	1,137,027
Total current liabilities	43,277,572
Long-term debt, excluding current installments	87,809,851
Capital lease obligations, excluding current installments	1,135,077
Other long-term liabilities	1,470,796
Accrued workers' compensation, professional, and general liability costs	8,817,682
Net pension liability	304,455,301
Net postemployment benefit obligation	13,977,882
Total liabilities	460,944,161
Net position:	
Net investment in capital assets	88,849,947
Restricted - nonexpendable for minority interest in blended component unit	869,840
Restricted - expendable for debt service	13,261,818
Unrestricted (deficit)	(246,723,299)
Total net position	(143,741,694)
Total liabilities and net position	$ 317,202,467

See accompanying notes.

Singing River Health System
Statement of Revenues, Expenses, and Changes in Net Position
Year Ended September 30, 2015

Patient service revenues, net of provision for bad debts of $111,699,602	$ 336,685,603
Other revenues	15,239,120
Total operating revenues	351,924,723
Operating expenses:	
Salaries and wages	133,325,340
Employee benefits	(35,931,074)
Professional fees	11,039,444
Supplies	71,391,958
Purchased services	44,103,034
Other expenses	37,254,090
Depreciation and amortization	24,517,262
Total operating expenses	285,700,054
Operating income	66,224,669
Nonoperating revenues (expenses):	
Net investment income	322,486
Interest expense	(4,986,420)
Gain on disposal of capital assets	13,250
Total nonoperating expense	(4,650,684)
Revenues in excess of expenses	61,573,985
Distributions to minority interest	(910,028)
Increase in net position	60,663,957
Net position, at beginning of period (as adjusted)	(204,405,651)
Net position, end of period	$ (143,741,694)

See accompanying notes.

Singing River Health Systems
Statements of Cash Flows
Year Ended September 30, 2015

Cash flows from operating activities:	
Cash received from patients and third-party payors	$ 344,116,550
Cash paid to employees	(161,074,614)
Cash paid to suppliers	(161,343,769)
Cash received from other operating activities	14,565,164
Net cash provided by operating activities	36,263,331
Cash flows from noncapital financing activities:	
Distributions to minority interest	(910,028)
Cash flows from capital and related financing activities:	
Capital expenditures	(3,929,701)
Repayment of long-term debt	(6,280,000)
Repayment of capital lease obligations	(1,227,417)
Repayment of other long-term liabilities	(1,068,900)
Interest paid on long-term debt	(5,079,218)
Net cash used in capital and related financing activities	(17,585,236)
Cash flows from investing activities:	
Proceeds from sale of investments	8,237,016
Net increase in cash and cash equivalents	26,005,083
Cash and cash equivalents, beginning of year	29,211,914
Cash and cash equivalents, end of year	$ 55,216,997
Reconciliation of operating income to net cash provided by operating activities:	
Operating income	$ 66,224,669
Adjustments to reconcile operating income to net cash provided by operating activities:	
Depreciation and amortization	24,517,262
Provision for bad debts	111,699,602
Changes in:	
Patient receivables	(102,696,026)
Estimated third-party payor settlements	(1,572,629)
Inventories and other current assets	(329,325)
Net pension liability	(37,537,663)
Pension deferrals	(22,437,089)
Net post employment benefit obligation	(1,554,619)
Accounts payable and other accrued expenses	(1,534,454)
Accrued workers' compensation, professional, and general liability costs	1,483,603
Net cash provided by operating activities	$ 36,263,331

See accompanying notes.

Reconciliation of cash and cash equivalents to:		
Cash and cash equivalents in current assets	$	45,033,845
Cash and cash equivalents in trusteed bond funds		7,672,820
Cash and cash equivalents in trustee for self-insurance funding		2,510,332
	$	55,216,997
Supplemental disclosure of noncash investing and capital and related financing activities:		
Capital assets acquired through capital lease obligations	$	1,590,542

Notes to Financial Statements

1. Nature Of Operations, Reporting Entity And Summary Of Significant Accounting Policies

Nature of Operations and Reporting Entity

Singing River Health System (the "Health System") is a multidimensional healthcare system consisting of:

- Singing River Hospital, a 435-bed hospital and related outpatient care and other facilities principally in Pascagoula, Mississippi.
- Ocean Springs Hospital, a 136-bed hospital and related outpatient care and other facilities principally located in Ocean Springs, Mississippi.
- Singing River Medical Park and Ocean Springs Medical Park, state-of-the-art outpatient services facilities designed to meet the specific needs of patients outside of the hospital setting. These buildings house radiology and imaging services, cardiac rehabilitation, physical therapy, neurosciences, a branch of The Regional Cancer Center, The Center for Cardiovascular Surgery, and the Health System's Healthplex.
- The Neuroscience Center, which offers the most comprehensive neurosciences program in the region.
- The Regional Cancer Center, which offers a comprehensive and integrated approach to cancer care comprised of expert medical and radiation oncologists, surgeons, radiologists, pharmacists, nurses and dietitians.
- Five primary care clinics located along the Mississippi Gulf Coast in Hurley, Pascagoula (two), Vancleave, Ocean Springs.

The Health System is a component unit of Jackson County, Mississippi, as defined by the Governmental Accounting Standards Board. The Health System's component unit relationship to the County is principally due to financial accountability as defined by the GASB. The Health System is operated by a nine-member Board of Trustees, seven of whom are appointed by the Board of Supervisors of Jackson County, Mississippi. Additionally, the chief-of-staff of the Health System serves on the Board.

Blended Component Units

SRHS Ambulatory Services, Inc. (“SRHSAS”) is a component unit of the Health System and is presented as a blended component unit as of September 30, 2015 in the Health System's financial statements. As the sole member of this not-for-profit organization, the Health System exerts control and has a financial benefit relationship. SRHSAS is operated by a Board of Directors, all of whom are appointed by the Health System's Board. SRHSAS is the 51% owner of two ambulatory surgery centers, Mississippi Coast Endoscopy and Ambulatory Surgery Center, LLC (“MCEASC”) and Ocean Springs Surgical and Endoscopy Center, LLC (“OSSEC”), both of which are presented as blended component units of SRHSAS. All significant intercompany transactions have been eliminated.

Anesthesia Services, LLC, is a component unit of the Health System and is presented as a blended component unit as of September 30, 2015 in the Health System’s financial statements. Anesthesia Services, LLC is a wholly owned subsidiary of the Health System, which provides management, scheduling and billing and collection services to certified registered nurse anesthetists. All significant intercompany transactions have been eliminated.

Budgetary Information

The Health System is required by statute of the State of Mississippi to prepare a non-appropriated annual budget. The budget is not subject to appropriation and is therefore not required to be presented as supplementary information.

Basis of Accounting

The Health System prepares its financial statements as a business-type activity in conformity with the applicable pronouncements of the GASB. The accompanying financial statements of the Health System have been prepared on the accrual basis of accounting using the economic resources measurement focus.

Use of Estimates

The accounting estimates used in the preparation of the financial statements will change as new events occur, as more experience is acquired and as additional information is obtained. Future events and their effects cannot be predicted with certainty; accordingly, our accounting estimates require the exercise of judgment. In particular, laws and regulations governing Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a possibility that recorded estimates related to these programs will change by a material amount in the near term.

Cash and Cash Equivalents

Cash and cash equivalents include investments in highly liquid debt instruments with an original maturity of three months or less when purchased.

Investments and Investment Income

Investments are carried at fair value, principally based on quoted market prices. Investment income from investments is reported as nonoperating revenue.

Patient Accounts Receivable

Patient accounts receivable are reported at net realizable value, after deduction of allowances for estimated uncollectible accounts and third-party contractual discounts. The allowance for uncollectible accounts is based on historical allowances and an analysis of currently outstanding amounts. This account is generally increased by charges to a provision for uncollectible accounts, and decreased by write-offs of accounts determined by management to be uncollectible. The allowances for third-party discounts are based on the estimated differences between the Health System's established rates and the actual amounts to be received under each contract. Changes in estimates by material amounts are reasonably possible in the near term.

Inventories

Inventories, consisting principally of medical supplies and pharmaceuticals, are stated at the lower of cost (first-in, first-out) or replacement market.

Funds Held by Trustees

Funds held by trustees include funds held for debt service and self-insurance funding.

Funds held by trustees for debt service under debt agreements that are required for obligations classified as current liabilities are reported as current assets.

Capital Assets, Net

Capital assets are recorded at cost or, if donated, at fair value at the date of receipt. Depreciation is provided over the useful life of each class of depreciable asset using the straight-line method. Capital assets under capital lease obligations are amortized using the straight-line method over the shorter of the lease term or the estimated useful life of the equipment. Major renewals and renovations are capitalized. Costs for repairs and maintenance are expensed when incurred. When assets are retired or otherwise disposed of, the cost and accumulated depreciation are removed from the accounts and the gain or loss, if any, is included in nonoperating revenues (expenses) in the statements of revenues, expenses and changes in net position.

All capital assets other than land are depreciated or amortized (in the case of capital leases) using these asset lives:

Land improvements	5 - 25 years
Buildings and improvements	10 - 40 years
Fixed equipment	5 - 25 years
Movable equipment	3 - 20 years

Capital assets are reviewed for impairment when service utility has declined significantly and unexpectedly. If such assets are no longer used, they are reported at the lower of carrying value or fair value. If such assets will continue to be used, the impairment loss is measured using a historical cost approach method that best reflects the diminished service utility of the capital asset. No charge related to impairment matters was required during 2015.

Cost of Borrowing

Bond issuance costs are expensed as incurred. Deferred loss on refunding, and bond discounts and premiums are being amortized over the terms of the related indebtedness using the interest method.

Interest cost is capitalized on qualified construction expenditures as a component of the cost of the related projects. No interest cost was capitalized in 2015.

Compensated Absences

The Health System's employees accumulate paid time off, such as vacation, holiday and sick leave, at varying rates depending upon their years of continuous service and their payroll classification, subject to maximum limitations. Upon termination of employment, employees are paid all unused accrued vacation and holiday time at their regular rate of pay up to a designated maximum number of days. Since the employees' vacation and holiday time both accumulate and vest, an accrual for this liability is included in accrued payroll and employee benefits.

Net Position

Net position of the Health System is classified into the following components:

Net investment in capital assets consists of capital assets, net of accumulated depreciation and reduced by outstanding balances of any borrowings used to finance the purchase or construction of those assets. To the extent debt has been incurred but not yet expended for capital assets, such debt is excluded from the calculation of net investment in capital assets.

Net position restricted for debt service is amounts deposited with trustees as required by bond indentures or debt agreements.

Unrestricted net position is remaining net position that does not meet the definition of invested in capital assets, net of related debt or restricted.

Patient Service Revenues

The Health System has agreements with third-party payors that provide for payments to the Health System at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges and per-diem payments. Patient service revenue is reported at estimated net realizable amounts from patients, third-party payors and others for services rendered, and includes estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are considered in the recognition and accrual of revenue 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 Health System provides medical care without charge or at a reduced charge to patients who meet certain criteria under its charity care policy. Because the Health System does not pursue collection of amounts determined to qualify as charity care, these charges are not reported as net patient service revenue and are written off as charity care.

Electronic Health Record Incentive Payments

The American Recovery and Reinvestment Act of 2009 provides for Medicare and Medicaid incentive payments beginning in 2011 for eligible hospitals and professionals that adopt and meaningfully use certified electronic health record ("EHR") technology. The Health System must also attest to certain criteria in order to qualify to receive the incentive payments. The amount of the incentive payments are calculated using predetermined formulas based on available information, primarily related to discharges and patient days. The Health System recognizes revenues related to Medicare incentive payments ratably over each EHR reporting period (October 1 to September 30) when it has demonstrated meaningful use requirements of certified EHR technology for the EHR reporting period. The Health System recognizes Medicaid incentive payments in the period that it qualifies for the funds based on the provisions of the Division of Medicaid ("DOM").

The Health System recognized approximately $303,000 of revenues related to the Medicare incentive program for the year ended September 30, 2015. This revenue is reflected in other operating revenues on the accompanying statement of revenues, expenses and changes in net position.

The Health System's attestation of demonstrating meaningful use is also subject to review by the appropriate government authorities. The amount of revenue recognized is based on management's best estimate, which is subject to change. Such changes would be reflected in the period in which changes occur.

Statements of Revenues, Expenses and Changes in Net Position

For purposes of presentation, transactions deemed by management to be ongoing, major or central to the provision of healthcare services, other than financing costs, are reported as operating revenues and operating expenses. Peripheral or incidental transactions, such as net investment income, interest expense, minority interests, grants from others and gain (loss) on disposal of capital assets, are reported as nonoperating revenues and expenses.

Income Taxes

The Health System is a not-for-profit entity as described in Section 501(c)(3) of the Internal Revenue Code (the "Code") and is exempt from federal and state income taxes on related income pursuant to Section 501(a) of the Code. The Health System is also a political subdivision of Jackson County, Mississippi and is operated as a community hospital under related statutes of the State of Mississippi.

2. Restatement

During the year ended September 30, 2015, the Health System implemented GASB Statement No. 68, *Accounting and Financial Reporting for Pensions – An Amendment of GASB Statement No. 27,* which among other things, established standards for measuring and recognizing liabilities, deferred outflows of resources, deferred inflows of resources, and expenses related to pensions. The standard also expands the disclosure requirements and adds additional supplementary information.

During fiscal 2015, the Health System also corrected immaterial misstatements related to unrecorded accounts receivable and the inclusion of a blended component unit, Anesthesia Services, LLC, as well as an error related to elimination of an intercompany capital lease.

The change in accounting principle and correction of immaterial misstatements resulted in a cumulative effect adjustment to unrestricted net position at October 1, 2014 as follows:

Net position, before cumulative effect adjustment	$ 83,699,069
Change in accounting principle	(288,610,400)
Correction of immaterial misstatement	505,680
Net position, as adjusted	$ (204,405,651)

The correction of an immaterial misstatement resulted in an adjustment to cash and cash equivalents at October 1, 2014 as follows:

Cash and cash equivalents, before adjustment	$ 28,646,010
Correction of immaterial misstatement	565,904
Cash and cash equivalents, as adjusted	$ 29,211,914

3. Patient Service Revenue

The Health System has agreements with governmental and other third-party payors that provide for reimbursement to the Health System at amounts different from its established rates. Contractual adjustments under third-party reimbursement programs represent the difference between the Health System's billings at established rates for services and amounts reimbursed by third-party payors. A summary of the basis of reimbursement with major third-party payors follows:

- Medicare – Inpatient acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates. These rates vary according to the patient classification system that is based on clinical, diagnostic and other factors. Inpatient services are paid under the traditional Part A plan or managed care (Medicare Advantage) negotiated rates under Part C. Outpatient services related to Medicare beneficiaries are reimbursed through a prospective payment system commonly known as Ambulatory Payment Classification ("APC"). Under the APC system, certain medical devices and drugs are reimbursed at cost or average wholesale price. Long-term care services are reimbursed under a prospective payment system that considers the Medicare beneficiaries' severity of illness among other clinical factors. Inpatient non-acute services are paid based on a prospective payment system. The Health System is reimbursed for cost-reimbursable items at a tentative rate, with final settlement determined after submission and review by the fiscal intermediary of annual cost reports. Revenue from the Medicare program accounted for approximately 50 percent of the Health System's net patient service revenue for the year ended September 30, 2015.

- Medicaid – Inpatient and outpatient services rendered to Medicaid program beneficiaries are reimbursed based upon a prospective reimbursement methodology. The Health System is reimbursed at a prospective rate, which is adjusted annually based on published market basket update. Revenue from the Medicaid program accounted for approximately 12 percent of the Health System's net patient service revenue for years ended September 30, 2015.

The Health System participates in the Mississippi Intergovernmental Transfer Program as a Medicaid Disproportionate Share Hospital ("DSH") and in the Medicaid Upper Payment Limit Program ("UPL").

Under these programs, the Health System receives enhanced reimbursement through a matching mechanism. For the year ended September 30, 2015, the Health System received approximately $17,957,000 in enhanced reimbursement through the DSH program. DSH amounts are recorded as a reduction of contractual adjustments. The net benefit to the Health System associated with participation in the UPL program was approximately $4,249,000 for the year ended September 30, 2015. UPL amounts, net of related tax assessments of approximately $12,440,000 for the year ended September 30, 2015 are also shown as a reduction of contractual adjustments. There can be no assurance that the Health System will continue to qualify for future participation in these programs or that the programs will not ultimately be discontinued or materially modified.

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The 2015 revenue increased approximately $1,654,000 due to retroactive adjustments in excess of amounts previously estimated. As of September 30, 2015, cost reports for fiscal years 2012 and prior have been settled. The Health System has also entered into payment agreements with certain commercial insurance carriers and preferred provider organizations. The basis for payment to the Health System under these agreements includes prospectively determined rates and discounts from established charges and prospectively determined per diem rates.

The composition of net patient service revenue are as follows at September 30, 2015:

Gross patient service revenue	$1,840,897,730
Less provision for contractual and other adjustments	(1,392,512,525)
Less provision for bad debts	(111,699,602)
Net patient service revenue	$ 336,685,603

4. Charity Care

The Health System maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone for services and supplies furnished under its charity care policy, the estimated costs of these services and supplies, and equivalent service statistics. Charges foregone, based on established rates, were approximately $41,209,000 for the year ended September 30, 2015. The estimated costs and expenses incurred to provide charity care were approximately $16,346,000 for the year ended September 30, 2015.

5. Capital Assets

Capital assets and related activity consisted of the following for the year ended September 30, 2015:

	Balance September 30, 2014	Additions	Retirements/ Transfers	Balance September 30, 2015
Capital assets not being depreciated:				
Land	$ 7,461,539	$ -	$ -	$ 7,461,539
Construction in progress	1,048,332	3,670,261	(1,051,138)	3,667,455
Total capital assets not being depreciated	8,509,871	3,670,261	(1,051,138)	11,128,994
Capital assets being depreciated:				
Land improvements	6,328,701	56,630	(21,660)	6,363,671
Buildings and improvements	212,454,456	299,804	(12,522)	212,741,738
Fixed equipment	14,446,299	213,910	(149,010)	14,511,199
Movable equipment	244,600,282	2,385,423	(6,296,654)	240,689,051
Total capital assets being depreciated	477,829,738	2,955,767	(6,479,846)	474,305,659
Less accumulated depreciation for:				
Land improvements	3,857,108	268,410	(21,660)	4,103,858
Buildings and improvements	99,590,248	8,254,045	(12,523)	107,831,770
Fixed equipment	12,065,691	352,662	(149,010)	12,269,343
Movable equipment	168,654,988	13,125,022	(6,255,428)	175,524,582
Total accumulated depreciation	284,168,035	22,000,139	(6,438,621)	299,729,553
Capital assets being depreciated, net	193,661,703	(19,044,372)	(41,225)	174,576,106
Capital assets, net	$ 202,171,574	$ (15,374,111)	$ (1,092,363)	$ 185,705,100

Construction in progress as of September 30, 2015 consisted primarily of expenditures associated with the addition of a new patient care floor, renovations to patient care areas, pharmacy, as well as the expansions of the emergency department, labor and delivery, relocation of emergency power system electrical upgrade and capitalized software license and support fees related to the information technology contract described in Note 9. The Health System has associated purchase commitments totaling approximately $14,640,000 at September 30, 2015, which will be funded through grant proceeds and designated funds. Completion dates are expected to range from fiscal 2015 through 2017.

6. Leases

The Health System was obligated under several capital leases at September 30, 2015, scheduled future payments on capital lease obligations are as follows:

	Principal	Interest
2016	$ 1,360,225	$ 119,597
2017	464,896	32,690
2018	387,326	15,501
2019	255,890	10,029
2020	26,965	123
Total	$ 2,495,302	$ 177,940

A schedule of changes in the Health System's capital lease obligation balances for the years ended September 30, 2015, follows:

Description	Rate	Date of Issuance	Balance October 1, 2014	Additions	Retired	Balance September 30, 2015	Due Within One Year
Subsidiary equipment leases							
Facility Development, LLC	7.71%	10/1/2001	$ 1,014,587	$ -	$ (462,896)	$ 551,691	$ 551,691
Hancock Bank	6.00%	3/10/2010	23,007	-	(23,007)	-	-
Hancock Bank	5.25%	5/20/2011	6,576	-	(6,576)	-	-
Hancock Bank	5.25%	4/10/2011	18,439	-	(18,439)	-	-
Hancock Bank	5.25%	12/10/2011	14,301	-	(10,954)	3,347	3,347
Hancock Bank	5.50%	4/10/2012	64,068	-	(39,881)	24,187	24,187
Hancock Bank	5.50%	4/20/2012	35,898	-	(22,368)	13,530	13,530
Hancock Bank	5.25%	12/10/2011	22,980	-	(19,633)	3,347	3,347
Hancock Bank	5.55%	4/10/2012	59,003	-	(54,454)	4,549	4,549
Hancock Bank	5.00%	11/30/2013	334,758	-	(71,736)	263,022	78,641
Hancock Bank	4.50%	2/10/2014	21,294	-	(15,847)	5,447	5,447
Hancock Bank	4.50%	6/20/2014	21,505	-	(12,700)	8,805	8,805
Hancock Bank	5.25%	9/10/2014	139,498	-	(25,265)	114,233	26,517
Hancock Bank	5.00%	12/30/2013	334,758	-	(71,736)	263,022	78,641
Hancock Bank	4.50%	6/20/2014	21,505	-	(12,700)	8,805	8,805
Hancock Bank	5.50%	11/10/2014	-	12,491	(3,133)	9,358	4,357
Hancock Bank	4.25%	5/20/2015	-	20,209	(8,323)	11,886	11,886
Hancock Bank	5.50%	12/17/2014	-	261,680	(35,285)	226,395	49,195
Hancock Bank	4.25%	2/20/2015	-	20,637	(13,667)	6,970	6,970
Hospital equipment leases							
GE Capital	4.20%	12/17/2014	-	663,335	(137,454)	525,881	120,164
GE Capital	4.20%	12/17/2014	-	340,034	(67,971)	272,063	272,063
IBM	2.93%	2/20/2015	-	272,156	(93,392)	178,764	88,083
			$ 2,132,177	$ 1,590,542	$ (1,227,417)	$ 2,495,302	$ 1,360,225

Capital assets totaling approximately $9,071,067 are related to the above capital lease obligations at September 30, 2015. Related accumulated amortization was approximately $6,229,169 at September 30, 2015.

Rental expense for all operating leases was approximately $6,195,000 in 2015. There are no significant noncancelable operating leases at September 30, 2015. Management expects that most lease agreements will be replaced, as they expire, with similar agreements.

7. Cash, Cash Equivalents And Investments

The Health System's bank balances are as follows at September 30, 2015:

Insured by the FDIC	$ 1,000,000
Uninsured, uncollateralized, or collateralized by securities held by the pledging institution or by its trust department or agent in other than the Health System's name	59,917,315
Total	$ 60,917,315
Carrying amount (cash and cash equivalents)	$ 55,216,997

The Health System owns certain investments recorded in trusteed bond funds on the statement of net position. A summary of investments follows for September 30, 2015:

	Value	Percentage	Maturities	Rate	Rating
U.S. Government agency obligations	$ 2,443,838	43.7%	Various	4.8%	N/A
Wachovia repurchase agreement	3,145,160	56.3%	3/1/2023	4.1%	N/A
Total	$ 5,588,998	100.00%			

Investment securities are exposed to various risks such as interest rate, market, and credit risks. The Health System does not have a formal investment policy, but limits its risk by investing primarily in fixed income securities. Custodial credit risk is the risk that, in the event of a bank failure, an organization's deposits may not be returned. The Health System has a deposit policy for custodial credit risk that requires deposits to be collateralized by securities held by the pledging institution or its trust department or agent in other than the Health System's name.

All funds designated by the Board would otherwise be classified as cash, cash equivalents or other current assets, except for the Health System Board's designation of such assets as held for the acquisition of long-term assets or the settlement of long-term obligations. All noncash funds designated by the Board have sufficient liquidity such that, at the discretion of the Health System's Board, they can be converted to cash as necessary.

Various funds were established in accordance with the requirements of the indentures related to the Series 2009A, Series 2009B and Series 2011 Bonds discussed in Note 8. A summary of the funds are as follows for September 30, 2015:

Reserve funds – long term	$ 7,701,820
Principal and interest funds – current	2,774,860
Capital improvement funds – long term	2,785,138
	$ 13,261,818

The reserve funds are generally equal to the maximum annual principal and interest requirements (as defined) for the revenue bonds. The principal and interest funds are for the annual debt service of the revenue bonds. The capital improvement funds represent proceeds of the revenue bonds to be used to fund costs of construction and installation of equipment and facilities. Deposits classified as current assets represent funds to be used to pay debt service and cost of issuance amounts classified as current liabilities at September 30, 2015.

The Health System does not have its own investment strategy; however, being a governmental entity, it follows the guidelines set forth by the State of Mississippi, which include the following:

1. Liquidity – To ensure the ability to meet all expected or unexpected cash flow needs by investing in securities which can be sold readily and efficiently.

2. Cash, money market funds and certificates of deposit that are either appropriately collateralized, insured or issued by investment grade financial institutions.

3. Investment agreements, including guaranteed investment contracts ("GIC"), commercial paper, repurchase agreements and other securities as required by the State of Mississippi.

Investment income is comprised of the following at September 30, 2015:

Dividend and interest income	$ 142,537
Net increase in the fair value of investments	179,949
	$ 322,486

8. Long-Term Debt

A summary of long-term debt based on contractual requirements is as follows at September 30, 2015:

Mississippi Development Bank Special Obligation Bonds – Series 2011	$ 31,700,000
Plus unamortized bond premium	793,486
	32,493,486
Mississippi Development Bank Special Obligation Bonds – Series 2009A	31,580,000
Less unamortized bond discount	(789,018)
	30,790,982
Mississippi Development Bank Special Obligation Refunding Bonds – Series 2009B	31,185,000
Less unamortized bond discount	(109,617)
	31,075,383
	94,359,851
Less current installments, based on contractual terms	6,550,000
Long-term debt, excluding current contractual installments	$ 87,809,851

On April 2, 2009, the Health System issued $35,000,000 of Special Obligation Bonds (the Series 2009A Bonds) through Mississippi Development Bank ("MDB"). The purpose of the bonds was to provide funding for constructing, remodeling, adding to, equipping and furnishing an addition to and expansion of the Health System, funding a debt service reserve fund for the Series 2009A bonds and paying cost of issuance on the Series 2009A bonds. The bonds consist of $6,455,000 of serial bonds and $28,545,000 term bonds bearing fixed rates ranging from 3.0 percent to 5.625 percent secured by a bond insurance policy provided by Assured Guaranty.

On October 27, 2009 the Health System refunded the Series 2008A bonds, outstanding in the amount of $44,000,000, with the Series 2009 B-l and 2009 B-2 bonds. The Series 2009 B-l and 2009 B-2 bonds bearing fixed rates ranging from 2.0 percent to 5.0 percent secured by a bond insurance policy provided by Assured Guaranty and a five mill pledge of the assessed real and personal property by Jackson County.

The Series 2009 B-l and B-2 Bonds were issued by the MDB as fixed interest rate securities and pay interest semiannually (January 1 and July 1) and principal annually (July 1 with the exception of the 2023 payment which is March 1). The Series 2009 B-l Bonds of $48,340,000 mature on March 1, 2023 and the Series 2009 B-2 Bonds of $2,395,000 matured on July 1, 2012.

On July 27, 2011, the Health System issued $36,610,000 of Special Obligation Bonds (the Series 2011 Bonds). The purpose of the 2011 Bonds is to provide funding for an electronic medical record system, constructing, remodeling, adding to, equipping and furnishing an addition to and expansion of the Health System, funding a debt service reserve fund, paying capitalized interest and paying costs of issuance on the Series 2011 Bonds. The bonds are fixed rate bonds secured by a bond insurance policy provided by Assured Guaranty and a five mill pledge of the assessed real and personal property by Jackson County. The Series 2011 Bonds were issued by the MDB and pay interest semiannually (January 1 and July 1) and principal annually (July 1). The bonds consist of $28,255,000 Serial Bonds maturing on July 1, 2023, $4,490,000 of Term Bonds maturing on July 1, 2031 and $3,865,000 of Term Bonds maturing on July 1, 2036 and are at fixed rates ranging from 3.0 percent to 5.375 percent.

As the Health System is a political subdivision of the State of Mississippi and is owned by Jackson County, Mississippi (the "County"), legally available mills have been pledged by the County as additional security for the 2009 and 2011 Revenue Bonds. To date, no such mills have been levied to support these or any other borrowings of the Health System.

Under the terms of the respective loan agreements in connection with the Series 2009 Bonds and Series 2011 Bonds, the Health System is obligated to meet certain financial covenants on March 31st and September 30th of each year, including availability of cash, debt service coverage and limitations on additional debt. On July 15, 2014, the loan agreements were amended to state that a failure to comply with the financial covenants set forth in the bond agreements are not events of default. Rather, the amendments provide that the Bond Insurer may determine, at their sole discretion, whether a financial covenant violation constitutes an event of default.

At September 30, 2015, the Health System was in violation of Section 10.4 of the Loan Agreements, which requires the Health System to maintain 65 days cash on hand. This violation requires the Health System to engage a management consultant and maintain 50 days cash of hand. The Health System subsequently received a waiver of the requirement to engage a management consultant from the Bond Insurer of the 2009 and 2011 bonds. As the Health System maintained greater than 50 days cash on hand at September 30, 2015 there was no event of default.

Through its investment in SRHSAS, the Health System had $1,000,000 and $400,000 line of credit agreements with a bank to finance operating costs. No amounts have been advanced on either line of credit as of September 30, 2015. Interest on both agreements accrues at 5.0 percent. The agreements mature on October 15, 2016.

Debt service requirements associated with the Health System's long-term debt are as follows at September 30, 2015:

	Principal	Interest	Total
2016	$ 6,550,000	$ 4,677,506	$ 11,227,506
2017	6,835,000	4,462,494	11,297,494
2018	7,135,000	4,238,494	11,373,494
2019	7,420,000	4,030,431	11,450,431
2020	7,745,000	3,789,419	11,534,419
2021 – 2025	28,550,000	11,341,484	39,891,484
2026 – 2030	9,145,000	7,342,150	16,487,150
2031 – 2035	11,865,000	4,619,425	16,484,425
2036 – 2040	9,220,000	1,254,206	10,474,206
	$ 94,465,000	$ 45,755,609	$ 140,220,609

A schedule of changes in the Health System's long-term debt balances are as follows for the year ended September 30, 2015:

Description	Date of Issuance	Balance October 1, 2014	Additions	Retired	Balance September 30, 2015	Due Within One Year
Series 2009B	10/27/2009	34,420,000	-	(3,235,000)	31,185,000	3,365,000
Series 2009A	4/2/2009	32,270,000	-	(690,000)	31,580,000	715,000
Series 2011	7/27/2011	34,055,000	-	(2,355,000)	31,700,000	2,470,000
		$100,745,000	$ -	$ (6,280,000)	$94,465,000	$ 6,550,000

9. Information Technology Contract

The Health System entered into a five-year software and services agreement with a major information technology vendor in 2011. The agreement generally commits the Health System to the purchase of a variety of information technology products and services from this vendor for a defined payment stream over the term of the contract. Certain software license and support fees (totaling approximately $13,992,400) were capitalized during fiscal year 2011, with recognition of an associated liability related to the Health System's acquisition of these intangible assets. Such costs are amortized over the estimated useful life of the software beginning as the software is placed in service. Other contract costs are evaluated for capitalization or expense recognition under relevant accounting literature as associated products and/or services are provided.

The following table summarizes the future payment commitments by year under the contract as of September 30, 2015:

2016	$ 436,282
Less amounts representing interest at 4.6 percent	(4,149)
Total obligation	432,133
Less current portion	(432,133)
Long-term obligation (included as other long-term liability in the accompanying 2015 statements of net position)	$ -

Interest paid under the agreement in fiscal year 2015 was $51,428.

The remaining obligation is recorded in current installments of other long-term liabilities on the statement of net position. The following is a summary of the changes in the Health System's long-term obligation for fiscal year 2015:

Balance at October 1	$ 1,586,930
Retired	(1,154,797)
Balance at September 30	$ 432,133

10. Pension Plan

General Information about the Pension Plan

Plan description. The Health System's defined benefit pension plan, Singing River Health System Employees' Retirement Plan and Trust (the "Pension Plan"), provides pensions for certain full-time employees of the Health System that were employed prior to October 1, 2011. The Pension Plan is a single-employer defined benefit pension plan administered by the Health System.

Benefits provided. The Pension Plan provides retirement, disability, and death benefits. Retirement benefits are calculated as a percentage of the employee's highest average monthly salary during any nineteen consecutive quarters of compensation during the forty consecutive quarters of employment immediately preceding the date of termination, plus the last quarter of employment compensation ("Average Monthly Compensation"). Normal retirement benefits are calculated as the sum of a) 1.625 percent of Average Monthly Compensation multiplied by years of credited service, up to twenty years, b) 1.75 percent of Average Monthly Compensation multiplied by years of credited service in excess of twenty years, up to thirty years, c) 2 percent of Average Monthly Compensation multiplied by years of credited service in excess of thirty years. Average Monthly Compensation is reduced by 50 percent in calculating benefits for participants with less than twenty years of service. In no case is the amount of normal retirement benefit to be less than years of credited service multiplied by five dollars.

Employees with ten years of credited service are eligible for normal retirement at age 65, or early retirement at age 60. The amount of early retirement benefit is equal to normal retirement benefit, reduced by 3 percent for each year that commencement precedes the normal retirement date. A participant with thirty years or more of credited service may commence early retirement without any reductions. Employees are eligible for disability benefits after 10 years of service if they are eligible for Social Security Disability. Disability retirement benefits are determined using final average earnings at the date of disability and the amount of service that would have been accrued if the participants worked to the later of the age of sixty or the date of disability, reduced 3 percent for each year that commencement precedes the normal retirement date, up to 15 percent. Death benefits equal the amount that would have been paid had the participant separated from service on the date of death and retired with a 100 percent qualified joint and survivor annuity, reduced 3 percent for each year the date of death precedes the normal retirement date. An employee who terminates service may withdraw his or her contributions, plus any accumulated interest.

Benefit terms provide for annual cost-of-living adjustments subsequent to the employee's retirement date. The annual adjustments are one-half of the change in the Consumer Price Index, limited to a maximum increase in retirement allowance of 2.5 percent

Employees covered by benefit terms. At September 30, 2015, the following employees were covered by the benefit terms:

Inactive employees or beneficiaries currently receiving benefits	618
Inactive employees entitled to but not yet receiving benefits	147
Inactive employees not entitled to benefits but with employee contributions	949
Active employees	1,429
	3,143

Effective October 1, 2011, the Pension Plan was amended to freeze entry to new participants.

Contributions. As a governmental entity, the Health System is exempt from the requirements of the Employee Retirement Income Security Act of 1974, and is otherwise not required by law or statute to make annual contributions to the Plan. The Health System did not make any contributions to the Pension Plan during fiscal 2015.

Through November 2014, active participants were required to contribute 3 percent of annual pay to the Pension Plan. Effective November 20, 2014, the Pension Plan was amended whereby employee contributions ceased subsequent to the first payroll period paid in December 2014.

Net Pension Liability

The Health System's net pension liability was measured as of September 30, 2015, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of October 1, 2014.

Actuarial assumptions. The total pension liability in the October 1, 2014 actuarial valuation was determined using the following actuarial assumptions, applied to all periods included in the measurement:

Cost of living increases	1.25%
Salary increases	2.8%
Investment rate of return	6.5%

Mortality rates were based on the RP-2014 Employee and Healthy Annuitant Mortality Tables, projected generationally with adjustments for mortality improvements based on Scale MP-2014.

The long-term expected rate of return on pension plan investments was determined based on input provided by the investment advisor regarding expected returns and standard deviations by asset class and a decision by the plan sponsor to select a conservative expected return within that model.

Discount rate. The discount rate used to measure the total pension liability at September 30, 2015 was 3.93 percent. The projection of cash flows used to determine the discount rate assumes that employee contributions will not be made in the future and that Health System contributions will be made at actuarially determined rates. Based on those assumptions, the pension plan's fiduciary net position was projected not to be available to make all projected future benefit payments of current active and inactive employees. Therefore, a blended rate of that utilizes the long-term expected rate of return on the Pension Plan investments of 6.5 percent and the twenty-year general obligation Federal Reserve Bond Buyer Index rate ("Muni Bond Rate") of 3.71 percent was applied to all periods of projected benefit payments to determine the total pension liability. The discount rate changed from the rate of 4.11 percent used at the previous measurement date at September 30, 2014 due to changes in the Muni Bond Rate.

Changes in the Net Pension Liability

	Total Pension Liability (a)	Plan Fiduciary Net Position (b)	Net Pension Liability (a) – (b)
Service cost	$ 1,636,685	$ -	$ 1,636,685
Interest	17,939,427	-	17,939,427
Changes in benefit terms	(77,583,377)	-	(77,583,377)
Differences between expected and actual experience	-	-	-
Contributions - employer	-	-	-
Contributions - employee	-	395,038	(395,038)
Net investment income	-	1,750,750	(1,750,750)
Changes of assumptions	22,058,366	-	22,058,366
Benefit payments, including refunds of employee Contributions	(14,368,870)	(14,368,870)	-
Administrative expense	-	(557,024)	557,024
Net change	(50,317,769)	(12,780,106)	(37,537,663)
Balance, beginning of year	492,186,069	150,193,105	341,992,964
Balance, end of year	$441,868,300	$137,412,999	$ 304,455,301

Effective November 20, 2014, the Health System froze benefit accruals for all Pension Plan participants. The effect of the benefit freeze is reflected in the total pension liability at September 30, 2015 and pension expense for the year then ended.

Sensitivity of the net pension liability to changes in the discount rate. The following presents the net pension liability of the Health System, calculated using the discount rate of 3.93 percent, as well as what the Health System's net pension liability would be if it were calculated using a discount rate that is one percentage point lower or one percentage point higher than the current rate:

Sensitivity	Discount Rate	Net Pension Liability
Current discount rate	3.93%	$ 304,455,301
1% decrease in discount rate	2.93%	$ 383,758,913
1% increase in discount rate	4.93%	$ 242,660,737

Pension plan fiduciary net position. Detailed information about the Pension Plan's fiduciary net position is available in the separately issued financial report.

Pension Expense and Deferred Outflows of Resources and Deferred Inflows of Resources Related to Pensions

For the year ended September 30, 2015, the Health System recognized (contra) pension expense of approximately ($59,975,000), which includes the effect of the benefit accrual freeze of approximately $77,583,000. Excluding the effect of this curtailment, pension expense totaled approximately $17,608,000.

At September 30, 2015, the Health System reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Outflows of Resources
Changes of assumptions	$ 16,402,375
Net difference between projected and actual earnings on investments	6,034,714
Total	$ 22,437,089

Amounts reported as deferred outflows of resources and deferred inflows of resources related to the Pension Plan will be recognized in pension expense as follows:

Year ended June 30:	
2016	$ 7,164,670
2017	7,164,670
2018	6,599,071
2019	1,508,678
2020	-
Thereafter	-

11. Postemployment Healthcare Plan

Singing River Health System Postretirement Medical Plan (the "Health Plan") is a single-employer defined benefit healthcare plan sponsored and administered by the Health System. The Health Plan provides medical and drug benefits to eligible retirees and their spouses. The Health System's Board of Trustees is authorized to establish and amend all provisions. The Health System does not issue a publicly available financial report that includes financial statements and required supplementary information for the Health Plan.

Funding Policy

The contribution requirements of employees and the Health System are established and may be amended by the Health System's Board of Trustees. Monthly contributions are required by retirees who are eligible for coverage. The Health System pays for costs in excess of required retiree contributions. The required contribution for the Health Plan is based on projected pay-as-you-go financing requirements. For fiscal year 2015 the Health System contributed approximately $231,461, to the Health Plan. The Health Plan members receiving benefits contributed approximately $355,854 in fiscal year 2015, through their required contributions.

Monthly contributions required by retirees depend on the service period at time of retirement (less than 20 years vs. 20 years or more) and the type of coverage (single or family). For active employees as of February 2011, contributions upon retirement increased starting January 1, 2012 to the full blended premium rates developed by the Health System. Effective January 1, 2014, the contribution rate for all retirees is the same regardless of years served or the date of retirement. The following table summarizes the monthly contribution rates for 2015:

Service	Single	Family
All retirees	$ 900	$ 1,900

Annual OPEB Cost and Net OPEB Obligation

The Health System's annual other postemployment benefit ("OPEB") cost (benefit) is calculated based on the annual required contribution of the employer ("ARC"), an amount actuarially determined in accordance with the parameters of GASB Statement No. 45. The ARC represents a level of funding that, if paid on an ongoing basis, is projected to cover normal cost each year and amortize any unfunded actuarial liabilities (or funding excess) over a period of 6.678 years. The following table shows the components of the Health System's annual OPEB cost for the year, the amount actually contributed to the Health Plan and changes in the Health System's net OPEB obligation:

	2015
Annual OPEB cost (benefit)	$ (1,331,158)
Contributions	(223,461)
Decrease in net OPEB obligation	(1,554,619)
Net OPEB obligation, beginning of year	15,532,501
Net OPEB obligation, end of year	$ 13,977,882

Three-Year Trend Information

Fiscal Year Ended	Annual OPEB cost (Benefit)	Percentage of Annual OPEB cost Contributed	Net OPEB Obligation
September 30, 2013	$ (1,444,161)	(88)	$ 18,118,420
September 30, 2014	(2,245,307)	(15)	15,532,501
September 30, 2015	(1,331,158)	(17)	13,977,882

Funded Status and Funding Progress

As of October 1, 2014, the most recent actuarial valuation date, the actuarial accrued liability for benefits was $0, resulting in an unfunded actuarial accrued liability ("UAAL") of $0. The UAAL is significantly different from the recorded net OPEB obligation at September 30, 2015 due to the increase in retiree premiums and reduction in participants. The net OPEB obligation will continue to be amortized over the expected remaining life of the Health Plan.

Actuarial valuations of an ongoing plan involve estimates of the value of reported amounts and assumptions about the probability of occurrence of events far into the future. Examples include assumptions about future employment, mortality and the healthcare cost trend. Amounts determined regarding the funded status of the Health Plan and the annual required contributions of the employer are subject to continual revision as actual results are compared with past expectations and new estimates are made about the future. The schedule of funding progress, as presented below as required supplementary information, presents multiyear trend information about whether the actuarial value of Health Plan assets is increasing or decreasing over time relative to the actuarial accrued liabilities for benefits.

Actuarial Methods and Assumptions

Projections of benefits for financial reporting purposes are based on the substantive Health Plan (the Health Plan as understood by the employer and the Plan members) and include the types of benefits provided at the time of each valuation and the historical pattern of sharing of benefit costs between the employer and Health Plan members to that point. The actuarial methods and assumptions used include techniques that are designed to reduce the effects of short-term volatility in actuarial accrued liabilities and the actuarial value of assets, consistent with the long-term perspective of the calculations.

In the October 1, 2014, actuarial valuation, the projected unit credit actuarial cost method was used. The actuarial assumptions include a 4 percent investment rate of return (net of administrative expenses), which is a long-term rate of return on general account assets, and retiree premiums are assumed to be equal to gross medical costs beginning January 1, 2014 with no cost to the Health System. The initial UAAL is being amortized over a ten-year period on the level dollar method on an open basis. All additions to the liability, such as annual actuarial gains (losses), are amortized over 10 years.

12. Business And Credit Concentrations

The Health System grants credit to patients, substantially all of whom are local area residents. The Health System generally does not require collateral or other security in extending credit to patients; however, it routinely obtains assignment of (or is otherwise entitled to receive) patients' benefits payable under their health insurance programs, plans or policies (e.g., Medicare, Medicaid, Blue Cross and commercial insurance policies).

The mix of receivables from patients and third-party payors follows:

	2015
Medicare	32%
Commercial insurance	18%
Patients	30%
Blue Cross	11%
Medicaid	9%
	100%

13. Risk Management

Effective October 1, 2003, the Health System implemented a self-insurance program for professional and general liability risks, both with respect to claims incurred after the effective date of the program and claims incurred but not reported prior to that date. The Health System does not maintain any excess coverage for its self-insurance because the Health System is a community hospital organized in accordance with the community statutes of the State of Mississippi and, as such, is afforded sovereign immunity in accordance with the Mississippi Tort Claims Act. Presently, sovereign immunity limits losses to $500,000 per claim. Prior to October 1, 2003, the Health System's insurance coverages for professional and general liability risks were provided under claims-made policies.

Incurred losses identified through the Health System's incident reporting system and incurred but not reported losses are accrued based on estimates that incorporate the Health System's current inventory of reported claims and historical experience, as well as considerations such as the nature of each claim or incident, relevant trend factors and advice from consulting actuaries. The Health System has established a self-insurance trust fund for payment of liability claims and makes deposits to the fund in amounts determined by consulting actuaries.

The self-insurance liability for professional and general liability is included in the accrued workers' compensation, professional, and general liability costs line item on the statement of net position. The following is a summary of changes in the Health System's self-insurance liability for professional and general liability costs for fiscal year 2015:

Balance at October 1, 2014	$ 4,444,000
Provisions for claims reported and claims incurred but not reported	2,095,682
Claims paid	(312,000)
Balance at September 30, 2015	$ 6,227,682

Like many other businesses, the Health System is exposed to various risks of loss related to torts; theft of, damage to and destruction of assets; business interruption; errors and omissions; employee injuries and illness; natural disasters and professional and general liability claims and judgments. Commercial insurance coverage is purchased for most claims arising from such matters. Claims settled through September 30, 2015 have not exceeded this commercial coverage in any of the three preceding years.

Prior to 2003, the Health System purchased insurance to cover workers' compensation claims. During 2003, the Health System purchased high-deductible workers' compensation insurance, which had the effect that the Health System is largely self-insured.

The self-insurance liability for workers' compensation claims is included in the accrued workers' compensation, professional, and general liability costs line item on the statement of net position. The following is a summary of changes in the Health System's self-insurance liability for worker's compensation coverages for fiscal year 2015:

Balance at October 1, 2014	$ 2,890,000
Provisions for claims reported and claims incurred but not reported	504,904
Claims paid	(804,904)
Balance at September 30, 2015	$ 2,590,000

The Health System is self-insured for employee health coverage up to a limit of $500,000 per individual claim. The Health System maintains coverage with a third-party carrier for excess losses up to $1 million (specific lifetime reimbursement per covered person).

The self-insurance liability for employee health coverage is included in the accrued payroll and employee benefits line item on the statement of net position. The following is a summary of changes in the Health System's self-insurance liability for employee health coverage for fiscal years 2015:

Balance at October 1, 2014	$ 3,314,781
Provisions for claims reported and claims incurred but not reported	23,939,102
Claims paid	(24,361,312)
Balance at September 30, 2015	$ 2,892,571

14. Blended Component Unit Reporting

The Condensed Combining Statement of Net Position, Condensed Combining Statement of Revenue, Expenses and Changes in Net Position and the Condensed Combining Statement of Cash Flows as of and for the year ended September 30, 2015, are detailed below:

Condensed Combining Statement of Net Positon:

	SRHS	SRHSAS	Anesthesia Services, LLC	Eliminations	Combined
Assets:					
Current assets	$ 84,986,264	$ 6,679,113	$ 1,272,764	$ (1,016,935)	$ 91,921,206
Capital assets	175,377,834	10,327,266	-	-	185,705,100
Other assets	28,360,930	-	-	(14,182,863)	14,178,067
Total assets	288,725,028	17,006,379	1,272,764	(15,199,798)	291,804,373
Total deferred outflows of resources	25,398,094	-	-	-	25,398,094
Total assets and deferred outflows	$ 314,123,122	$ 17,006,379	$ 1,272,764	$ (15,199,798)	$ 317,202,467
Current liabilities	$ 41,767,053	$ 1,929,393	$ 1,025,091	$ (1,443,965)	$ 43,277,572
Long-term liabilities	416,842,764	1,108,453	-	(284,628)	417,666,589
Total liabilities	458,609,817	3,037,846	1,025,091	(1,728,593)	460,944,161
Net position:					
Net investment capital assets	80,041,276	8,097,013	-	711,658	88,849,947
Restricted	13,261,818	869,840	-	-	14,131,658
Unrestricted	(237,789,789)	5,001,680	247,673	(14,182,863)	(246,723,299)
Total liabilities and net position	$ 314,123,122	$ 17,006,379	$ 1,272,764	$ (15,199,798)	$ 317,202,467

Condensed Combining Statement of Revenues, Expenses, and Changes in Net Positon:

	SRHS	SRHSAS	Anesthesia Services, LLC	Eliminations	Combined
Net patient service revenue	$ 324,688,041	$ 9,639,235	$ 2,358,327	$ -	$ 336,685,603
Other revenues	15,460,077	(8,959)	4,039,740	(4,251,738)	15,239,120
Total revenues	340,148,118	9,630,276	6,398,067	(4,251,738)	351,924,723
Depreciation	23,449,945	1,067,317	-	-	24,517,262
Other operating expenses	252,299,797	6,486,597	6,436,862	(4,040,464)	261,182,792
Total operating expenses	275,749,742	7,553,914	6,436,862	(4,040,464)	285,700,054
Operating income	64,398,376	2,076,362	(38,795)	(211,274)	66,224,669
Nonoperating revenues (expenses)	(3,605,126)	(342,043)	-	(703,515)	(4,650,684)
Distributions to minority interest	-	(910,028)	-	-	(910,028)
Change in net position	60,793,250	824,291	(38,795)	(914,789)	60,663,957
Net position, beginning of period	(205,279,945)	13,144,242	286,468	(12,556,416)	(204,405,651)
Net position, end of period	$ (144,486,695)	$ 13,968,533	$ 247,673	$ (13,471,205)	$ (143,741,694)

Condensed Combining Statement of Cash Flows:

	SRHS	SRHSAS	Anesthesia Services, LLC	Eliminations	Combined
Net cash provided (used) by operating activities	$ 32,944,715	$ 3,401,711	$ 450,774	$ (533,869)	$ 36,263,331
Net cash used by noncapital financing activities	-	(910,028)	-	-	(910,028)
Net cash provided (used) by capital and related financing activities	(16,448,762)	(1,670,343)	-	533,869	(17,585,236)
Net cash provided by investing activities	8,237,016	-	-	-	8,237,016
Net increase in cash and cash equivalents	24,732,969	821,340	450,774	-	26,005,083
Cash and cash equivalents, beginning of year	24,258,103	4,387,906	565,905	-	29,211,914
Cash and cash equivalents, end of year	$ 48,991,072	$ 5,209,246	$ 1,016,679	$ -	$ 55,216,997

15. Recent Reporting And Disclosure Developments

Accounting Pronouncements Issued Not Yet Adopted

The Health System will adopt GASB No. 72, *Fair Value Measurement and Application* in fiscal year 2016. This statement defines fair value and provides guidance for determining a fair value measurement for financial reporting purposes and also provides guidance for applying fair value to certain investments and disclosures related to all fair value measurements.

16. Risks And Uncertainties

Current Economic and Regulatory Conditions

The current economic environment continues to present hospitals with unprecedented circumstances and challenges. These conditions, including factors such as the unemployment rate, have made it difficult for certain of the Health System's patients to pay for services rendered. As employers make adjustments to health insurance plans putting more of the burden for the cost of health care on employees, or as more patients become unemployed, services provided to self-pay and other payers may significantly impact net patient service revenue, which could have an adverse impact on the Health System's future operating results. Other factors such as the Health System's responsibility to absorb the costs of care for indigent and uninsured, increases in labor and supply costs, heightened competition, specialist shortages, and rising insurance costs could also have an impact.

The effect of regulatory changes, including programs like the Centers for Medicare and Medicaid Services ("CMS") Value Based Purchasing Program, lack of Medicaid expansion in Mississippi, reductions in Disproportionate Share Hospital (DSH) payments to states like Mississippi under the Patient Protection and Affordable Care Act and the Health System (PPACA), Health Insurance Exchanges under the PPACA shifting more beneficiaries into lower-paying plans with plan reimbursement rates that are significantly lower than traditional employer-sponsored plans, the Readmissions Reduction Program established by the PPACA which cut Medicare reimbursement by up to two percent, the Federal Recovery Audit Contract ("RAC") program which subjects hospitals to long cumbersome appeal processes for perfectly valid claims, Value Based Payment Program reductions implemented by Medicare, Medicaid, and certain insurers to put payments to providers at varying levels of risk, Bundled Payments reductions where certain costs like lab costs are associated with other procedures in the overall encounter must be absorbed by the hospital with no separate credit given for those services, Sequestration Reductions which reduce Medicare payments by two percent, and other regulatory changes could have an adverse impact on the Health System's future operating results. The accompanying financial statements have been prepared using values and information currently available to the Health System.

Other Uncertainties

Currently, there are nine state court actions pending in the Chancery Court, fifteen court actions in Circuit Court, and three Federal Court actions pending pertaining to the Health System and the Pension Plan. Six of the state cases aimed to prevent the Health System from terminating the Pension Plan via a permanent injunction while two of the other state court actions allege violations of the Mississippi Uniform Trust Act, among other allegations. In addition, three putative class action lawsuits have been filed against the Health System and others in Federal Court alleging a variety of causes of action including Breach of Contract, and fiduciary allegations. The complaints seek monetary relief and in some instances injunctive relief which could prevent termination of the Pension Plan. Currently, the Health System will continue to pay all the retirees as set forth in the Pension Plan, thereby preventing any further action from the Health System to terminate the Pension Plan during this period. The ultimate outcome in these matters cannot be reasonably determined as of the date of the financial statements.

The Health System is also involved in various other litigation arising in the normal course of business. Based on consultations with legal counsel, management is of the opinion that these matters will be resolved without material adverse effect on the Health System's future financial position or the results of its future operations, to the extent determinable.

Supplementary Information

DIXON HUGHES GOODMAN LLP

Independent Auditor's Report On Internal Control Over Financial Reporting And On Compliance And Other Matters Based On An Audit Of Financial Statements Performed In Accordance With *Government Auditing Standards*

Board of Trustees
Singing River Health System
Gautier, Mississippi

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in Government Auditing Standards issued by the Comptroller General of the United States, the financial statements of the business-type activities of Singing River Health System (the "Health System"), as of and for the year ended September 30, 2015, and the related notes to the financial statements, which collectively comprise the Health System's basic financial statements, and have issued our report thereon dated December 30, 2015.

Internal Control over Financial Reporting

In planning and performing our audit of the financial statements of Health System") we considered the Health System's internal control over financial reporting (internal control) as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Health System's internal control. Accordingly, we do not express an opinion on the effectiveness of the Health System's internal control.

Our consideration of internal control was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies, and therefore material weaknesses or significant deficiencies may exist that were not identified. However, as discussed below, we identified certain deficiencies in internal control that we consider to be significant deficiencies.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect and correct misstatements on a timely basis. A material weakness is a deficiency or combination of deficiencies in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected on a timely basis. We did not identify any deficiencies in internal control that we consider to be material weaknesses.

A significant deficiency is a deficiency or a combination of deficiencies in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance. We consider the following deficiencies in the Health System's internal control to be significant deficiencies:

- Prior to the current year audit, Anesthesia Services, LLC was not being consolidated as a blended component unit. We recommend including the Anesthesia Services, LLC accounts and appropriate eliminations in the internal consolidating financial statements during close out procedures.

- Anesthesia Services, LLC does not record patient accounts receivable and revenues on an accrual basis. Receivables/payables to intercompany entities are recorded when cash is received. DHG recommends implementing procedures to either (1) record receivables/revenues on accrual basis each month, or (2) calculate the appropriate period ending receivables/revenues and make a top-side entry to convert the entity to the accrual basis prior to consolidation.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Health System's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Dixon Hughes Goodman LLP

Birmingham, Alabama
December 30, 2015

Singing River Health System
Schedule of Changes in Net Pension Liability and Related Ratios
Years Ended September 30, 2015 and 2014

	2015	2014
Total pension liability:		
Service cost	$ 1,636,685	$ 9,301,301
Interest	17,939,427	19,601,873
Changes in benefit terms	(77,583,377)	-
Differences between expected and actual experience	-	(10,574,128)
Changes of assumptions	22,058,366	70,788,607
Benefit payments, including refunds of employee contributions	(14,368,870)	(12,507,174)
Net change in total pension liability	(50,317,769)	76,610,479
Total pension liability - beginning of year	492,186,069	415,576,590
Total pension liability - end of year	441,868,300	492,187,069
Plan fiduciary net position:		
Contributions - employer	-	-
Contributions - employee	395,038	3,158,856
Net investment income	1,750,750	14,796,956
Benefit payments, including refunds of employee contributions	(14,368,870)	(12,508,174)
Administrative expense	(557,024)	(370,020)
Other	-	-
Net change in plan fiduciary net position	(12,780,106)	5,077,618
Plan fiduciary net position - beginning of year	150,193,105	145,115,487
Plan fiduciary net position - end of year	137,412,999	150,193,105
Net pension liability - end of year	$ 304,455,301	$ 341,993,964
Plan fiduciary net position as a percentage of total pension liability	31.1%	30.5%
Covered-employee payroll	86,061,783	86,397,101
Net pension liability as a percentage of covered-employee payroll	353.8%	395.8%

Notes to Schedule:
Benefit changes - In November 2014, benefit terms were modified to freeze benefit accruals for all participants.

Changes of assumptions - In fiscal 2015, amounts reported as changes in assumptions resulted primarily from changes in the discount rate, due to changes in benchmark municipal bond index rates.

Singing River Health Systems
Schedule of Surety Bonds for Officers and Employees
September 30, 2015

Name	Position	Company	Amount of Bond
Lawrence H. Cosper	Trustee	Western Surety Company	$ 10,000
Ira S. Polk	Trustee	Western Surety Company	$ 10,000
Michael J. Heidelberg	Trustee	Western Surety Company	$ 10,000
Scott Taylor	Trustee	Western Surety Company	$ 10,000
Michael D. Tolleson	Trustee	Western Surety Company	$ 10,000
Tommy L. Leonard	Trustee	Western Surety Company	$ 10,000
Stephen Nunemacher	Trustee	Western Surety Company	$ 10,000
Kevin Holland	Chief Executive Officer	Western Surety Company	$ 10,000
Lee Bond	Chief Financial Officer	Western Surety Company	$ 10,000