HOSPITAL AUTHORITY OF ALBANY-DOUGHERTY COUNTY

MINUTES OF THE NOVEMBER 13, 2014 MEETING

(Open Session)

Attendees:

Authority Board Members: Ralph Rosenberg; Dr. Charles Lingle; John Hayes; Lamar Reese; Fred Ghiglieri; Dr. Michael N. Laslie; Ferrell Moultrie; and Joel Callins. Legal Counsel: James E. Reynolds, Jr. and E. B. Wilkin, Jr.; Accountant: Lin Harris. Also present on behalf of Phoebe Putney Memorial Hospital, Inc. were: Joel Wernick; Kerry Loudermilk; Thomas Chambless; Joe Austin; Tom Sullivan and others

Recorder, Mary Barfield.

Absent Authority Members:

Dr. Edward J. Vance, Jr. (Pre-existing schedule conflict)

Open Meeting and Establish a Quorum:

Chairman Rosenberg called the meeting to order at 7:30 A.M. in the Willson Board Room of Phoebe's Main Campus. Chairman Rosenberg thanked all the members for their attendance and participation and he observed that a quorum was clearly present with eight Members being in attendance.

Approval of the Agenda:

The proposed Agenda had been previously provided to the Authority Members and a motion to adopt the proposed Agenda for the meeting was made by Lamar Reese and seconded by Fred Ghiglieri, which motion was approved by all Authority Members.

Approval of Minutes:

The proposed minutes of the open session of the August 21, 2014 meeting of the Authority had likewise been provided to Members prior to this meeting and the same were considered for approval. Dr. Lingle made a motion and Dr. Laslie seconded the motion to approve the Minutes as previously provided. The motion passed unanimously by vote of all Members in attendance.

Budget and Financial Reports for the Authority:

Kerry Loudermilk, CFO of Phoebe Putney Memorial Hospital, Inc., presented a proposed (12) month Budget for the Hospital Authority for its FYE 2015 (copy attached). The proposed Budget for the Authority showed revenues of $100,000 and $250,000 in expenses making for an operating income loss of $150,000. Non-operating income is budgetted at $200,000 resulting in net income of $50,000. After discussions and questions, Mr. Ghiglieri made a motion, seconded by Mr. Reese, to approve and adopt the Authority 2015 Budget as presented. Mr. Loudermilk also presented internally prepared financials for the Authority.

Mr. Lin Harris presented the audited Financial Statements for the Authority, prepared by Draffin & Tucker, for the Authority's fiscal years ending July 31, 2014 and 2013. Following discussions and questions, Mr. Reese made a motion, seconded by Dr. Lingle, to approve the Authority's audited Financial Statements, a copy of which is attached.

The above motions concerning the 2015 Budget and the Audited Financials were each unanimously passed by vote of the Members in attendance.

CEO Report:

Mr. Wernick reported to the Authority on behalf of the Hospital, including a presentation on the family medicine residency program and the new physician housing project and the impact of such programs on recruitment of healthcare professionals for our community. A copy of a portion of Mr. Wernick's presentation is attached.

Closing of the Meeting:

A motion was made by Mr. Moultrie and seconded by Dr. Lingle to close the meeting in order to consult with legal counsel pertaining to pending or potential claims and litigation and to discuss potentially commercially valuable plans or strategies that may be of competitive advantage in the operation of the Hospital or its medical facilities.

Mr. Rosenberg polled each individual Authority Member present with respect to his vote on the motion and each of the Members shown below voted to close the meeting, with no Member opposing:

Ralph Rosenberg	Yes
Dr. Charles Lingle	Yes
Fred Ghiglieri	Yes
Ferrell Moultrie	Yes
Lamar Reese	Yes
John Hayes	Yes
Dr. Michael Laslie	Yes
Joel Callins	Yes

The motion having passed, the meeting closed.

Open Session Reconvened:

Following unanimous vote of all Members in attendance, the meeting reopened at approximately 9:15 A.M.

Additional Business:

Mr. Rosenberg proposed that a Resolution be prepared on behalf of the Authority in recognition of the many years of community service provided by Jeff Sinyard and Jack Stone, each of whom was stepping down from the County Commission. A motion was made by Mr. Gighlieri, seconded by Mr. Hayes, that such a Resolution be prepared and presented to Mr. Stone and Mr. Sinyard.

Adjournment:

The meeting was adjourned at 9:30 A.M.

Mary Barfield

Mary Barfield, Recorder

AGENDA

HOSPITAL AUTHORITY OF ALBANY-DOUGHERTY COUNTY, GEORGIA

(OPEN SESSION)

Meeting of November 13, 2014
(Willson Board Room)

I.	Open meeting and establish quorum	Ralph Rosenberg
II.	Consider Approval of Agenda	Ralph Rosenberg
III.	Consideration of Open Session Minutes of August 21, 2014 meeting (draft previously provided to Members)	Ralph Rosenberg
IV.	Internally prepared Financial Reports for Authority, proposed Authority Budget for FYE 2015 and Audited Authority Financial Statements for FYE 7/31/2014	Kerry Loudermilk/ Lin Harris
V.	Phoebe Putney Memorial Hospital, Inc., CEO and Operational Reports, including 2014 annual update	Joel Wernick
VI.	Consider and vote to close meeting for purposes of: (i) engaging in privileged consultation with legal counsel; (ii) to discuss potentially valuable commercial plans, proposals or strategy that may be of competitive advantage in the operation of Phoebe Putney Memorial Hospital or its medical facilities, and (iii) to discuss confidential matters or information pertaining to peer review or provided by a review organization as defined in O.C.G.A §31-7-131.	Ralph Rosenberg/ Jay Reynolds
VII.	Additional Business, if any	Ralph Rosenberg
VIII.	Adjournment	Ralph Rosenberg

Financial Report

Kerry Loudermilk, CFO

FINANCIAL HIGHLIGHTS

HOSPITAL AUTHORITY OF ALBANY-DOUGHERTY COUNTY, GA

FISCAL YEAR ENDING JULY 31, 2015

Proposed Budget

Operating Summary	Actual
Revenues	$100,000
Net Operating Revenue	$100,000
Expenses	250,000
Operating Income (Loss)	($150,000)
Non-Operating Income	200,000
Net Investment Income (Loss)	0
Net Income	$50,000

FINANCIAL HIGHLIGHTS
HOSPITAL AUTHORITY OF ALBANY-DOUGHERTY COUNTY, GA
FISCAL YEAR ENDING JULY 31, 2015

Operating Summary	October 31, 2014 Year-to-Date Actual
Revenues	$24,999
Net Operating Revenue	$24,999
Expenses	13,117
Operating Income (Loss)	$11,882
Operating Income (Loss)	$11,882
Non-Operating Income	0
Investment Income	0
Interest Expense	0
Net Investment Income (Loss)	0
Net Income	$11,882

HOSPITAL AUTHORITY
BOARD MEETING

THURSDAY, NOVEMBER 13, 2014

Commission on Cancer®

Accredited Cancer Program Performance Report for

Phoebe Putney Memorial Hospital

Albany, GA

Facility Identification Number **6380010**

Accreditation Award:

3 YR with Commendation

Survey Performed: **8/14/2014**

Surveyed by: **Peter Scott Hopewood, MD, FACS**

Next Survey Due: **0**

Accreditation Details	
Total number of standards rated - Compliant	27
Total number of standards rated - Non-compliant	0
Total number of standards rated - Not applicable	1
Total number of standards rated - Commendation	6
Accreditation Award	3 YR with Commendation

Rural hospitals in critical condition

ACA ACCELERATES DEMISE OF RURAL HOSPITALS THAT SERVE MANY OF SOCIETY'S MOST VULNERABLE.

Jayne O'Donnell and Laura Ungar, USA TODAY

Introduction

A MATTER OF TIME

SHARE THIS STORY

RICHLAND, Ga. — Stewart-Webster Hospital had only 25 beds when it still treated patients. The rural hospital served this small town of 1,400 residents and those in the surrounding farms and crossroads for more than six decades.

But since the hospital closed in the spring of last year, many of those in need have to travel up to 40 miles to other hospitals. That's roughly the same distance it takes to get from Times Square to Greenwich, Conn., or from the White House to Baltimore, or from downtown San Francisco to San Jose.

Those trips would be unthinkable for city residents, but it's becoming a common way of life for many rural residents in this state, and across the nation.

Since the beginning of 2010, 43 rural hospitals — with a total of more than 1,500 beds — have closed, according to data from the North Carolina Rural Health Research Program. The pace of closures has quickened: from 3 in 2010 to 13 in 2013, and 12 already this year. Georgia alone has lost five rural hospitals since 2012, and at least six more are teetering on the brink of collapse. Each of the state's closed hospitals served about 10,000 people — a lot for remaining area hospitals to absorb.

The Affordable Care Act was designed to improve access to health care for all Americans and will give them another chance at getting health insurance during open enrollment starting this Saturday. But critics say the ACA is also accelerating the demise of rural outposts that cater to many of society's most vulnerable. These hospitals treat some of the sickest and poorest patients — those least aware of how to stay healthy. Hospital officials contend that the law's penalties for having to re-admit patients soon after they're released are impossible to avoid and create a crushing burden.

"The stand-alone, community hospital is going the way of the dinosaur," says Angela Mattie, chairwoman of the health care management and organizational leadership department at Connecticut's Quinnipiac University, known for its public opinion surveys on issues including public health.

CHAPTERS

SHARE

The closings threaten to decimate a network of rural hospitals the federal government first established beginning in the late 1940s to ensure that no one would be without health care. It was a theme that resonated during the push for the new health law. But rural hospital officials and others say that federal regulators — along with state governments — are now starving the hospitals they created with policies and reimbursement rates that make it nearly impossible for them to stay afloat.

Low Medicare and Medicaid reimbursements hurt these hospitals more than others because it's how most of their patients are insured, if they are at all. Here in Stewart County, it's a problem that expanding Medicaid to all of the poorest patients — which the ACA intended but 23 states including Georgia have not done, according to the federal government — would help, but wouldn't solve.

"They set the whole rural system up for failure," says Jimmy Lewis, CEO of Hometown Health, an association representing rural hospitals in Georgia and Alabama, believed to be the next state facing mass closures. "Through entitlements and a mandate to provide service without regard to condition, they got us to (the highest reimbursements), and now they're pulling the rug out from under us."

For many rural hospitals, partnering with big health systems is the only hope for survival. Some have resorted to begging large hospitals for mergers or at least money to help them pay their bills. But Douglas Leonard, president of the Indiana Hospital Association, said these days, "I'm not sure they can get anyone to answer the phone when they call."

County and town council members, hardly health care experts, are faced with life or death (or least injurious) decisions on whether to raise taxes in poor towns and counties that depend on their hospitals for care as well as good jobs. Some rural hospitals, even their advocates acknowledge, are in such bad shape and serve so few people that they probably don't deserve to stay open. But what about those still providing good and needed care? In those cases, rural residents lose out.

There's a "golden hour" after heart attacks, trauma and stroke in which treatment is needed to prevent loss of heart muscle and brain tissue, says Janis Orlowski, chief medical officer for the Association of American Medical Colleges.

Stewart County EMS on a run in downtown Richland, Ga. The two ambulances are often tied up making the average 90-mile round trip to the nearest hospital.

(Photo: Michael A. Schwarz, USA TODAY)

With just two ambulances, which are often tied up making the average 90-mile round trip to the nearest hospital, "We're pretty much shot around here with the golden hour," says Ed Lynch, Stewart County's director of emergency medical services.

"It's never OK for these people to get lower quality medical care," says Orlowski, a practicing nephrologist (kidney doctor) and former hospital chief operating officer. "We're a big enough country to figure this out."

Chapter 1

'WE SAVED LIVES'

Dozens of rural hospitals have closed since 2010 due in part to the Affordable Care Act. Members of one small south Georgia town share how the closure of their local hospital has negatively affected their community.

The ambulance got to Walter Skellie in plenty of time in September. But the 45-minute ride to the nearest hospital since Stewart-Webster closed was so long he became violently ill. He had two strokes hours later.

Skellie, 59, who had to do rehab for balance and numbness issues after his strokes, was out of work for more than a month. "If the hospital had been down there, the doctors on call could have stabilized me," Skellie says. "I'm not saying the stroke wouldn't have happened, but I would have gotten medical attention a lot sooner."

Peanut and cotton farmer Buren "Bill" Jones, 52, died of a heart attack a month after Stewart-Webster closed. His family had to wait about 15 minutes for an ambulance to take him to a hospital 22 miles away, where doctors couldn't revive him. The closed hospital was 9 miles from his house, a distance his wife or daughter — who performed CPR on him at home — might have driven.

Stewart County Coroner Sybil Ammons says the deaths of at least one other heart attack patient and a stabbing victim would likely have been prevented if their local hospital was open. She says the stress Skellie's violent vomiting in the ambulance likely increased pressure on his brain and probably made the strokes more severe.

CHAPTERS

SHARE

"We saved lives," says Ammons, who was a nurse at the Stewart-Webster. "We saved a

lot of lives."

Many U.S. counties had no hospitals after the Great Depression and World War II. But the 1946 Hill-Burton Act sought to change that with grants and loans for the construction of new hospitals. The number of hospitals soared, creating the backbone of today's modern health system.

Department of Health and Human Services Secretary Sylvia Burwell, in office since June, grew up in rural West Virginia and says she is "particularly acutely focused on" the challenges facing rural hospitals. More Medicaid expansion would go a long way toward addressing them, she said in a news briefing in October.

After consulting with the National Governors Association, HHS awarded $100 million to states in July so they could provide grants for technical support to help doctors and hospitals reform health care delivery for people on Medicaid, she says. Change, including a move to costly electronic health records required under the ACA, can be difficult, and Burwell says HHS will "work to incorporate feedback" from rural hospitals on how it's going.

"Transition takes time," she said.

But the $1 million or more it was going to cost to change over to electronic records was one of the last straws for Randy Stigleman, former owner of Stewart-Webster. Efforts to sell the hospital never panned out.

Walter Skellie recovers at his Richland, Ga., home after suffering strokes following his 45-minute ride to the nearest hospital earlier this fall. He recently returned to work.

(Photo: Michael A. Schwarz, USA TODAY)

The anger residents feel toward Stigleman is palpable here in Richland. He appeared to shut the hospital down suddenly — giving them only a week's notice. But Stigleman says he just couldn't put any more money into the hospital.

While mergers and partnerships with large health systems are one way for hospitals to survive, "once they look at the demographics of Richland, nobody's going to give you money," he says.

Even if they aren't regularly filling their beds, rural hospitals are typically among the largest employers in their areas. Stewart-Webster, with its 75 employees, was only topped by a large immigrant holding prison. Once a hospital closes, it usually takes other businesses with it — and thwarts efforts to attract more, city and county officials say.

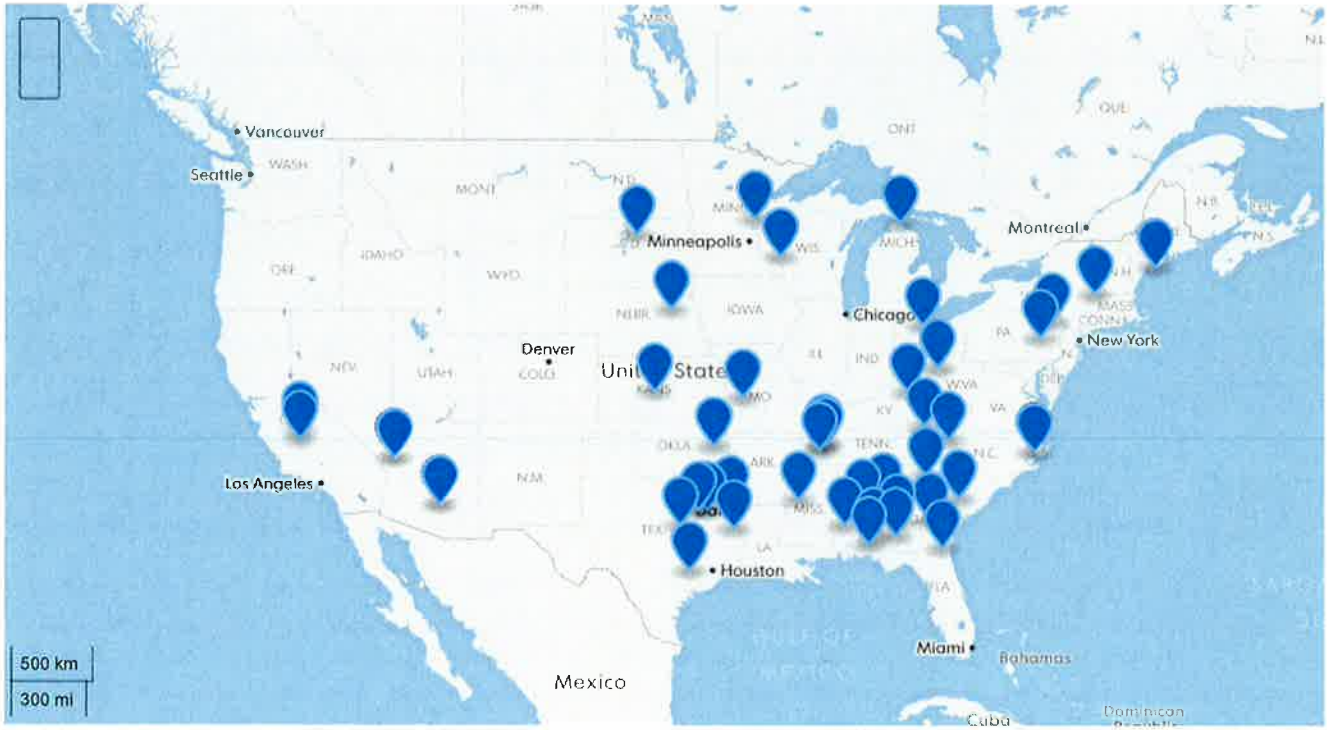
Richland Mayor Adolph McLendon says two dollar-type stores in town closed, and the local Subway shop left, since the hospital shut down. When he's not trying to find investors to help him open another health care facility, the 74-year-old mayor is often trying to attract new businesses.

Half of the rural hospitals that shuttered since early 2010 closed completely. Many of the rest now operate as rehabilitation and nursing facilities, or outpatient clinics. A few operate as emergency departments or 24-hour urgent care centers, offering some — but far from all — the services the former hospitals did. But Lewis and others say that while these 24-hour facilities could stabilize stroke or heart attack victims before they head on to larger hospitals, they are even less financially viable, given the poor, uninsured populations they serve and the fact that emergency rooms are the most expensive parts of hospitals.

Here in Stewart County, and across the U.S., officials repeatedly describe a "perfect storm" of cuts in reimbursement and tougher regulations under ACA, especially those that penalize them when they have to re-admit patients and require them to use electronic health records.

RURAL HOSPITALS CLOSING ACROSS U.S.

More than 40 rural hospitals have closed in the U.S. since January 2010. These facilities, which treat some of the nation's poorest patients, are hurt by Medicare and Medicaid funding losses and changes in federal regulation.



CREDITS Mitchell Thorson, George Petras and Karl Gelles, USA TODAY
SOURCE Cecil G. Sheps Center for Health Services Research

It's a storm that's swept through several states:

CHAPTERS

SHARE

• Tennessee: Three hospitals have closed or stopped offering inpatient services since January, and "our concern is there's going to be many more," says Craig Becker, president of the Tennessee Hospital Association. When a hospital closes, he says, the ripples reach far beyond, sometimes pushing out physician practices, pharmacies and other medical companies.

He says the states' decision not to expand Medicaid puts Tennessee hospitals at a disadvantage because they are still getting hit with government cuts that assumed all states would expand the program.

• Kentucky: Even expanding Medicaid couldn't save Nicholas County Hospital. The state's new Medicaid managed-care system brought slower-than-ever reimbursements — which were low anyway because most patients had government insurance.

Ultimately, Lois Gates, chairwoman of the hospital board, says it couldn't maintain a 24-hour ER, had to cut staff, and was $2.3 million in debt when it shut down in May. A sign near the empty emergency room says: "This facility is CLOSED. If you need immediate care call 911" and gives the locations of the closest ERs — nearly 20 miles away on winding country roads.

"We were trying to keep it open any way we can," said Mike Pryor, the county's judge-executive.

• Indiana: Many of the state's small hospitals are teetering, two recently closed, and one filed for bankruptcy, says Leonard, of the state hospital association. The state has 30 "critical access hospitals," which receive preferable reimbursement under the federal Medicare program — currently 99% of "reasonable" inpatient and outpatient costs. These hospitals have 25 beds or less, are almost always located in rural areas, and must be at least a 35-mile drive from the nearest hospital, or a 15-mile drive in mountainous or other hard-to-travel regions.

• Colorado: While none of the state's 49 rural hospitals have closed, a handful are "on the watch list," says Gail Finley of the Colorado Hospital Association. She says almost any hospital closing in Colorado would strand patients, since some hospitals are the only ones for 35 to 100 miles.

Chapter 3

EXPENSES KEEP GROWING

The day before USA TODAY visited Elbert Memorial Hospital in Elberton, Ga., this fall, the hospital had to borrow $200,000 from a hospital partner so it could make payroll. A month earlier, after contentious debate — and an ER visit for heart attack symptoms by a council member — the county council voted to pass a $500,000 property tax increase to fund the hospital.

CHAPTERS

The Tuesday morning visit found George Amah , a more expensive kind of temporary ER doctor, working a 24-hour shift, but with no current patients: "It can be really busy or really quiet," he says.

SHARE

Amah works for a contract company that guarantees 24/7 physician coverage. Elbert CEO Jim Yarborough says he has to pay that company more than he would for staff doctors, but he can't attract enough staff for round-the-clock coverage because so few want to work in rural areas.

Upstairs in a renovated room, Greg Willoughby , a beefy former truck driver now on disability, is one of the only signs of patient life this late September morning. He's recuperating from cellulitis, a potentially life-threatening bacterial skin infection. "I hope they don't ever go out of business," Willoughby says. "What would happen to people who have heart attacks and a lot worse conditions than I have?"

While providing a large share of care for the poor, rural hospitals also face growing expenses for staff, equipment and especially facilities, many of which are not up to code because they were built so long ago.

"There's kind of a tipping point when they can't afford the repairs and may need new buildings," Finley says.

Greg Willoughby, 46, was disoriented from cellulitis when he had his daughter bring him to the ER in late September. He was admitted and appreciated the well-appointed rooms in the renovated Elbert Memorial Hospital in Elberton, Ga. "My bathroom needs some sprucing up," he jokes. But mostly he worries what would happen to neighbors with even more serious conditions.

(Photo: Jayne O'Donnell, USA TODAY)

As of June 30, there were 1,326 critical access hospitals across the USA — which critics argue is too many. A study last year by HHS' Office of Inspector General found two-thirds of these hospitals wouldn't meet location requirements if they had to re-enroll in Medicare today, and most wouldn't meet distance requirements, either. The study recommended that hospitals be dropped from the program unless their Medicare patients "would otherwise be unable to reasonably access hospital services." In a new report on high Medicare costs at these hospitals, the OIG again recommended some hospitals be dropped earlier this month, a move that Lewis said "would be a killer of killers" for rural hospitals.

Meanwhile, as this debate continues in Washington, it's having consequences in local communities.

The fate of hospitals is left in the hands of county boards in Stewart, Elberton and Lavonia counties, which represent a cross-section of those working in the few businesses that remain. They include chicken farmers, granite company salesmen, a fertilizer salesman, a pastor and a few other "good old boys," as Elberton-Elbert County Hospital Authority Board Chairman Jim Lloyd calls them.

When it comes to complicated health care issues, asks Orlowski. "How can the local townspeople, no matter how good they are, make the decisions?"

Chapter 4

IS SELF-INTEREST TO BLAME?

Belhaven, N.C., Mayor Adam O'Neal walked 273 miles to Washington in July to protest the closing of the local Vidant Pungo Hospital July 1. Though he blamed state officials for not expanding Medicaid, much of his ire was directed at Vidant Health, which acquired the hospital and then closed it a couple of years later. He says the company reneged on a deal that would have kept the hospital open and decided instead to expand facilities elsewhere and open a 24-hour clinic. Vidant says the town didn't have a viable plan to keep the hospital open.

Big companies aren't rushing out to buy these hospitals, either.

In Kentucky, officials hoped Nicholas County Hospital would be saved when one of the state's largest health care companies, KentuckyOne Health, took over a three-year management affiliation from its predecessor. Matt Gibson, KentuckyOne's vice president of strategy and business development, says his company did a lot to aid the hospital, such as helping it pass an accreditation and recruit advanced practice nurses.

Buying the hospital "is something that we evaluated, but it didn't fit with our strategic plan," Gibson says, particularly with health care moving to outpatient care.

"I guess they saw how financially unstable it was," says Gates, of Nicholas County.

The majority of the nation's hospitals — big and small — are nonprofit, meaning they must provide community benefit in exchange for tax exemptions. As such, big companies "do have a responsibility to help, although they need to remain solvent themselves," Kentucky State Auditor Adam Edelen says.

If something isn't done soon, Edelen says, many more patients will suffer. In his state, rural hospitals serve nearly half the population — one stabilized his father when a farming accident mangled his hand. And Pryor, the Nicholas County judge-executive, says his community's now-closed hospital saved his father's life twice after heart attacks.

"I have heard our little hospital called a Band-Aid station," says Mike Pryor, judge-executive of Nicholas County Ky., which lost its small, rural hospital in May. "But that little Band-Aid station saved my father's life two times after heart attacks."

(Photo: Matt Goins, for USA TODAY)

> "I don't want to be in a Kentucky where a farmer has to bleed out in a field because he doesn't have access to a rural hospital, or a woman with a troubled pregnancy can't get the help she needs to deliver a healthy baby," Edelen says.

Edelen's office decided to do "financial stress tests" on 66 rural hospitals there and has sponsored 10 packed public hearings on the topic that have attracted residents, hospital officials and employees.

In addition to such grass-roots efforts, advocates say government can do more; state legislatures can adopt policies that bolster small hospitals, and the federal government can pay Medicare and Medicaid providers at least their costs and revamp the critical access program in light of the ACA.

But they say none of these are magic bullets, and true solutions are likely as varied as the myriad affected communities in the nation's vast rural expanses.

O'Donnell reported from Georgia and McLean, Va.; Ungar, who also reports for The (Louisville) Courier-Journal, reported from Kentucky. Database reporter Meghan Hoyer contributed to this report.

PHOEBE

Student Physician Housing on the campus of Phoebe Putney Memorial Hospital in Albany, Georgia

A proposal to help increase the number of rural primary care physicians to better serve the growing population of Southwest Georgia

February 2014

One of the biggest challenges facing Southwest Georgia is the recruitment of physicians – especially primary care.
The New England Journal of Medicine ranked these states as having the biggest challenge of building enough primary care capacity by 2014:

1. Oklahoma

2. Georgia

3. Texas

4. Louisiana

5. Arkansas

6. Nevada

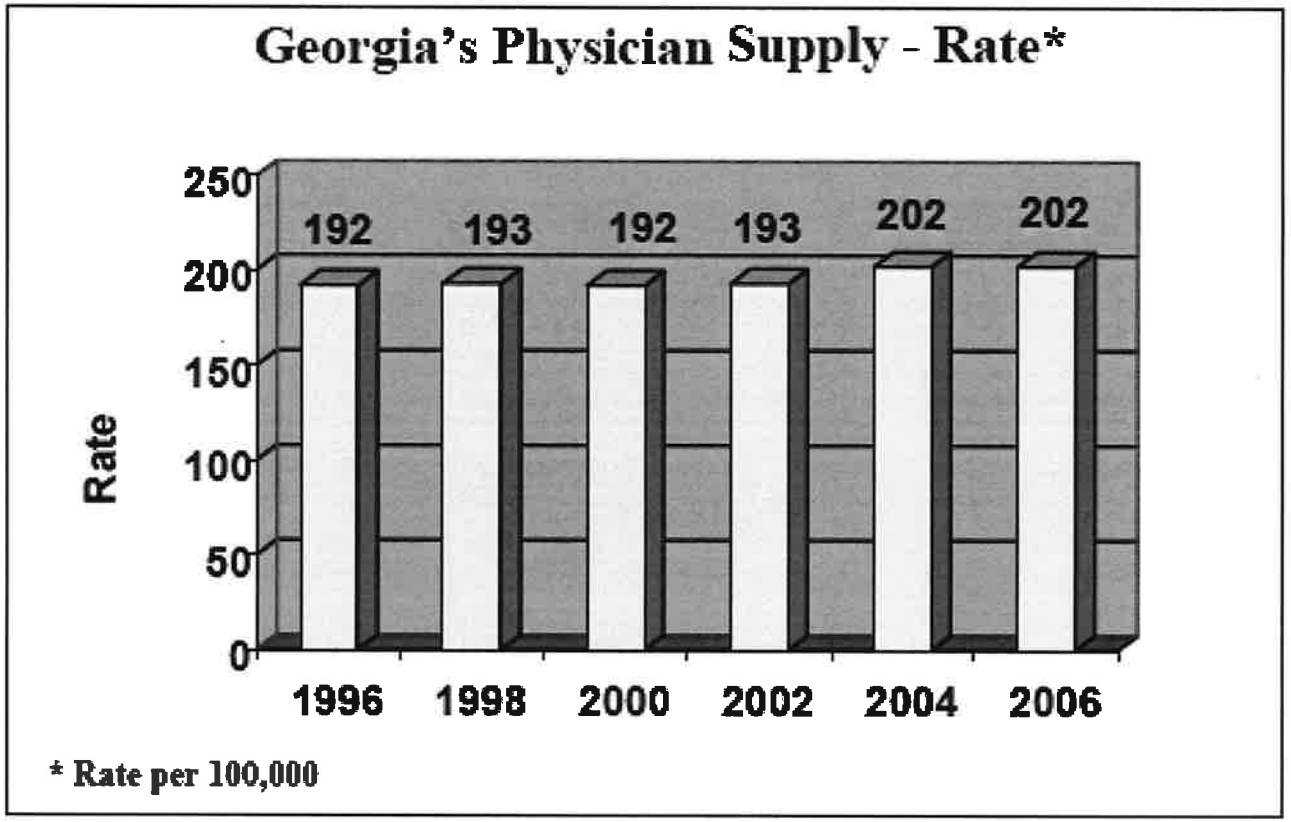
7. North Carolina

8. Kentucky

9. Alabama

10. Ohio

For every 100,000 people, Georgia has only 202 physicians

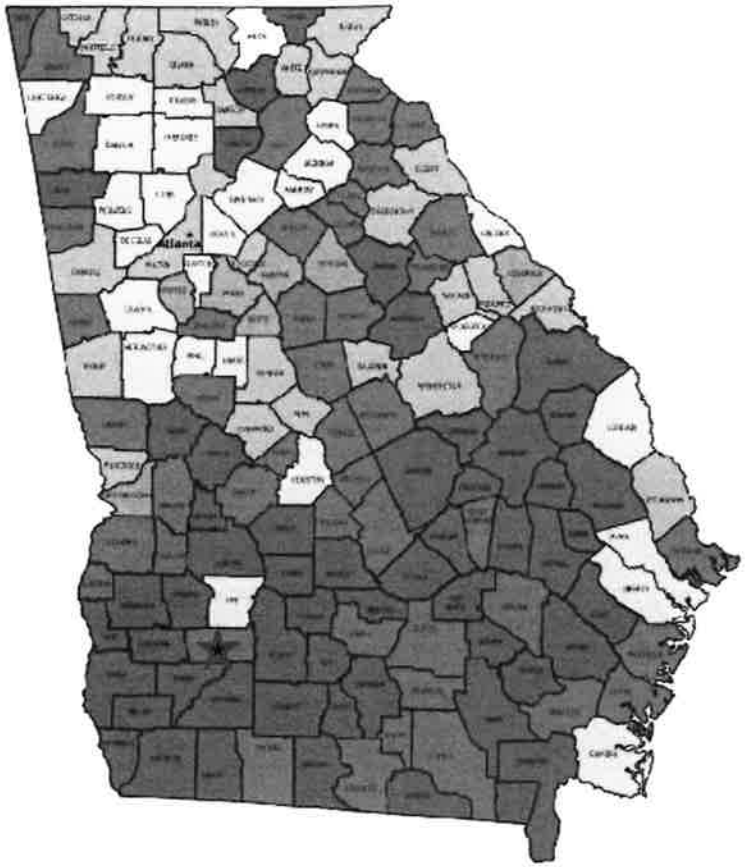


Source: Georgia Board for Physician Workforce -December 2008

The state currently ranks 41st in the nation for the number of physicians per 100,000 population and projections show Georgia will fall about 5,000 physicians short of needed levels by 2030.

With a third of all doctors projected to retire this decade and not enough upcoming physicians to fill the gaps, the emerging doctor shortage in Georgia could become critical.

Georgia's Health Disparities Socioeconomic Summary Grades

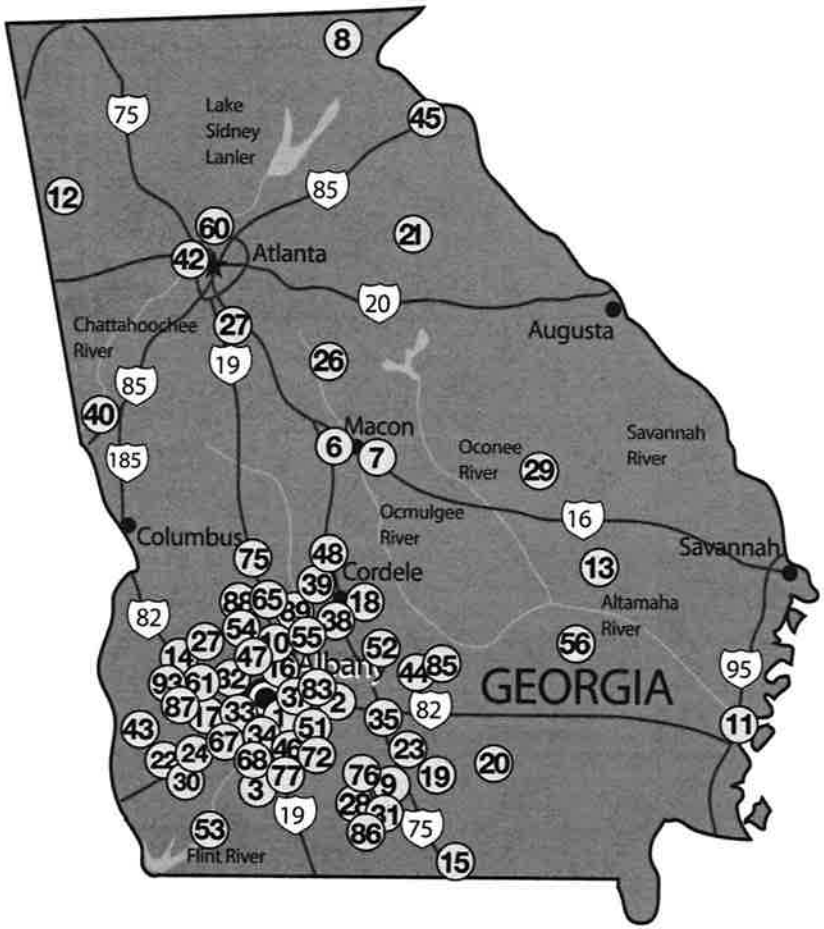


- Not graded (1) *
- A (7)
- B (25)
- C (25)
- D (47)
- F (54)

* The minority population is not represented in significant numbers to effectively assign a grade.

Factors include health behavior, clinical care, physical environment, and social and economic factors, which include the percentage of children in poverty, unemployment and education rates. (2012)

Practice Locations of Southwest Georgia Family Residency Program graduates



The Southwest Georgia Family Medicine Residency program currently accepts six residents in each class, comprising a full complement of eighteen residents. The program aims for the 60/60 rule, a goal that 60 percent of our graduates will practice within 60 miles of Albany. To date, we've met and exceeded that goal. Currently, about 70 percent practice within a 100-mile radius after graduating from the program.

70% of new physicians practice where they are trained

SOUTHWEST GEORGIA
FAMILY MEDICINE RESIDENCY

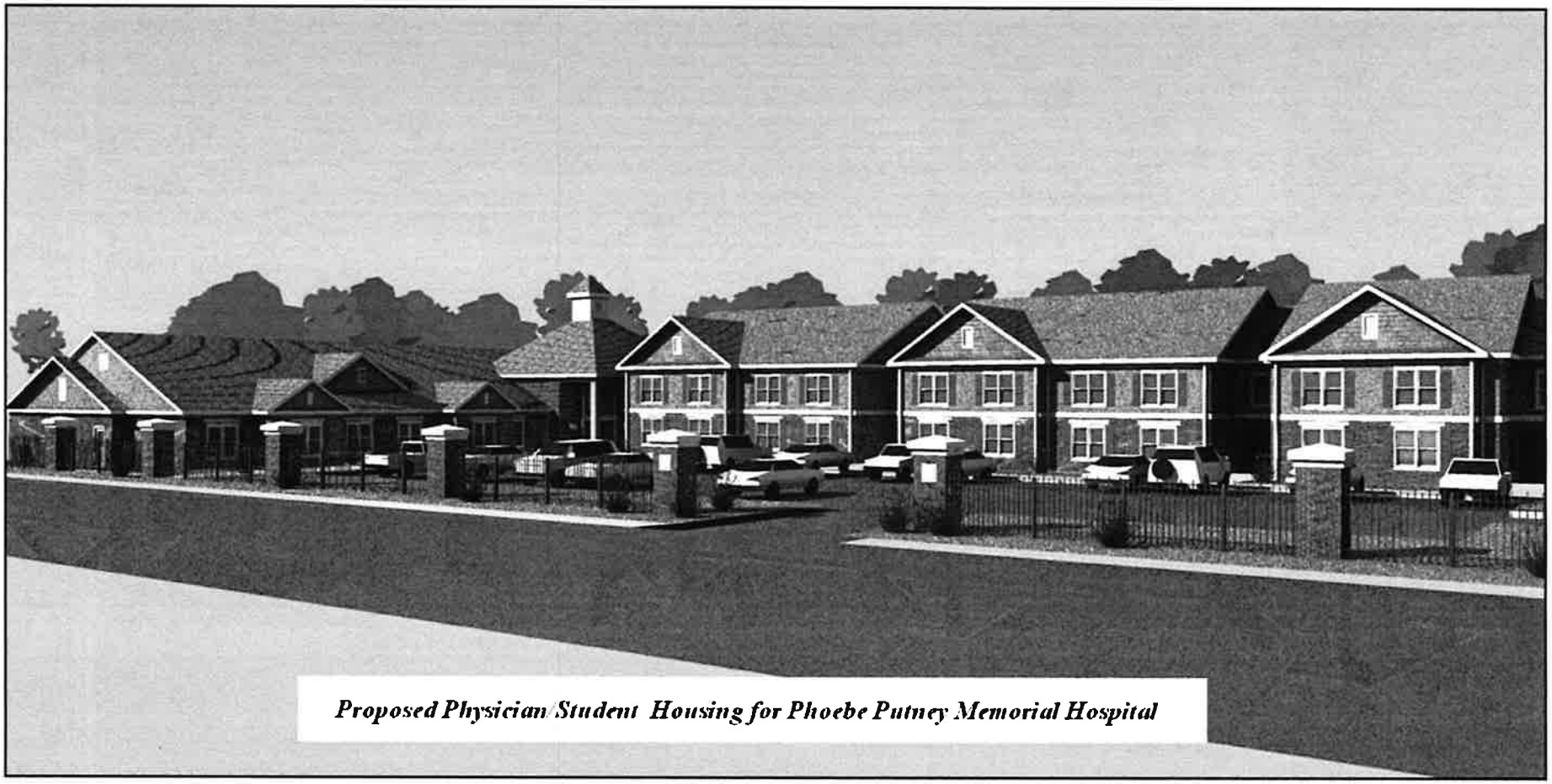
First off-site MCG clinical campus

MCG School of Medicine expansion will place 3rd and 4th year medical students at Phoebe.

SOUTHWEST GEORGIA FAMILY MEDICINE RESIDENCY

Medical and Allied Health Training includes:

- Southwest Georgia Regional Family Medicine Residency Program
- MCG Clinical Campus
- UGA Pharmacy Training Program
- Pathways - AHEC



Proposed Physician/Student Housing for Phoebe Putney Memorial Hospital

A vital resource that has been identified to help meet this need is

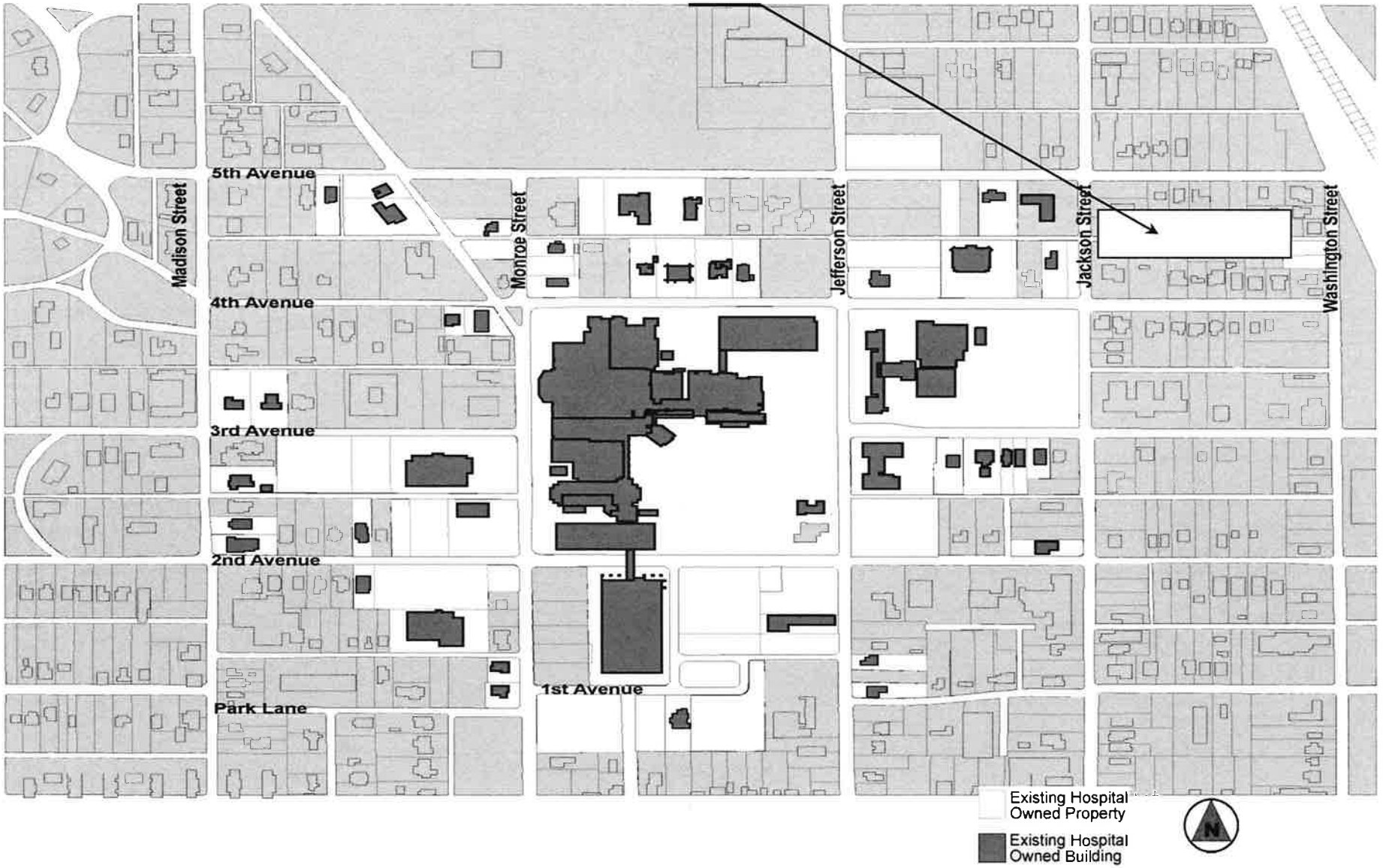
to offer

Student Physician Housing

on the Phoebe Putney Memorial Hospital campus

Resident Housing

Proposed Site



Projected cost of the project is $5 million. Phoebe Putney has the capacity to match donations up to $2.5 million. In addition, PPMH has reserve of up to $1 million to apply to upkeep and maintenance of this property.

The land has been procured, and once the amount of $2.5 million has been raised construction can begin.

Proposed Physician Student Housing for Phoebe Putney Memorial Hospital

HOSPITAL AUTHORITY OF ALBANY-DOUGHERTY COUNTY, GEORGIA

FINANCIAL STATEMENTS

for the years ended July 31, 2014 and 2013

CONTENTS

Draffin & Tucker, LLP
CERTIFIED PUBLIC ACCOUNTANTS

Member:
THE AMERICAN INSTITUTE OF
CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT

Board of Directors
Hospital Authority of Albany-Dougherty
County, Georgia
Albany, Georgia

We have audited the accompanying financial statements of Hospital Authority of Albany-Dougherty County, Georgia (Authority), which comprise the balance sheets as of July 31, 2014 and 2013, and the related statements of revenues, expenses, and changes in net position, and cash flows for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

Continued

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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 Authority'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 Authority'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 Hospital Authority of Albany-Dougherty County, Georgia as of July 31, 2014 and 2013, and the results of its operations and changes in net position and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matter

Management has omitted the Management's Discussion and Analysis that accounting principles generally accepted in the United States of America requires to be presented to supplement the basic financial statements. Such missing information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of the financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. Our opinion on the basic financial statements is not affected by this missing information.

Draffin + Tucker, LLP

Albany, Georgia
November 13, 2014

HOSPITAL AUTHORITY OF ALBANY-DOUGHERTY COUNTY, GEORGIA

BALANCE SHEETS, July 31, 2014 and 2013

	2014	2013
ASSETS		
Assets:		
Cash	$ 193,001	$ 213,343
Contributions receivable from Phoebe Putney Memorial Hospital, Inc.	150,000	500,000
Total assets	$ 343,001	$ 713,343
LIABILITIES AND NET POSITION		
Liabilities:		
Accounts payable	$ 264,047	$ 754,620
Net position:		
Unrestricted	78,954	(41,277)
Total liabilities and net position	$ 343,001	$ 713,343

See accompanying notes to financial statements.

HOSPITAL AUTHORITY OF ALBANY-DOUGHERTY COUNTY, GEORGIA

STATEMENTS OF REVENUES, EXPENSES AND
CHANGES IN NET POSITION
for the years ended July 31, 2014 and 2013

	2014	2013
Operating revenues:		
Lease revenue	$ 100,000	$ 100,000
Operating expenses:		
Purchased services and other	329,859	2,239,744
Operating loss	(229,859)	(2,139,744)
Nonoperating revenues:		
Contributions from Phoebe Putney Memorial Hospital, Inc.	350,090	1,693,400
Gain on long-term lease	-	2,910,545
Total nonoperating revenues	350,090	4,603,945
Excess revenues	120,231	2,464,201
Net position, beginning of year	(41,277)	(2,505,478)
Net position, end of year	$ 78,954	$(41,277)

See accompanying notes to financial statements.

HOSPITAL AUTHORITY OF ALBANY-DOUGHERTY COUNTY, GEORGIA

STATEMENTS OF CASH FLOWS
for the years ended July 31, 2014 and 2013

	2014	2013
Cash flows from operating activities:		
Funds paid to Georgia Department of Community Health:		
Indigent Care Trust Fund	$(3,567,004)	$(3,676,472)
Upper payment limit	(778,802)	(1,502,937)
Funds received from Georgia Department of Community Health:		
Indigent Care Trust Fund	10,469,631	10,152,546
Upper payment limit	2,278,942	4,390,135
Lease revenue	100,000	-
Transfer of funds received from Georgia Department of Community Health to Phoebe Putney Memorial Hospital, Inc.	(8,402,767)	(9,363,272)
Payments to suppliers	(820,432)	(1,293,230)
Net cash used by operating activities	(720,432)	(1,293,230)
Cash flows from capital and related financing activities:		
Payments on short-term obligations	-	(17,316,845)
Cash flows from noncapital financing activities:		
Transfer from Phoebe Putney Memorial Hospital, Inc.	4,345,806	5,179,409
Transfer to Phoebe Putney Memorial Hospital, Inc.	(4,345,806)	(5,179,409)
Noncapital contributions	700,090	1,175,000
Net cash provided by noncapital financing activities	700,090	1,175,000
Net decrease in cash	(20,342)	(17,435,075)
Cash, beginning of year	213,343	17,648,418
Cash, end of year	$ 193,001	$ 213,343

Continued

HOSPITAL AUTHORITY OF ALBANY-DOUGHERTY COUNTY, GEORGIA

STATEMENTS OF CASH FLOWS, Continued
for the years ended July 31, 2014 and 2013

	2014	2013
Reconciliation of cash and cash equivalents to the balance sheet:		
Cash in current assets	$ 193,001	$ 213,343
Reconciliation of operating loss to net cash flows used by operating activities:		
Operating loss	$(229,859)	$(2,139,744)
Changes in:		
Accounts payable	(490,573)	946,514
Unearned revenue	-	(100,000)
Net cash used by operating activities	$(720,432)	$(1,293,230)

Supplemental disclosures of cash flow information:

- See Note 7 for additional information related to the lease of Palmyra to Phoebe Putney Memorial Hospital, Inc.

See accompanying notes to financial statements.

1. Summary of Significant Accounting Policies

Reporting Entity

The Hospital Authority of Albany-Dougherty County, Georgia (Authority) is a public corporation organized to operate, control, and manage matters concerning the County's health care functions.

On September 1, 1991, the Hospital Authority implemented a reorganization plan whereby all of the assets and day-to-day management of Phoebe Putney Memorial Hospital were transferred to Phoebe Putney Memorial Hospital, Inc. (Corporation), a not-for-profit corporation, qualified as an organization described in Section 501(c)(3) of the Internal Revenue Code. The transfer was made pursuant to a lease and transfer agreement dated as of December 11, 1990 between the Hospital Authority and the Corporation. During 2009, the lease term was renewed to the original term of forty years.

Under the terms of the Agreement, any debt issued by the Hospital Authority will be the responsibility of the Corporation. As of July 31, 2014, approximately $297,525,000 of Revenue Anticipation Certificates are outstanding in the Authority's name. These certificates are recorded and disclosed in the financial statements of the Corporation for the year ended July 31, 2014.

On December 15, 2011, the Authority purchased substantially all assets of Palmyra Park Hospital, LLC (Palmyra), a general acute care hospital located in Albany, Georgia. The Authority operated Palmyra under the name Phoebe North.

Effective August 1, 2012, the lease and transfer agreement between the Corporation and the Authority was amended and restated. The amendment was made for the transfer and inclusion of the hospital formerly known as Palmyra. The amendment included the extension of the lease for a term of forty years from the date of the current amendment. An annual lease payment is paid to the Authority. See Note 7 for additional information related to the lease of Palmyra to the Corporation.

Continued

1. Summary of Significant Accounting Policies, Continued

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Enterprise Fund Accounting

The Authority uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus. The Authority prepares its financial statements as a business-type activity in conformity with applicable pronouncements of the Governmental Accounting Standards Board (GASB).

Capital Assets

Capital asset acquisitions are recorded at cost. Equipment under capital lease obligations is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the financial statements. Depreciation is provided over the estimated useful life of each depreciable asset (per the American Hospital Association (AHA) Guidelines for Depreciable Assets) and is computed using the straight-line method. The AHA Guidelines generally provide the following range in asset life by category:

Land improvements	10 to 20 years
Buildings and improvements	10 to 40 years
Equipment	3 to 15 years

Continued

1. Summary of Significant Accounting Policies, Continued

Net Position

Net position of the Authority is classified as *unrestricted net position*. *Unrestricted net position* is the remaining net amount of assets and liabilities that are not invested in capital assets and do not contain restrictions on their use.

Operating Revenues and Nonoperating Revenues

The Authority's statement of revenues, expenses and changes in net position distinguishes between operating and nonoperating revenues. Operating revenues result from the lease agreement with the Corporation. Nonexchange revenues, including contributions received for purposes other than capital asset acquisition are reported as nonoperating revenues.

Grants and Contributions

Revenues from grants and contributions (including contributions of capital assets) are recognized when all eligibility requirements, including time requirements are met. Grants and contributions may be restricted for either specific operating purposes or for capital purposes. Amounts that are unrestricted or that are restricted to a specific operating purpose are reported as nonoperating revenue. Amounts restricted to capital acquisitions are reported after nonoperating revenue.

Prior Year Reclassifications

Certain reclassifications have been made to the fiscal year 2013 financial statements to conform to the fiscal year 2014 presentation. These reclassifications had no impact on the change in net position in the accompanying financial statements.

Income Taxes

The Authority is a governmental entity and is exempt from income taxes. Therefore, no provision for income taxes is made in the financial statements.

Continued

1. Summary of Significant Accounting Policies, Continued

Restricted Resources

When the Authority has both restricted and unrestricted resources available to finance a particular program, it is the Authority's policy to use restricted resources before unrestricted resources.

2. Deposits

State law requires collateralization of all deposits with federal depository insurance and other acceptable collateral in specific amounts. The Authority's bylaws require that all bank balances be insured or collateralized by U.S. government securities held by the pledging financial institution's trust department in the name of the Authority. The Authority had no uncollateralized cash balances at July 31, 2014 and 2013.

The carrying amount of deposits included in the Authority's balance sheets is as follows:

	2014	2013
Cash	$ 193,001	$ 213,343

3. Accounts Payable

Accounts payable reported as current liabilities by the Authority at July 31, 2014 and 2013 consisted of these amounts:

	2014	2013
Accounts payable:		
Payable to suppliers	$ 264,047	$ 754,620

Continued

4. Capital Assets

Capital asset changes for the year ended July 31, 2013 were as follows:

	July 31, 2012	Increases	Decreases	July 31, 2013
Land	$ 5,664,620	$ -	$ 5,664,620	$ -
Construction-in-progress	849,654	-	849,654	-
Total capital assets not being depreciated	6,514,274	-	6,514,274	-
Land improvements	104,465	-	104,465	-
Buildings and improvements	25,058,287	-	25,058,287	-
Equipment	6,533,599	-	6,533,599	-
Total capital assets being depreciated	31,696,351	-	31,696,351	-
Less accumulated depreciation and amortization for:				
Land improvements	8,558	-	8,558	-
Buildings and improvements	1,189,039	-	1,189,039	-
Equipment	1,429,058	-	1,429,058	-
Total accumulated depreciation	2,626,655	-	2,626,655	-
Capital assets being depreciated, net	29,069,696	-	29,069,696	-
Total capital assets, net	$ 35,583,970	$ -	$ 35,583,970	$ -

No depreciation expense was recorded for the years ended July 31, 2014 and 2013.

Continued

5. Short-Term Obligations

A schedule of changes in the Authority's short-term obligations follows:

	2012 Balance	Additions	Reductions	2013 Balance
Due to Phoebe Putney Memorial Hospital	$ 3,006,703	$ -	$ 3,006,703	$ -
Due to Phoebe Putney Health System	214,886,360	-	214,886,360	-
Total short-term obligations	$ 217,893,063	$ -	$ 217,893,063	$ -

The short-term obligations are made up of funds provided to the Authority by the Corporation and Phoebe Putney Health System to finance the purchase of Palmyra and to fund the day-to-day operations of the Authority. These obligations were satisfied through the lease and transfer of assets between the Authority and the Corporation on August 1, 2012.

6. Goodwill

On December 15, 2011, the Authority purchased the assets of Palmyra Park Hospital, LLC, an acute care hospital located in Dougherty County, Georgia. This transaction resulted in approximately $157,345,000 of goodwill. The goodwill recognized is the result of a long history of successful operations resulting in strong earnings and consistent growth in revenues. The goodwill recognized was transferred to the Corporation through the lease and transfer of assets between the Authority and Corporation on August 1, 2012. No goodwill was reported on the balance sheet for the years ended July 31, 2014 and 2013.

Continued

6. Goodwill, Continued

The changes in the carrying amount of goodwill for the year ended July 31, 2013 are as follows:

	2013
Balance at beginning of year:	
Goodwill	$ 157,345,334
Accumulated impairment losses	-
	157,345,334
Goodwill acquired during the year	-
Impairment losses	-
Lease transfer to the Corporation	(157,345,334)
Balance at end of year:	
Goodwill	-
Accumulated impairment losses	-
Total	$ -

7. Lease Amendment – Phoebe Putney Memorial Hospital, Inc.

On August 1, 2012, the Corporation leased Palmyra from the Authority. The following assets and liabilities were transferred to the Corporation pursuant to the lease:

Cash	$ 17,316,845
Patient accounts receivable	9,092,766
Prepaid expenses, supplies, and other assets	3,178,373
Capital assets	35,583,970
Current liabilities	(7,534,770)
Net position transferred to the Corporation	57,637,184
Removal of associated goodwill	157,345,334
Gain on long-term lease	2,910,545
Satisfaction of the payable to the Corporation	$ 217,893,063

Continued

8. Health Care Reform

In recent years, there has been increasing pressure on Congress and some state legislatures to control and reduce the cost of healthcare on the national and state levels. In 2010, legislation was enacted which included cost controls on hospitals, insurance market reforms, delivery system reforms and various individual and business mandates among other provisions. The costs of certain provisions will be funded in part by reductions in payments by government programs, including Medicare and Medicaid. There can be no assurance that these changes will not adversely affect the Authority.

9. Litigation

The Authority is involved in litigation and regulatory investigations arising in the course of business. After consultation with legal counsel, management estimates that these matters will be resolved without material adverse effect on the Authority's future financial position or results from operations.

STATE OF GEORGIA
COUNTY OF DOUGHERTY

AFFIDAVIT RELATIVE TO CLOSED MEETING

Personally appeared before the undersigned, RALPH S. ROSENBERG, who having been duly sworn, deposes and states as follows:

1. I am over the age of 18 years, I am suffering under no disabilities and I am competent to testify to the matters contained herein.

2. I am the Chairperson of the Board of the Hospital Authority of Albany-Dougherty County, Georgia (the "Authority").

3. On the 13th day of November, 2014 , at a meeting of the Authority Board, a motion was duly approved in a roll call vote for the Authority Board to go into closed session for the purposes of : (i) engaging in privileged consultation with legal counsel; (ii) to discuss potentially valuable commercial plans, proposals or strategy that may be of competitive advantage in the operation of Phoebe Putney Memorial Hospital or its medical facilities; and (iii) to discuss confidential matters or information pertaining to peer review or provided by a review organization as defined in O.C.G.A §31-7-131.

4. To the best of my knowledge and belief, the business conducted during the closed portion of the meeting was devoted solely to the above matters for which the meeting was closed.

This the 13th day of November, 2014.

Ralph S. Rosenberg

Chairperson

Sworn to and subscribed before me this
13th day of November, 2014.

Mary S. Barfield

NOTARY PUBLIC (SEAL)
Dougherty County, Georgia
My Commission Expires: _____