HOSPITAL AUTHORITY OF ALBANY-DOUGHERTY COUNTY, GEORGIA

AND

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.

LOAN AGREEMENT
(Series 2012)

Dated as of December 1, 2012

The interest of the HOSPITAL AUTHORITY OF ALBANY-DOUGHERTY COUNTY, GEORGIA (the "Issuer") in this Loan Agreement has been assigned (except for "Reserved Rights" defined in this Loan Agreement) pursuant to the Indenture of Trust dated as of the date hereof from the Issuer to [NAME OF TRUSTEE], as trustee (the "Trustee"), and is subject to the security interest of the Trustee thereunder.

LOAN AGREEMENT

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(This Table of Contents is not a part of the Loan Agreement and is only for convenience of reference.)

LOAN AGREEMENT

THIS LOAN AGREEMENT, dated as of December 1, 2012, between the HOSPITAL AUTHORITY OF ALBANY-DOUGHERTY COUNTY, GEORGIA, a public body corporate and politic and an instrumentality of the State of Georgia created and existing under the Constitution and Laws of the State of Georgia (the "Issuer") and PHOEBE PUTNEY MEMORIAL HOSPITAL, INC., a corporation organized and existing under the laws of the State of Georgia (the "Hospital");

W I T N E S S E T H:

That the parties hereto, intending to be legally bound hereby, and for and in consideration of the premises and the mutual covenants hereinafter contained, do hereby covenant, agree and bind themselves as follows: provided, that any obligation of the Issuer created by or arising out of this Agreement shall never constitute a debt or a pledge of the faith and credit or the taxing power of the Issuer or any political subdivision or taxing district of the State of Georgia but shall be payable solely out of the Trust Estate (as defined in the Indenture), anything herein contained to the contrary by implication or otherwise notwithstanding:

ARTICLE 1

DEFINITIONS

Section 1.01 Definitions

All capitalized, undefined terms used herein have the same meanings as used in *Article I* of the hereinafter defined Indenture. In addition, the following words and phrases shall have the following meanings:

"Continuing Disclosure Certificate" means the Continuing Disclosure Certificate dated December __, 2012 executed by the Hospital with respect to the Bonds.

"Cost" or **"Costs"** means and includes all items permitted to be financed under the provisions of the Code and the Act.

"Default" means any Default under this Agreement as specified in and defined by ***Section 8.01*** hereof.

"Governmental Unit" means a state, a political subdivision or instrumentality of the foregoing within the meaning of Section 141(b)(6) of the Code.

"Indenture" means the Indenture of Trust dated as of this date between the Issuer and the Trustee, pursuant to which the Bonds are authorized to be issued, and any amendments and supplements thereto.

"Project" means the facilities financed with proceeds of the Bonds and described in Exhibit A hereto.

"Qualified Project Costs" means Costs and expenses of the Project which constitute land costs or costs for property of a character subject to the allowance for depreciation excluding specifically working capital and inventory costs, provided, however, that (i) costs or expenses paid more than sixty (60) days prior to the adoption by the Issuer of its resolution declaring its intent to reimburse Project

expenditures with Bond proceeds, shall not be deemed to be Qualified Project Costs; (ii) costs that are treated as costs of issuing or carrying the Bonds under existing Treasury Department regulations and rulings will not be deemed to be Qualified Project Costs; (iii) interest during the Construction Period shall be allocated between Qualified Project Costs and other Costs and expenses to be paid from the proceeds of the Bonds; (iv) interest following the Construction Period shall not constitute a Qualified Project Cost; (v) letter of credit fees and municipal bond insurance premiums which represent a transfer of credit risk shall be allocated between Qualified Project Costs and other costs and expenses to be paid from the proceeds of the Bonds; and (vi) letter of credit fees and municipal bond insurance premiums which do not represent a transfer of credit risk shall not constitute Qualified Project Costs.

"Reserved Rights" means amounts payable to the Issuer under ***Sections 4.02(c)***, ***7.02*** and ***8.04*** of this Agreement and the right of the Issuer to receive notices.

"Tax-Exempt Organization" means an entity organized under the laws of the United States of America or any state thereof which is an organization described in Section 501(c)(3) of the Code, which is exempt from federal income taxes under Section 501(a) of the Code, and which is not a "private foundation" within the meaning of Section 509(a) of the Code, or corresponding provisions of federal income tax laws from time to time in effect.

"Term of Agreement" means the term of this Agreement as specified in ***Section 9.01*** hereof.

Section 1.02 Uses of Phrases

Words of the masculine gender shall be deemed and construed to include correlative words of the feminine and neuter genders. Unless the context shall otherwise indicate, the words "Bond," "Bondholder," "Owner," "registered owner" and "person" shall include the plural as well as the singular number, and the word "person" shall include corporations and associations, including public bodies, as well as persons. Any percentage of Bonds, specified herein for any purpose, is to be figured on the unpaid principal amount thereof then Outstanding. All references herein to specific Sections of the Code refer to such Sections of the Code and all successor or replacement provisions thereto.

ARTICLE 2

REPRESENTATIONS, COVENANTS AND WARRANTIES

Section 2.01 Representations, Covenants and Warranties of the Issuer

The Issuer represents, covenants and warrants that:

(a) The Issuer is a public body corporate and politic and an instrumentality of the State. Under the provisions of the Act, the Issuer is authorized to enter into the transactions contemplated by this Agreement and the Indenture and to carry out its obligations hereunder and thereunder. The Issuer has been duly authorized to execute and deliver this Agreement and the Indenture.

(b) The Issuer covenants that it will not pledge the amounts derived from this Agreement other than as contemplated by the Indenture.

Section 2.02 Representations, Covenants and Warranties of the Hospital

The Hospital represents, covenants and warrants that:

(a) The Hospital is a nonprofit corporation duly organized and validly existing under the laws of the State of Georgia organized and operated exclusively for charitable purposes, no part of the net earnings of which inure to the benefit of any person, private stockholder of individual. The Hospital is not in violation of any provision of its Articles of Incorporation, as amended, has the corporate power to enter into this Agreement, the Master Indenture and the Series 2012 Master Note, and has duly authorized the execution and delivery of this Agreement, the Master Indenture and the Series 2012 Master Note, and is qualified to do business and is in good standing under the laws of the State.

(b) Neither the execution and delivery of this Agreement, the Master Indenture or the Series 2012 Master Note, nor the consummation of the transactions contemplated hereby and thereby, nor the fulfillment of or compliance with the terms and conditions hereof or thereof conflicts with or results in a breach of the terms, conditions, or provisions of any agreement or instrument to which the Hospital is now a party or by which the Hospital is bound, or constitutes a default under any of the foregoing, or results in the creation or imposition of any lien, charge or encumbrance whatsoever upon any of the property or assets of the Hospital under the terms of any such instrument or agreement.

(c) There is no action, suit, proceeding, inquiry or investigation, at law or in equity, before or by any court, public board or body, known to be pending or threatened against or affecting the Hospital or any of its officers, nor to the best knowledge of the Hospital is there any basis therefor, wherein an unfavorable decision, ruling, or finding would materially adversely affect the transactions contemplated by this Agreement or which would adversely affect, in any way, the validity or enforceability of the Bonds, this Agreement, the Master Indenture or the Series 2012 Note, or any agreement or instrument to which the Hospital is a party, used or contemplated for use in the consummation of the transactions contemplated hereby.

(d) The Project is of the type authorized and permitted by the Act.

(e) The proceeds from the sale of the Bonds will be used only for payment of Costs of the Project.

(f) The proceeds from the sale of the Bonds will be used only as contemplated in the Indenture.

(g) The Hospital will use due diligence to cause the Project to be operated in accordance with the laws, rulings, regulations and ordinances of the State and the departments, agencies and political subdivisions thereof. The Hospital has obtained or caused to be obtained all requisite approvals of the State and of other federal, state, regional and local governmental bodies for the acquisition, construction, improving and equipping of the Project.

(h) The Hospital will fully and faithfully perform all the duties and obligations which the Issuer has covenanted and agreed in the Indenture to cause the Hospital to perform and any duties and obligations which the Hospital is required in the Indenture to perform. The foregoing will not apply to any duty or undertaking of the Issuer which by its nature cannot be delegated or assigned.

Section 2.03 Tax-Exempt Status of the Bonds

It is the intention of the parties hereto that the interest on the Certificates be and remain excludable from gross income for federal income tax purposes in accordance with Sections 103 and 145 of the Code, and to that end the Hospital represents, warrants and agrees as follows:

(a) All of the proceeds of the Bonds, together with all proceeds from investment thereof, have been or will be used to pay, or to reimburse the Hospital for payment of, costs of acquiring, constructing and equipping the Project and of issuing the Bonds.

(b) No portion of the Project now consists or will consist of any airplane, skybox or other luxury box, facility primarily used for gambling, or store the principal business of which is the sale of alcoholic beverages for consumption off premises.

(c) The Project will be owned by (i) the Authority and leased to the Hospital pursuant to the Lease and Transfer Agreement, as amended, between the Authority and the Hospital, or (ii) by the Hospital, by Phoebe Putney Health System, Inc. ("Health System") or by a subsidiary of the Hospital or Health System.

(d) No portion of the Project is or will be (i) used in an "unrelated trade or business", within the meaning of Section 513(a) of the Code, of the Hospital, (ii) used in a "trade or business" under Section 141(b)(6) of the Code (a "Trade or Business"), of any person other than the Hospital, or (iii) used in any activity of the Hospital which is not directly related to the exempt purpose of the Hospital.

(e) The Project will be used only in activities directly related to the Hospital's exempt purpose. No portion of or interest in the Project is or will be owned or used by any person or entity other than the Hospital, either directly or indirectly, including use through a management agreement.

(f) All of the property financed by the proceeds of the Bonds (including earnings on amounts in the Project Fund and on amounts held in the reserve fund, if any, prior to completion of the Project to the extent exceeding the amount reasonably required to be retained therein) will be owned by the Hospital or by another Tax-Exempt Organization or a Governmental Unit.

(g) The Hospital will not permit more than 5% of the proceeds of the Bonds to be used, directly or indirectly, in the trade or business of any person other than a Governmental Unit or a Tax-Exempt Organization (a "Private Business Use"), unless: (i) not more than 5% of the payments of principal, premium, if any, or interest on the Bonds (1) is to be derived, directly or indirectly, from payments in respect of property, or borrowed money, used or to be used for a Private Business Use or (2) is to be secured, directly or indirectly, by property used or to be used in a Private Business Use of by payments with respect to any such property.

(h) During the period commencing 15 days prior to the date of issuance of the Bonds and ending 15 days after said date, no tax-exempt obligations have been or will be issued which are guaranteed or otherwise secured by payments to be made by the Hospital or any "related person" (or group of "related persons"). Except for the Hospital or any "related person" (or group of "related persons"), no person has (1) guaranteed, arranged, participated in, assisted with or paid any portion of the cost of the issuance of, the Bonds, or (2) provided any property or any franchise, trademark or trade name (within the meaning of Section 1253 of the Code) which is to be used in connection with the Project.

(i) All of the Project will be located in Dougherty County, Georgia.

(j) The "average reasonably expected economic life" (as that term is used in Section 147(b) of the Code) of the Project will be at least [__] years.

(k) The statements, recitals and representations contained in the Information Return for Private Activity Bond Issues (Form 8038) dated the date of issuance of the Bonds with respect to the Bonds are in all respects true, correct and complete.

(l) Neither the obligations of the Hospital under this Agreement nor the Bonds are or will be "federally guaranteed", as defined in Section 149(b) of the Code.

(m) The Hospital is and will remain a Tax-Exempt Organization. The Hospital has received a determination letter from the Internal Revenue Service to the foregoing effect, which letter is still in full force and effect. The Hospital does not now have, and will not have, any "unrelated business taxable income" as defined in Section 512 of the Code which could have a material adverse effect on the Hospital's status as a Tax-Exempt Organization.

(n) The total of all costs of issuance of the Bonds paid for with, or for which the Hospital is reimbursed from, proceeds of the Bonds will not exceed 2% of the proceeds of the Bonds.

Section 2.04 Notice of Determination of Taxability

Promptly after the Hospital first becomes aware of any Determination of Taxability, the Hospital will give written notice thereof to the Issuer and the Trustee.

ARTICLE 3

ISSUANCE OF THE BONDS

Section 3.01 Agreement to Issue the Bonds; Application of Bond Proceeds

In order to provide funds to finance the costs of the Project, the Issuer, beginning concurrently with the execution of this Agreement, will issue, sell, and deliver the Bonds and deposit the proceeds thereof with the Trustee as contemplated in the Indenture.

Section 3.02 Disbursements from the Project Fund

The Issuer has, in the Indenture, authorized and directed the Trustee to make disbursements from the Project Fund to pay the Costs of the Project, or to reimburse the Hospital for any Cost of the Project paid by it. Disbursements from the Project Fund will be made by the Trustee upon receipt of a written requisition for such payment signed by the Hospital by a Hospital Representative in substantially the form contained as Exhibit B hereto. In making any such payment from the Project Fund or the Costs of Issuance Account therein, the Trustee may rely on any such requisitions delivered to it pursuant to this Section and the Trustee will be relieved of all liability with respect to making such payments in accordance with such requisitions and such certificates without inspection of the Project or any other investigation.

Section 3.03 Special Arbitrage Certifications

The Hospital and the Issuer covenant not to cause or direct any moneys on deposit in any fund or account to be used in a manner which would cause the Bonds to be classified as "arbitrage bonds" within the meaning of Section 148 of the Code, and the Hospital certifies and covenants to and for the benefit of the Issuer and the Owners of the Bonds that so long as there are any Bonds Outstanding, moneys on deposit in any fund or account in connection with the Bonds, whether such moneys were derived from the proceeds of the sale of the Bonds or from any other sources, will not be used in a manner which will cause the Bonds to be classified as "arbitrage bonds" within the meaning of Section 148 of the Code.

ARTICLE 4

LOAN PROVISIONS

Section 4.01 Loan of Proceeds

The Issuer agrees, upon the terms and conditions contained in this Agreement and the Indenture, to lend to the Hospital the proceeds received by the Issuer from the sale of the Bonds. Such proceeds shall be disbursed to or on behalf of the Hospital as provided in the Indenture.

Section 4.02 Amounts Payable

(a) The Hospital hereby covenants and agrees to repay the loan, as follows: on or before any Interest Payment Date for the Bonds or any other date that any payment of interest, premium, if any, or principal is required to be made in respect of the Bonds pursuant to the Indenture, until the principal of, premium, if any, and interest on the Bonds shall have been fully paid or provision for the payment thereof shall have been made in accordance with the Indenture, in immediately available funds, a sum which, together with any other moneys available for such payment in any account of the Bond Fund, will enable the Trustee to pay the amount payable on such date as principal of (whether at maturity or upon redemption or acceleration or otherwise), premium, if any, and interest on the Bonds as provided in the Indenture. Contemporaneously with the execution and delivery of this Agreement, the Hospital executed and delivered the Series 2012 Master Note to the Issuer, and the Issuer assigned the Series 2012 Master Note to the Trustee, which provides for payments which correspond as to time and amount with the payments due on the Bonds; provided that the Obligated Group will receive a credit against its obligation to pay principal of, premium, if any, and interest on the Series 2012 Master Note to the extent that funds are on deposit with the Trustee and available to pay principal of, premium, if any, and interest on the Bonds. If for any reason, amounts paid by the Hospital together with any other amounts available in the Bond Fund are not sufficient to pay the principal of and interest on the Bonds when due, the Hospital agrees to pay the amount required to make up such deficiency.

(b) It is understood and agreed pursuant to the Indenture, that all payments payable by the Hospital under subsection (a) of this ***Section 4.02*** are assigned by the Issuer to the Trustee for the benefit of the Owners of the Bonds. The Hospital assents to such assignment. The Issuer hereby directs the Hospital and the Hospital hereby agrees to pay to the Trustee at the Principal Office of the Trustee all payments payable by the Hospital pursuant to this subsection. The Issuer has delivered the Series 2012 Master Note to the Trustee, as assignee of the Issuer.

(c) The Hospital will also pay the reasonable expenses of the Issuer related to the issuance of the Bonds and incurred upon the written request of the Hospital.

(d) The Hospital will also pay the reasonable fees and expenses of the Trustee under the Indenture and all other amounts which may be payable to the Trustee under ***Section 10.02*** of the Indenture, such amounts to be paid directly to the Trustee for the Trustee's own account as and when such amounts become due and payable.

(e) In the event the Hospital fails to make any of the payments required in this ***Section 4.02***, the item or installment so in default will continue as an obligation of the Hospital until the amount in default shall have been fully paid, and the Hospital agrees to pay the same with interest thereon, to the extent permitted by law, from the date when such payment was due, at the rate of interest borne by the Bonds.

Section 4.03 Obligations of Hospital Unconditional

The obligations of the Hospital to make the payments required in ***Section 4.02*** hereof and to perform and observe the other agreements contained herein will be absolute and unconditional and will not be subject to any defense or any right of setoff, counterclaim or recoupment arising out of any breach by the Issuer or the Trustee of any obligation to the Hospital, whether hereunder or otherwise, or out of any indebtedness or liability at any time owing to the Hospital by the Issuer or the Trustee, and, until such time as the principal of, premium, if any, and interest on the Bonds shall have been fully paid or provision for the payment thereof have been made in accordance with the Indenture, the Hospital (i) will not suspend or discontinue any payments provided for in ***Section 4.02*** hereof, (ii) will perform and observe all other agreements contained in this Agreement and (iii) except as otherwise provided herein, will not terminate the Term of Agreement for any cause, including, without limiting the generality of the foregoing, failure of the Hospital to complete the acquisition, construction, improving and equipping of the Project, the occurrence of any acts or circumstances that may constitute failure of consideration, eviction or constructive eviction, destruction of or damage to the Project, the taking by eminent domain of title to or temporary use of any or all of the Project, commercial frustration of purpose, any change in the tax or other laws of the United States of America or of the State or any political subdivision of either thereof or any failure of the Issuer or the Trustee to perform and observe any agreement, whether express or implied, or any duty, liability or obligation arising out of or connected with this Agreement. Nothing contained in this Section shall be construed to release the Issuer from the performance of any of the agreements on its part herein contained, and in the event the Issuer or the Trustee should fail to perform any such agreement on its part, the Hospital may institute such action against the Issuer or the Trustee as the Hospital may deem necessary to compel performance so long as such action does not abrogate the obligations of the Hospital contained in the first sentence of this Section.

ARTICLE 5

PREPAYMENT AND REDEMPTION

Section 5.01 Prepayment and Redemption

The Hospital has the option to prepay its obligations hereunder at the times and in the amounts as necessary to exercise its option to cause the Bonds to be redeemed as set forth in the Indenture and in the Bonds. The Hospital hereby agrees that it shall prepay its obligations hereunder at the times and in the amounts as necessary to accomplish the mandatory redemption of the Bonds as set forth in the Indenture and in the Bonds. The Issuer, at the request of the Hospital, will take all steps (other than the payment of the money required for such redemption) necessary under the applicable redemption provisions of the Indenture to effect redemption of all or part of the Outstanding Bonds, as may be specified by the Hospital, on the date established for such redemption.

ARTICLE 6

SPECIAL COVENANTS

Section 6.01 No Warranty of Condition or Suitability by Issuer

THE ISSUER MAKES NO WARRANTY, EITHER EXPRESS OR IMPLIED, AS TO THE PROJECT OR THE CONDITION THEREOF, OR THAT THE PROJECT WILL BE SUITABLE FOR THE PURPOSES OR NEEDS OF THE COMPANY. THE ISSUER MAKES NO REPRESENTATION OR WARRANTY, EXPRESS OR IMPLIED, THAT THE COMPANY WILL HAVE QUIET AND PEACEFUL POSSESSION OF THE PROJECT. THE ISSUER MAKES NO REPRESENTATION OR WARRANTY, EXPRESS OR IMPLIED, WITH RESPECT TO THE MERCHANTABILITY, CONDITION OR WORKMANSHIP OF ANY PART OF THE PROJECT OR ITS SUITABILITY FOR THE COMPANY'S PURPOSES.

Section 6.02 Access to the Project

The Hospital agrees that the Issuer, the Trustee and their duly authorized agents, attorneys, experts, engineers, accountants and representatives will have the right to inspect the Project at all reasonable times and on reasonable notice. The Issuer, the Trustee and their duly authorized agents shall also be permitted, at all reasonable times, to examine the books and records of the Hospital with respect to the Project.

Section 6.03 Further Assurances and Corrective Instruments

The Issuer and the Hospital agree that they will, from time to time, execute, acknowledge and deliver, or cause to be executed, acknowledged and delivered, such supplements hereto and such further instruments as may reasonably be required for carrying out the expressed intention of this Agreement.

Section 6.04 Issuer and Hospital Representatives

Whenever under the provisions of this Agreement the approval of the Issuer or the Hospital is required or the Issuer or the Hospital is required to take some action at the request of the other, such approval or such request shall be given for the Issuer by an Issuer Representative and for the Hospital by a Hospital Representative. The Trustee shall be authorized to act on any such approval or request.

Section 6.05 Financing Statements

The Hospital agrees to execute and file or cause to be executed and filed any and all financing statements or amendments thereof or continuation statements necessary to perfect and continue the perfection of the security interests granted in the Indenture. The Hospital shall pay all costs of filing such instruments.

Section 6.06 Covenant to Provide Ongoing Disclosure

The Hospital has delivered the Continuing Disclosure Certificate in conjunction with the issuance of the Bonds. The Hospital agrees that, while the Bonds are Outstanding, it will perform its obligations under the Continuing Disclosure Certificate or enter into an agreement, which agreement will provide for the dissemination of the financial statements and notices required by Rule 15c2-12 under the Securities Exchange Act of 1934, as amended. Notwithstanding any other provision of this Agreement, failure of

the Hospital to comply with the Continuing Disclosure Certificate will not constitute a Default under this Agreement of the Indenture.

ARTICLE 7

ASSIGNMENT, SELLING, LEASING; INDEMNIFICATION; REDEMPTION

Section 7.01 Assignment, Selling and Leasing

This Agreement may be assigned and the Project may be sold or leased, as a whole or in part, with written notice to, but without the necessity of obtaining the consent of, either the Issuer or the Trustee; provided that no such assignment, sale or lease, in the opinion of Bond Counsel, results in interest on any of the Bonds becoming includable in gross income for federal income tax purposes, or shall otherwise violate any provisions of the Act; provided further that no such assignment, sale or lease will relieve the Hospital of any of its obligations under this Agreement.

Section 7.02 Release and Indemnification Covenants

(a) The Hospital agrees to indemnify and save the Issuer and the Trustee harmless against and from all claims by or on behalf of any person, firm, corporation or other legal entity arising from the conduct or management of, or from any work or thing done on, the Project during the Term of Agreement, including without limitation, (i) any condition of the Project, (ii) any breach or default on the part of the Hospital in the performance of any of its obligations under this Agreement, (iii) any act or negligence of the Hospital or of any of its agents, contractors, servants, employees or licensees or (iv) any act or negligence of any assignee or lessee of the Hospital, or of any agents, contractors, servants, employees or licensees of any assignee or lessee of the Hospital. The Hospital shall indemnify and save the Issuer and the Trustee harmless from any such claim arising as aforesaid, or in connection with any action or proceeding brought thereon, and upon notice from the Issuer or the Trustee, the Hospital will defend them or either of them in any such action or proceeding.

(b) Notwithstanding the fact that it is the intention of the parties hereto that the Issuer not incur any pecuniary liability by reason of the terms of this Agreement or the undertakings required of the Issuer hereunder, by reason of the issuance of the Bonds, the execution of the Indenture or the performance of any act requested of the Issuer by the Hospital, including all claims, liabilities or losses arising in connection with the violation of any statutes or regulation pertaining to the foregoing; nevertheless, if the Issuer should incur any such pecuniary liability, then in such event the Hospital will indemnify and hold the Issuer harmless against all claims, demands or causes of action whatsoever, by or on behalf of any person, firm or corporation or other legal entity arising out of the same or out of any offering statement or lack of offering statement in connection with the sale or resale of the Bonds and all costs and expenses incurred in connection with any such claim or in connection with any action or proceeding brought thereon, and upon notice from the Issuer, the Hospital will defend the Issuer in any such action or proceeding. All references to the Issuer in this ***Section 7.02*** will be deemed to include its members, directors, officers, employees, and agents.

(c) Notwithstanding anything to the contrary contained herein, the Hospital will have no liability under this ***Section 7.02*** to indemnify the Issuer against claims or damages resulting from the Issuer's own gross negligence or willful misconduct.

Section 7.03 Issuer to Grant Security Interest to Trustee

The parties hereto agree that pursuant to the Indenture, the Issuer shall assign to the Trustee, in order to secure payment of the Bonds, all of the Issuer's right, title and interest in and to this Agreement, except for Reserved Rights.

Section 7.04 Indemnification of Trustee

The Hospital shall and hereby agrees to indemnify the Trustee for, and hold the Trustee harmless against, any loss, liability or expense (including the costs and expenses of defending against any claim of liability) incurred without gross negligence or willful misconduct by the Trustee and arising out of or in connection with its acting as Trustee under the Indenture.

ARTICLE 8

DEFAULTS AND REMEDIES

Section 8.01 Defaults Defined

The following will be "Defaults" under this Agreement and the term "Default" means, whenever it is used in this Agreement, any one or more of the following events:

(a) Failure by the Hospital to pay any amount required to be paid under ***Section 4.02(a) or (d)*** hereof or of the Obligated Group to pay any amount required to be paid under the Series 2012 Master Note.

(b) Failure by the Hospital to observe and perform any covenant, condition or agreement on its part to be observed or performed, other than as referred to in ***Section 8.01(a)*** hereof, for a period of 30 days after written notice specifying such failure and requesting that it be remedied has been given to the Hospital by the Issuer or the Trustee, unless the Issuer and the Trustee agree in writing to an extension of such time prior to its expiration; provided that if the failure stated in the notice cannot be corrected within the applicable period, the Issuer and the Trustee will not unreasonably withhold their consent to an extension of such time if corrective action is instituted by the Hospital within the applicable period and diligently pursued until such failure is corrected.

(c) The dissolution or liquidation of the Hospital, except as authorized by ***Section 2.02*** hereof, or the voluntary initiation by the Hospital of any proceeding under any federal or state law relating to bankruptcy, insolvency, arrangement, reorganization, readjustment of debt or any other form of debtor relief, or the initiation against the Hospital of any such proceeding which shall remain undismissed for 60 days, or failure by the Hospital to promptly have discharged any execution, garnishment or attachment of such consequence as would impair the ability of the Hospital to carry on its operations at the Project, or assignment by the Hospital for the benefit of creditors, or the entry by the Hospital into an agreement of composition with its creditors or the failure generally by the Hospital to pay its debts as they become due.

(d) The occurrence of a Default under the Indenture.

(e) The occurrence of an Event of Default under the Master Indenture which results in the acceleration of all Obligations issued thereunder.

(f) Any judgment or order for the payment of money is rendered against the Hospital and the amount thereof for which the applicable insurance carrier has denied liability exceeds $5,000,000, and either (i) enforcement proceedings have been commenced by any creditor upon such judgment or order or (ii) there is a period of 30 consecutive days during which a stay of enforcement of such judgment or order, by reason of a pending appeal or otherwise, is not be in effect.

The provisions of subsection (b) of this Section are subject to the following limitation: if by reason of force majeure the Hospital is unable in whole or in part to carry out any of its agreements contained herein (other than its obligations contained in ***Article IV*** hereof), the Hospital will not be deemed in Default during the continuance of such inability. The term "force majeure" as used herein means, without limitation, the following: acts of God; strikes or other industrial disturbances; acts of public enemies; orders or restraints of any kind of the government of the United States of America or of the State or of any of their departments, agencies or officials, or of any civil or military authority; insurrections; riots; landslides; earthquakes; fires; storms; droughts; floods; explosions; breakage or accident to machinery, transmission pipes or canals; and any other cause or event not reasonably within the control of the Hospital. The Hospital agrees, however, to remedy with all reasonable dispatch the cause or causes preventing the Hospital from carrying out its agreement, provided that the settlement of strikes and other industrial disturbances will be entirely within the discretion of the Hospital and the Hospital will not be required to settle strikes, lockouts and other industrial disturbances by acceding to the demands of the opposing party or parties when such course is in the judgment of the Hospital unfavorable to the Hospital.

Section 8.02 Remedies on Default

Whenever any Default referred to in ***Section 8.01*** hereof has occurred and is continuing, the Trustee, or the Issuer with the written consent of the Trustee, may take one or any combination of the following remedial steps:

(a) If the Trustee has declared the Bonds immediately due and payable pursuant to Section 9.02 of the Indenture, by written notice to the Hospital, declare an amount equal to all amounts then due and payable on the Bonds, whether by acceleration of maturity (as provided in the Indenture) or otherwise, to be immediately due and payable as liquidated damages under this Agreement and not as a penalty, whereupon the same shall become immediately due and payable;

(b) Have reasonable access to and inspect, examine and make copies of the books and records and any and all accounts, data and income tax and other tax returns of the Hospital during regular business hours of the Hospital if reasonably necessary in the opinion of the Trustee; or

(c) Take whatever action at law or in equity may appear necessary or desirable to collect the amounts then due and thereafter to become due, or to enforce performance and observance of any obligation, agreement or covenant of the Hospital under this Agreement.

Any amounts collected pursuant to action taken under this Section shall be paid into the Bond Fund and applied in accordance with the provisions of the Indenture.

Section 8.03 No Remedy Exclusive

Subject to Section 9.02 of the Indenture, no remedy herein conferred upon or reserved to the Issuer or the Trustee is intended to be exclusive of any other available remedy or remedies, but each and every such remedy will be cumulative and in addition to every other remedy given under this Agreement

or now or hereafter existing at law or in equity. No delay or omission to exercise any right or power accruing upon any Default will impair any such right or power or be construed to be a waiver thereof, but any such right or power may be exercised from time to time and as often as may be deemed expedient. In order to entitle the Issuer or the Trustee to exercise any remedy reserved to it in this Article, it will not be necessary to give any notice, other than such notice as may be required in this Article. Such rights and remedies as are given the Issuer hereunder also extend to the Trustee, and the Trustee and the Owners of the Bonds, subject to the provisions of the Indenture, will be entitled to the benefit of all covenants and agreements herein contained.

Section 8.04 Agreement to Pay Attorneys' Fees and Expenses

If the Hospital defaults under any of the provisions of this Agreement and the Issuer employs attorneys or incurs other expenses for the collection of payments required hereunder or the enforcement of performance or observance of any obligation or agreement on the part of the Hospital herein contained, the Hospital agrees that it will on demand therefor pay to the Issuer the reasonable fee of such attorneys and such other expenses so incurred by the Issuer.

Section 8.05 No Additional Waiver Implied by One Waiver

If any agreement contained in this Agreement is breached by either party and thereafter waived by the other party, such waiver will be limited to the particular breach so waived and will not be deemed to waive any other breach hereunder.

ARTICLE 9

MISCELLANEOUS

Section 9.01 Term of Agreement

This Agreement will remain in full force and effect from the date hereof to and including **[December 1, 2042]** or until such time as all of the Bonds and the fees and expenses of the Issuer and the Trustee have been fully paid or provision made for such payments, whichever is later; provided that this Agreement may be terminated prior to such date pursuant to ***Article V*** of this Agreement, but in no event before all of the obligations and duties of the Hospital hereunder have been fully performed, including, without limitation, the payments of all costs and fees mandated hereunder.

Section 9.02 Notices

Any notice, request, complaint, demand, communication or other paper will be sufficiently given and be deemed given when delivered or mailed by registered or certified mail, postage prepaid or sent by telegram, addressed as provided in ***Section 13.04*** of the Indenture. A duplicate copy of each notice, certificate or other communication given hereunder by the Issuer or the Hospital will be given to the Trustee. The Issuer, the Hospital and the Trustee may, by written notice given hereunder, designate any further or different addresses to which subsequent notices, certificates or other communications are to be sent.

Section 9.03 Binding Effect

This Agreement will inure to the benefit of and be binding upon the Issuer, the Hospital, the Trustee, the Owners of Bonds and their respective permitted successors and assigns.

Section 9.04 Severability

In the event any provision of this Agreement is held invalid or unenforceable by any court of competent jurisdiction, such holding will not invalidate or render unenforceable any other provision hereof.

Section 9.05 Amounts Remaining in Funds

Subject to the provisions of ***Section 6.08*** of the Indenture, it is agreed by the parties hereto that any amounts remaining in any account of the Bond Fund or any other fund (other than the Rebate Fund) created under the Indenture upon expiration or earlier termination of this Agreement, as provided in this Agreement, after payment in full of the Bonds (or provision for payment thereof having been made in accordance with the provisions of the Indenture) and the fees and expenses of the Trustee in accordance with the Indenture, shall be applied as provided in such ***Section 6.08*** of the Indenture.

Section 9.06 Amendments, Changes and Modifications

Subsequent to the issuance of Bonds and prior to their payment in full (or provision for the payment thereof having been made in accordance with the provisions of the Indenture), and except as otherwise herein expressly provided, this Agreement may not be effectively amended, changed, modified, altered or terminated without the written consent of the Trustee, all in accordance with the provisions of the Indenture. Any such amendment, change modification, alteration or termination must be in writing executed by the Issuer and the Hospital.

Section 9.07 Execution in Counterparts

This Agreement may be simultaneously executed in several counterparts, each of which will be deemed an original and all of which will constitute but one and the same instrument.

Section 9.08 Applicable Law

This Agreement will be governed by and construed in accordance with the laws of the State.

Section 9.09 Captions

The captions and headings in this Agreement are for convenience only and in no way define, limit or describe the scope or intent of any provisions or Sections of this Agreement.

[SIGNATURES BEGIN ON THE FOLLOWING PAGE]

IN WITNESS WHEREOF, the Issuer and the Hospital have caused this Agreement to be executed in their respective corporate names and their respective corporate seals to be hereunto affixed and attested by their duly authorized officers, all as of the date first above written.

HOSPITAL AUTHORITY OF ALBANY-DOUGHERTY COUNTY, GEORGIA

(SEAL)

By:_____
Name:
Title:

Attest:

By: _____
Name:
Title:

[SIGNATURES CONTINUE ON THE FOLLOWING PAGE]

[COUNTERPART SIGNATURE PAGE TO LOAN AGREEMENT]

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.

(SEAL)

By:_____
Joel Wernick,
President and Chief Executive Officer

Attest:

By: _____
Kerry Loudermilk
Sr. Vice President and Chief Financial Officer

EXHIBIT A

DESCRIPTION OF THE PROJECT

The Project comprises the following: (i) renovations and improvements on or adjacent to the campus of the Hospital located at 417 Third Avenue, Albany, Georgia, including the acquisition of furniture, fixtures and equipment related thereto, (ii) acquisition of an acute care facility, formerly known as Palmyra Medical Center and located at 2000 Palmyra Road, Albany, Georgia, (iii) renovations and improvements at Phoebe Northwest in the 2000 block of Dawson Road, Albany, Georgia, including the acquisition of furniture, fixtures and equipment related thereto, (iv) construction, expansion, renovation and capital improvements to the Hospital's facilities located in the 2000 block of Meredyth Drive, 2000 block of Ray Knight Way and Nancy Lopez Lane, Albany, Georgia, (v) construction of a distribution center on Lots 4A & 4B on Honeysuckle Drive, Albany, Georgia, (vi) construction, renovations and capital improvements of an early childhood education center located at 2530 Lafayette Drive, Albany, Georgia, and (vii) acquisition of various computer, medical and other equipment for the Hospital.

EXHIBIT B

REQUISITION AND CERTIFICATE

Requisition and Certificate No. ____

Date : _____

Amount of Requisition: $_____ for payment from the

_____ Project Fund maintained by the Trustee pursuant to the Indenture:
or
_____ Costs of Issuance Account of the Project Fund maintained by the Trustee pursuant to the Indenture:

[Name of Trustee], as Trustee under the Indenture of
Trust, dated as of December 1, 2012, relating to the Hospital Authority of
Albany-Dougherty County, Georgia, Revenue Anticipation Certificates
(Phoebe Putney Memorial Hospital)
Series 2012 (the "Bonds").

To the Addressee:

Pursuant to Section 3.02 of the Loan Agreement (the "Loan Agreement") between Phoebe Putney Memorial Hospital, Inc., a Georgia non-profit corporation (the "Hospital"), and the Hospital Authority of Albany-Dougherty County, Georgia (the "Issuer"), and Section 6.05 of the Indenture of Trust (the "Indenture") between the Issuer and **[Name of Trustee]**, as Trustee (the "Trustee"), each dated as of December 1, 2012, the Hospital hereby requests that the Trustee disburse proceeds from the Project Fund established under the Indenture, in the aggregate sum shown above as the requested amount, and, unless otherwise indicated on Schedule A attached hereto, to cause such aggregate sum to be transferred by wire transfer to Account No. _____ at _____, _____, _____ to reimburse the Hospital as indicated on Schedule A attached hereto, for costs incurred by the Hospital in connection with the items listed on such Schedule A as shown thereon.* All capitalized terms used herein and not defined herein will have the meanings ascribed to them in the Indenture or, if no meaning is therein ascribed, in the Loan Agreement.

The Hospital hereby further certifies with respect to each item for which a disbursement is requested hereby as follows:

(1) Each such item is properly payable from the Project Fund in accordance with the terms and conditions of the Loan Agreement and the Indenture and none of such items for which payment is requested has formed the basis for any payment previously made from proceeds of the Bonds.

(2) Payment of such item from the Project Fund will not violate any of the representations, covenants and warranties contained in Section 2.03 of the Loan Agreement, including, without limitation, that representation and covenant with respect to the "average reasonably expected economic life" (as that term is used in Section 147(b) of the Code) of the Project.

(3) With respect to such item, the Hospital has incurred and paid in full, or will pay in full on the date hereof, costs in that amount for the acquisition, construction or installation of the Project or for the issuance of the Bonds.

(4) Insofar as the disbursement requested hereby is to pay obligations incurred for labor, services, material, supplies or equipment in connection with the acquisition, construction and installation of the Project, such labor and services were to the Hospital's knowledge performed and such material, supplies or equipment were or are to be used in connection with the acquisition, construction and installation of the Project or delivered at the site of the Project for such purpose. The Hospital has no notice of any vendor's, mechanic's, or other liens or right to liens, chattel mortgages or conditional sales contracts, or other contracts or obligations (other than those being contested in good faith) which should be satisfied or discharged before such payment is made.

(5) This requisition contains no item representing payment on account of any retained percentages which the Hospital is, as of the date of such requisition, entitled to retain under retained percentage agreements.

(6) With respect to any such payment which is not being made to the Hospital, attached hereto is an invoice from the provider in the amount of such payment.

The individual signing this Requisition and Certificate on behalf of the Hospital is an authorized Hospital Representative.

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.

_____

Name:
Title:

SCHEDULE A

Project	Provider	Purpose	Amount	Invoice No.*	Date Paid*

*These items do not need to be completed for payments that are being made directly to the provider rather than to the Hospital.

SERIES 2012 SUPPLEMENT TO MASTER INDENTURE

This SERIES 2012 SUPPLEMENT TO MASTER INDENTURE dated as of December 1, 2012 (this "Supplemental Indenture") supplements the Master Indenture dated as of March 1, 2002 (the "Master Indenture") between U.S. Bank National Association (as successor to SunTrust Bank), as trustee thereunder (the "Master Trustee") and the Members from time to time of the Obligated Group thereunder. All capitalized terms are used herein with the meanings given them in the Master Indenture.

RECITALS

Phoebe Putney Memorial Hospital, Inc. (the "Hospital"), as Member of the Obligated Group, has requested the Hospital Authority of Albany-Dougherty County, Georgia (the "Authority") to issue its Revenue Anticipation Certificates, Series 2012 (the "Series 2012 Certificates"), which are being issued concurrently with the execution and delivery of this Supplemental Indenture in the aggregate principal amount of $[_____] pursuant to an Indenture of Trust dated as of December 1, 2012 (the "Certificate Indenture") between the Authority and **[Name of Trustee]**, as trustee (the "Certificate Trustee").

The proceeds from the sale of the Series 2012 Certificates will be loaned to the Hospital pursuant to a Loan Agreement dated as of December 1, 2012 (the "Loan Agreement") between the Authority and the Hospital.

The Hospital has agreed to execute and deliver to the Certificate Trustee the 2012 Master Note issued pursuant to the Master Indenture under which the Obligated Group is obligated to repay the loans made pursuant to each Loan Agreement and, therefore, the payment of Series 2012 Certificates.

The Obligated Group is authorized pursuant to the Master Indenture and deems it necessary and desirable to issue the Series 2012 Master Note. All acts and things necessary to make the Series 2012 Master Note, when authorized and executed by the Hospital and authenticated and delivered by the Master Trustee as provided in the Master Indenture, the valid, binding and legal obligation of the Obligated Group, and to constitute these presents a valid indenture and agreement according to its terms, have been done and performed.

Section 1. *Authorization of Series 2012 Master Note.* There is hereby authorized to be issued pursuant to the Master Indenture the Series 2012 Master Note as contemplated hereby in the maximum aggregate principal amount of $[_____].

Section 2. *Form of Series 2012 Master Note.* The Series 2012 Master Note will be substantially in the form attached hereto as Exhibit A.

Section 3. *Series 2012 Master Note.* The Series 2012 Master Note will be (i) in the principal amount of the Series 2012 Certificates, (ii) executed and delivered in accordance with Article II of the Master Indenture, (iii) in the form of a single fully registered Obligation without coupons, numbered R-2012, (iv) registered in the name of and delivered to the Certificate Trustee, and (v) dated the same date as the Series 2012 Certificates. The Series 2012 Master Note will be exchangeable solely for another fully registered Obligation of such series. The Series 2012 Master Note will bear interest from its date at a rate or rates equal to the interest accruing on and payable with respect to the Series 2012 Certificates. The Series 2012 Master Note is subject to redemption before maturity at the times, in the manner, and at the redemption prices at which the Series 2012 Certificates are redeemable under the Certificate Indenture.

Payment of principal of, premium, if any, and interest on the Series 2012 Master Note will be made at the times, in the amounts and in the manner required for payments under the Certificate Indenture and the Loan Agreement for the Series 2012 Certificates. The Obligated Group will receive a credit against its obligation to pay principal of, premium, if any, and interest on the Series 2012 Master Note to the extent that funds are on deposit with the Certificate Trustee and available for to pay principal of, premium, if any, and interest on the Series 2012 Certificates.

Section 4. *Registration of Transfer and Exchange.* The Series 2012 Master Note may not be registered as transferred except to a successor Certificate Trustee under the Certificate Indenture.

Section 5. *Payments by the Hospital.* The Obligated Group hereby elects that payments on the Series 2012 Master Note will be made directly by the Hospital to the Certificate Trustee by check or draft or wire transfer, as provided in Section 2.2 of the Master Indenture, in any case delivered on or prior to the due date of each such payment.

Section 6. *Authentication.* The Master Trustee will execute, authenticate and deliver the Series 2012 Master Note as provided in Sections 2.3 and 2.4 of the Master Indenture.

[Signatures Begin on Following Page]

IN WITNESS WHEREOF, the parties hereto have caused this Supplemental Indenture to be duly executed by persons duly authorized, as of the day and year first written above.

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.,
a Member of the Obligated Group

[Seal]

Attest:

By _____
Joel Wernick,
President and Chief Executive Officer

_____
Kerry Loudermilk, Senior Vice
President and Chief Financial Officer

PHOEBE PUTNEY HEALTH SYSTEM, INC..,
a Member of the Obligated Group

[Seal]

Attest:

By _____
Joel Wernick,
President and Chief Executive Officer

_____
Kerry Loudermilk, Senior Vice
President and Chief Financial Officer

[SIGNATURES CONTINUED ON FOLLOWING PAGE]

[COUNTERPART SIGNATURE PAGE TO SERIES 2012 SUPPLEMENT TO MASTER INDENTURE]

U.S. BANK, NATIONAL ASSOCIATION, as Master Trustee

By: _____
George Hogan
Vice President

EXHIBIT A

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.

FORM OF SERIES 2012 MASTER NOTE

No. R-2012 Dated Date: December __, 2012 $_____

Phoebe Putney Memorial Hospital, Inc., a Georgia non-profit corporation (the "Member"), for value received, hereby promises to pay to the Hospital Authority of Albany-Dougherty County, Georgia (the "Authority"), or registered assigns, the principal amount of _____ Dollars ($_____) in installments in the amounts and on the dates set forth in the hereinafter-defined Certificate Indenture, subject to redemption as provided herein, and to pay interest on such principal amount at the rate per annum due on the hereiafter defined Series 2012 Certificates from the dated date of this Master Note. Payment of principal of, premium, if any, and interest on this Master Note will be made at the times, in the amounts and in the manner required for payments under the defined Certificate Indenture, subject to any credits against such deposits as provided therein.

The principal of and the premium, if any, and interest on this Master Note are payable by check or draft, hand-delivered or wire-transferred to the principal corporate trust office of **[Name of Trustee]**, as trustee (together with any successors or assigns, the "Certificate Trustee") under the Indenture of Trust, dated as of December 1, 2012 (the "Certificate Indenture"), between the Authority and the Certificate Trustee pursuant to which the Authority has issued its Revenue Anticipation Certificates, (Phoebe Putney Memorial Hospital), Series 2012 (the "Series 2012 Certificates").

This Master Note is issued under and secured by and entitled to the security of a Master Trust Indenture, dated as of March 1, 2002 (as amended and supplemented, the "Master Indenture"), between the Members from time to time of the Obligated Group thereunder and U.S. Bank, National Association (as successor to SunTrust Bank) as master trustee (the "Master Trustee"). The Members of the Obligated Group agree under the Master Indenture to be jointly and severally liable on all Obligations issued under the Master Indenture (including this Master Note). The Master Indenture provides that the members of the Obligated Group may hereafter issue Additional Obligations (as defined in the Master Indenture) from time to time, and if issued, such Additional Obligations will rank pari passu with this Master Note and all other Obligations theretofore or thereafter issued under the Master Indenture, except as otherwise provided in the Master Indenture. Reference is made to the Master Indenture, to all indentures supplemental thereto and to all amendments thereto for the provisions, among others, with respect to the nature and extent of the security for this Master Note, the rights, duties and obligations of the Members of the Obligated Group and the Master Trustee and the rights of the holder of this Master Note, and to all the provisions to which the holder hereof by the acceptance of this Master Note assents.

This Master Note is transferable by its registered owner in person or by duly authorized attorney at the Master Trustee's principal corporate trust office, but only in the manner, subject to the limitations and upon payment of the charges provided in the Master Indenture, and upon surrender and cancellation of this Master Note. Upon such transfer, a new registered Master Note without coupons of the same series and maturity and of authorized denomination or denominations, for the same aggregate principal amount will be issued to the transferee in exchange therefor. The Master Trustee may deem and treat the registered owner of this Master Note as its absolute owner for receiving payment of or on account of principal hereof and premium, if any, hereon and interest due hereon and for all other purposes, and the Master Trustee will not be affected by any notice to the contrary.

This Master Note is subject to redemption before maturity at the times, in the manner, and at the redemption prices at which the Series 2012 Certificates are redeemable under the Certificate Indenture.

This Master Note or the portion of it so called for prepayment will cease to bear interest on the specified prepayment date, provided funds for its prepayment are on deposit at the place of payment at that time, and this Master Note or such portion of it will no longer be deemed to be outstanding under or secured by the provisions of the Master Indenture.

The registered owner of this Master Note will have no right to enforce the provisions of the Master Indenture or to institute action to enforce the covenants therein, or to take any action with respect to any event of default under the Master Indenture, or to institute, appear in or defend any suit or other proceedings with respect thereto, except as provided in the Master Indenture.

In certain events (including without limitation the occurrence of an "event of default" as defined in the Master Indenture and in the Certificate Indenture), on the conditions, in the manner and with the effect set forth in the Master Indenture and in the Certificate Indenture, the outstanding principal of this Master Note may become or may be declared due and payable before its stated maturity, together with interest accrued on it. This Master Note is an Accelerable Instrument (as defined in the Master Indenture).

Modifications or alterations of the Master Indenture, or of any supplements thereto, may be made to the extent and in the circumstances permitted by the Master Indenture.

It is hereby certified that all conditions, acts and things required to exist, happen and be performed under the Master Indenture precedent to and in the issuance of this Master Note, exist, have happened and have been performed, and that the issuance, authentication and delivery of this Master Note have been duly authorized by resolution of the Member duly adopted.

No recourse will be had for the payment of the principal of or premium or interest on this Master Note or for any claim based hereon or upon any obligation, covenant or agreement in the Master Indenture contained against any past, present or future officer, trustee, director, member, employee or agent of any Member of the Obligated Group, or any incorporator, officer, director, member, employee or agent of any successor corporation, as such, either directly or through any successor corporation, under any rule of law or equity, statute or constitution or by the enforcement of any assessment or penalty or otherwise, and all such liability of any such incorporators, officers, directors, members, employees or agents, as such, is hereby expressly waived and released as a condition of and consideration for the execution of the Master Indenture and the issuance of this Master Note.

The Member, on behalf of itself and the other members of the Obligated Group, hereby waives presentment for payment, demand, protest, notice of protest, notice of dishonor and all defenses on the grounds of extension of time of payment for the payment hereof which may be given (other than in writing) by the Master Trustee to such Members.

This Master Note will not be valid or become obligatory for any purpose or be entitled to any security or benefit under the Master Indenture until the Master Trustee has duly executed the certificate of authentication appearing below.

IN WITNESS WHEREOF, Phoebe Putney Memorial Hospital, Inc. has caused this Master Note to be executed in its name and on its behalf by the manual or facsimile signature of its President or one of its Vice Presidents and has caused its seal to be hereunto affixed either manually or by facsimile, and attested by the manual or facsimile signature of its Secretary or one its Assistant Secretaries, all as of the dated date set forth above.

PHOEBE PUTNEY MEMORIAL HOSPITAL, INC.,
a Member of the Obligated Group

[Seal]

Attest:

By _____
Joel Wernick,
President and Chief Executive Officer

_____
Kerry Loudermilk, Senior Vice
President and Chief Financial Officer

MASTER TRUSTEE'S AUTHENTICATION CERTIFICATE

This Master Note is one of the Obligations described in the within-mentioned Master Indenture.

U.S. BANK, NATIONAL ASSOCIATION,
as Master Trustee

By:_____
Authorized Officer

ASSIGNMENT

The Hospital Authority of Albany-Dougherty County, Georgia (the "Authority"), hereby irrevocably assigns the foregoing Master Note without recourse to **[Name of Trustee]**, as trustee (the "Certificate Trustee"), acting pursuant to an Indenture of Trust, dated as of December 1, 2012 (the "Certificate Indenture"), between the Authority and the Certificate Trustee, and hereby directs Phoebe Putney Memorial Hospital, Inc., as the maker of the foregoing Master Note, to make all payments of principal of and premium, if any, and interest thereon directly to the Certificate Trustee at its principal corporate trust office in Atlanta, Georgia. Such assignment is made as security for the payment of the Authority's revenue anticipation certificates issued under the Certificate Indenture.

HOSPITAL AUTHORITY OF ALBANY-DOUGHERTY, GEORGIA

[SEAL]

By:_____
Name:
Title:

Attest:

By _____
Name:
Title:

PRELIMINARY OFFICIAL STATEMENT DATED NOVEMBER __, 2012

NEW ISSUE
(Book-Entry Only)

RATINGS
[Rating Agency:]
See "MISCELLANEOUS - Ratings" herein.

In the opinion of McKenna Long & Aldridge LLP, Bond Counsel, subject to the limitations and conditions described herein, interest on the Series 2012 Certificates is (i) excludable from gross income for federal income tax purposes and not treated as an item of tax preference in computing the federal alternative minimum tax (although, it is to be taken into account by corporations as an adjustment to adjusted current earnings in determining alternative minimum taxable income) and (ii) exempt from present State of Georgia income taxation. For further details, see "TAX EXEMPTION AND OTHER TAX MATTERS."

$[Principal Amount]*

PPMH Logo

HOSPITAL AUTHORITY OF ALBANY-DOUGHERTY COUNTY, GEORGIA
REVENUE ANTICIPATION CERTIFICATES
(PHOEBE PUTNEY MEMORIAL HOSPITAL)
SERIES 2012

Dated: Date of Delivery **Due: December 1 as shown on the Inside Cover**

$[Principal Amount]* of Revenue Anticipation Certificates (Phoebe Putney Memorial Hospital) Series 2012 (the "Series 2012 Certificates") are being issued by the Hospital Authority of Albany-Dougherty County, Georgia (the "Authority") to provide funds to lend to Phoebe Putney Memorial Hospital, Inc. ("PPMH") to (i) finance the costs of making certain additions, extensions, and capital improvements to its health care system, and (ii) pay the costs of issuing the Series 2012 Certificates. See **"PLAN OF FINANCING"** herein.

The Series 2012 Certificates are being issued pursuant to an Indenture of Trust (the "Certificate Indenture"), dated as of December 1, 2012, between the Authority and [Name of Trustee], as certificate trustee (the "Certificate Trustee"). The Series 2012 Certificates are special limited obligations of the Authority payable from and secured by a pledge of the payments to be made under the hereinafter described Series 2012 Obligation and certain funds held under the Certificate Indenture. To evidence its obligation to repay the loan of the proceeds of the Series 2012 Certificates, PPMH will issue and deliver to the Authority its Series 2012 Obligation in the original principal amount of $[Principal Amount]* (the "Series 2012 Obligation"), under a Master Trust Indenture, dated as of March 1, 2002, as supplemented and amended (the "Master Indenture"), between PPMH and U.S. Bank National Association, as successor master trustee. The Series 2012 Obligation is a joint and several general obligation of PPMH, Phoebe Putney Health System, Inc., and affiliates of these corporations that may in the future become obligated under the Master Indenture (collectively the "Obligated Group"), secured by a pledge of the gross receipts of the Obligated Group, to the extent and subject to the limitations described herein. To secure its obligations under the Series 2012 Certificates, the Authority will assign and pledge to the Certificate Trustee all of its right, title, and interest in and to the Series 2012 Obligation pursuant to the Certificate Indenture. See "SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2012 CERTIFICATES" herein.

The Series 2012 Certificates will only be issued in book-entry form registered in the name of Cede & Co., the nominee of The Depository Trust Company, New York, New York ("DTC"). Payment of the principal of, premium, if any, and interest on the Series 2012 Certificates will be made by the Certificate Trustee directly to Cede & Co., as nominee for DTC, as registered owner of the Series 2012 Certificates, and will be subsequently disbursed by Cede & Co. to DTC Participants and thereafter to Beneficial Owners of the Series 2012 Certificates, all as further described herein. See "DESCRIPTION OF THE SERIES 2012 CERTIFICATES – Book-Entry System of Registration" herein. Interest on the Series 2012 Certificates will be payable semiannually on each June 1 and December 1, commencing June 1, 2013. See "DESCRIPTION OF THE SERIES 2012 CERTIFICATES" herein.

The Series 2012 Certificates are subject to optional and extraordinary redemption prior to maturity as described herein. See "THE SERIES 2012 CERTIFICATES - Redemption" herein.

The Series 2012 Certificates do not constitute a debt, liability, general or moral obligation, or pledge of the faith and credit or taxing power of the City of Albany, Georgia or Dougherty County, Georgia. No governmental entity, including the City of Albany and Dougherty County, is obligated to levy any tax for the payment of the Series 2012 Certificates. The Authority has no taxing power.

This cover page contains certain information for quick reference only. It is *not* a summary of this issue. Investors must read the entire Official Statement to obtain information essential to making an informed investment decision.

The Series 2012 Certificates are offered when, as, and if issued by the Authority and accepted by the Underwriters, subject to prior sale and to withdrawal or modification of the offer without notice, and are subject to the approving opinion of McKenna Long & Aldridge LLP, Atlanta, Georgia, Bond Counsel. Certain legal matters will be passed on for the Authority by its counsel, Perry & Walters, LLP, Albany, Georgia, for the Obligated Group by its counsel, The Baudino Law Group, Des Moines, Iowa, and Thomas S. Chambless, Senior Vice President and General Counsel of PPMH, and for the Underwriters by their counsel, Peck, Shaffer & Williams LLP, Atlanta, Georgia. The Series 2012 Certificates in definitive form will be delivered to the Certificate Trustee on behalf of DTC under the DTC FAST system of registration on or about December __, 2012.

BofA Merrill Lynch **Morgan Stanley** **Raymond James | Morgan Keegan**

Dated: December __, 2012

* Preliminary, subject to change.

MATURITY SCHEDULE

Maturity (December 1)	Principal Amount	Interest Rate	Yield	CUSIP‡

$ *___% Term Certificates due December 1, 20__, Priced to Yield: ____%, CUSIP _____
$ *___% Term Certificates due December 1, 20__, Priced to Yield: ____%, CUSIP _____

PRELIMINARY NOTICES

No dealer, salesman or other person has been authorized to give any information or to make any representations other than those contained in this Official Statement, and if given or made, such information or representations must not be relied upon as having been authorized by PPMH, the Authority, or the Underwriters. The information set forth herein concerning PPMH has been furnished by PPMH and is believed to be reliable, but is not guaranteed as to accuracy or completeness by, and is not to be construed as a representation by, the Authority or the Underwriters. The Authority takes no responsibility as to the accuracy or completeness of the information contained in this Official Statement other than that under the heading "THE AUTHORITY" and under the heading "LITIGATION – The Authority." The information contained herein is subject to change without notice, and neither the delivery of this Official Statement nor any sale made hereunder shall under any circumstances create an implication that there has been no change in the affairs of the Authority or PPMH since the date hereof.

This Official Statement does not constitute an offer to sell or a solicitation of an offer to buy any of the securities offered hereby in any state to any person to whom it is unlawful to make such offer in such state. Except where otherwise indicated, this Official Statement speaks as of the date hereof. The information and expressions of opinion herein are subject to change without notice and neither the delivery of this Official Statement nor any sale hereunder will under any circumstances create any implication that there has been no change in the affairs of PPMH since the date hereof.

In making an investment decision, investors must rely on their own examination of the Series 2012 Certificates, PPMH, and the terms of the offering, including the merits and risks involved. The Series 2012 Certificates have not been recommended by any federal or state securities commission or regulatory authority. Furthermore, no such commission or

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‡ None of the Authority, the Obligated Group or the Underwriter take responsibility for the accuracy of the CUSIP® numbers, which are included solely for the convenience of the purchasers of the Series 2012 Bonds. CUSIP numbers on the inside cover of this Official Statement are copyright 2009 by the American Bankers Association. CUSIP data herein is provided by Standard & Poor's, CUSIP Service Bureau, a division of The McGraw-Hill Companies, Inc. This data is not intended to create a database and does not serve in any way as a substitute for the CUSIP Service Bureau.

* Preliminary, subject to change.

regulatory authority has confirmed the accuracy or determined the adequacy of this Official Statement. Any representation to the contrary is a criminal offense.

The Underwriters have provided the following sentence for inclusion in this Official Statement. The Underwriters have reviewed the information in this Official Statement in accordance with, and as part of, their responsibilities to investors under the federal securities laws as applied to the facts and circumstances of this transaction, but the Underwriters do not guarantee the accuracy or completeness of such information. The information contained in this Official Statement has been furnished by PPMH, the Authority, DTC and other sources which are believed to be reliable, but such information is not guaranteed as to accuracy or completeness by, and is not to be construed as a representation of, the Underwriters. The information and expressions of opinion herein are subject to change without notice, and neither the delivery of this Official Statement nor any sale made hereunder shall, under any circumstances, create any implication that there has been no change in the affairs of the parties referred to above since the date hereof.

THE SERIES 2012 CERTIFICATES HAVE NOT BEEN REGISTERED UNDER THE SECURITIES ACT OF 1933, AS AMENDED, AND THE CERTIFICATE INDENTURE HAS NOT BEEN QUALIFIED UNDER THE TRUST INDENTURE ACT OF 1939, AS AMENDED, IN RELIANCE UPON EXEMPTIONS CONTAINED IN SUCH ACTS. THE REGISTRATION OR QUALIFICATION OF THE SERIES 2012 CERTIFICATES IN ACCORDANCE WITH APPLICABLE PROVISIONS OF LAWS OF THE STATES IN WHICH SERIES 2012 CERTIFICATES HAVE BEEN REGISTERED OR QUALIFIED AND THE EXEMPTION FROM REGISTRATION OR QUALIFICATION IN OTHER STATES CANNOT BE REGARDED AS A RECOMMENDATION THEREOF. NEITHER THESE STATES NOR ANY OF THEIR AGENCIES HAVE PASSED UPON THE MERITS OF THE SERIES 2012 CERTIFICATES OR THE ACCURACY OR COMPLETENESS OF THIS OFFICIAL STATEMENT. ANY REPRESENTATION TO THE CONTRARY MAY BE A CRIMINAL OFFENSE.

IN CONNECTION WITH THIS OFFERING, THE UNDERWRITERS MAY OVER-ALLOT OR EFFECT TRANSACTIONS THAT STABILIZE OR MAINTAIN THE MARKET PRICE OF THE SERIES 2012 CERTIFICATES AT A LEVEL ABOVE THAT WHICH MIGHT OTHERWISE PREVAIL IN THE OPEN MARKET. SUCH STABILIZING, IF COMMENCED, MAY BE DISCONTINUED AT ANY TIME. THE UNDERWRITERS MAY OFFER AND SELL THE SERIES 2012 CERTIFICATES TO CERTAIN DEALERS AT PRICES LOWER THAN THE PUBLIC OFFERING PRICES STATED ON THE INSIDE COVER PAGE HEREOF AND SAID PUBLIC OFFERING PRICES MAY BE CHANGED FROM TIME TO TIME BY THE UNDERWRITERS.

THE SERIES 2012 CERTIFICATES HAVE NOT BEEN REGISTERED WITH THE SECURITIES AND EXCHANGE COMMISSION UNDER THE SECURITIES ACT OF 1933, AS AMENDED, IN RELIANCE ON CERTAIN EXEMPTIONS FROM REGISTRATION.

Cautionary Statements Regarding Forward-Looking Statements

This Official Statement contains statements which should be considered "forward-looking statements," within the meaning of the United States Private Securities Litigation Reform Act of 1995, Section 21E of the United States Securities Exchange Act of 1934, as amended, and Section 27A of the United States Securities Act of 1933, as amended, meaning they refer to possible future events or conditions. Such statements are generally identifiable by the words such as "anticipate," "believe," "budget," "estimate," "expect," "intend," "plan," "forecast," or similar words.

THE ACHIEVEMENT OF CERTAIN RESULTS OR OTHER EXPECTATIONS CONTAINED IN SUCH FORWARD-LOOKING STATEMENTS INVOLVE KNOWN AND UNKNOWN RISKS, UNCERTAINTIES AND OTHER FACTORS THAT MAY CAUSE ACTUAL RESULTS, PERFORMANCE OR ACHIEVEMENTS DESCRIBED TO BE MATERIALLY DIFFERENT FROM ANY FUTURE RESULTS, PERFORMANCE OR ACHIEVEMENTS EXPRESSED OR IMPLIED BY SUCH FORWARD-LOOKING STATEMENTS. PPMH DOES NOT EXPECT OR INTEND TO ISSUE ANY UPDATES OR REVISIONS TO THOSE FORWARD-LOOKING STATEMENTS IF OR WHEN ITS EXPECTATIONS, OR EVENTS, CONDITIONS OR CIRCUMSTANCES ON WHICH SUCH STATEMENTS ARE BASED OCCUR.

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OFFICIAL STATEMENT

of the

HOSPITAL AUTHORITY OF ALBANY-DOUGHERTY COUNTY, GEORGIA

relating to its

$[Principal Amount]*
REVENUE ANTICIPATION CERTIFICATES
(PHOEBE PUTNEY MEMORIAL HOSPITAL)
SERIES 2012

INTRODUCTION

The purpose of this Official Statement, which includes the cover page and the Appendices hereto, is to furnish certain information in connection with the sale by the Hospital Authority of Albany-Dougherty County, Georgia of $[Principal Amount] * in aggregate principal amount of its Revenue Anticipation Certificates (Phoebe Putney Memorial Hospital) Series 2012 (the "Series 2012 Certificates"). Definitions of certain terms used in this Official Statement and not otherwise defined herein are set forth in Appendix C to this Official Statement under the heading "DEFINITIONS OF CERTAIN TERMS."

This Introduction is not a summary of this Official Statement and is intended only for quick reference. It is only a brief description of and guide to, and is qualified in its entirety by reference to, more complete and detailed information contained in the entire Official Statement, including the cover page and the Appendices, and the documents summarized or described herein. Potential investors should fully review the entire Official Statement. The offering of the Series 2012 Certificates to potential investors is made only by means of the entire Official Statement, including the Appendices hereto. No person is authorized to detach this Introduction from the Official Statement or to otherwise use it without the entire Official Statement, including the Appendices hereto.

The Authority

The Hospital Authority of Albany-Dougherty County, Georgia (the "Authority"), the issuer of the Series 2012 Certificates, is a public body corporate and politic created and existing under the laws of the State of Georgia. For more complete information, see "THE AUTHORITY" herein.

The Combined Group

Under a holding company structure with Phoebe Putney Health System, Inc. (the "Parent") as the parent corporation, Phoebe Putney Memorial Hospital, Inc. ("PPMH") and nine other entities as subordinate affiliates, provide a variety of health care and related services. The Parent, PPMH, and affiliates of these corporations that may in the future become obligated under the hereinafter described Master Indenture are referred to collectively in this Official Statement as the "Obligated Group." The Obligated Group and affiliates of the Obligated Group with respect to which members of the Obligated Group may in the future agree to cause compliance with certain restrictions contained in the Master Indenture are referred to collectively in this Official Statement as the "Combined Group." For more complete information, see "THE COMBINED GROUP" herein.

Certificate Trustee and Master Trustee

[Name of Trustee], Atlanta, Georgia, will act as trustee, as certificate registrar, and as paying agent for the Series 2012 Certificates under the hereinafter described Certificate Indenture and U.S. Bank National Association is the master trustee under the hereinafter described Master Indenture.

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* Preliminary, subject to change.

Purpose of the Series 2012 Certificates

The Authority will lend the proceeds of the Series 2012 Certificates to PPMH to finance or reimburse PPMH for the costs of (i) making certain additions, extensions, and capital improvements to its health care system, including, but not limited to, the acquisition of Palmyra Medical Center, a 248-bed acute care facility located in Albany, Georgia (collectively, the "2012 Project"), and (ii) issuing the Series 2012 Certificates, pursuant to the terms of a Loan Agreement (the "Loan Agreement"), dated as of December 1, 2012, between the Authority and PPMH. For more complete information, see "PLAN OF FINANCING" herein.

The System

The Combined Group owns and operates a health care system known as the "Phoebe Putney Health System" (the "System"), which is a vertically integrated health care delivery system providing a full range of health services. The primary facility of the System is Phoebe Putney Memorial Hospital (the "Hospital"), a 450-bed general acute care hospital located in Albany, Dougherty County, Georgia. Albany, Georgia, the fifth largest city in the State of Georgia, is approximately 170 miles south of Atlanta, Georgia. The System's primary service area consists of Dougherty, Lee, Mitchell, Terrell, and Worth Counties, Georgia, containing approximately 2,100 square miles and an estimated population in excess of 173,000. The System's entire service area contains an estimated population in excess of 349,000. The Hospital is the largest hospital in its service area. For more complete information, see "THE SYSTEM" herein.

Security and Sources of Payment for the Series 2012 Certificates

The Series 2012 Certificates are special limited obligations of the Authority payable from and secured by the amounts pledged under an Indenture of Trust (the "Certificate Indenture"), dated as of December 1, 2012, between the Authority and [Name of Trustee], as trustee (the "Certificate Trustee").

The Series 2012 Certificates do not and will not constitute a debt, liability, general or moral obligation, or pledge of the faith and credit or taxing power of the City of Albany, Georgia or Dougherty County, Georgia. No governmental entity, including the City of Albany and Dougherty County, is obligated to levy any tax for the payment of the Series 2012 Certificates. The Authority has no taxing power.

The Authority has previously issued its (i) Revenue Certificates (Phoebe Putney Memorial Hospital), Series 1993 in the aggregate principal amount of $36,715,000, of which $14,280,000 remains outstanding (the "Series 1993 Certificates"), (ii) Revenue Anticipation Certificates (Phoebe Putney Memorial Hospital) Series 2008A in the aggregate principal amount of $54,225,000, of which $48,680,000 remains outstanding (the "Series 2008A Certificates"), (iii) Revenue Anticipation Certificates (Phoebe Putney Memorial Hospital) Series 2008B in the aggregate principal amount of $54,100,000, of which $48,590,000 remains outstanding (the "Series 2008B Certificates"), and (iv) Revenue Anticipation Certificates (Phoebe Putney Memorial Hospital) Series 2010A in the aggregate principal amount of up to $99,000,000, of which $97,475,000 is outstanding (the "Series 2010A Certificates" and together with the Series 1993 Certificates, the Series 2008A Certificates, and the Series 2008B Certificates, the "Prior Certificates"). See 'PLAN OF FINANCING" herein.

PPMH entered into a Master Trust Indenture dated as of March 1, 2002 (the "Master Indenture") with U.S. Bank, National Association (as successor to SunTrust Bank), as master trustee (in such capacity, the "Master Trustee"), pursuant to which PPMH issued the Existing Certificates Obligation in the principal amount of $81,040,000 (the "Existing Certificate Obligation") pursuant to the Existing Certificates Supplement to Master Indenture as security for the Series 1993 Certificates. PPMH previously issued the Series 2008A Obligation in the principal amount of $54,225,000 (the "Series 2008A Obligation") and the Series 2008B Obligation in the principal amount of $54,100,000 (the "Series 2008B Obligation") pursuant to the Series 2008 Supplement to Master Indenture as security for the Series 2008A Certificates and the Series 2008B Certificates, respectively and the Series 2010A Obligation in the principal amount of up to $99,000,000 (the "Series 2010A Obligation") pursuant to the Series 2010 Supplement to Master Indenture as security for the Series 2010A Certificates. The Existing Certificate Obligation, the Series 2008A Obligation, the Series 2008B Obligation, and the Series 2010A Obligation are referred to collectively as the "Prior Certificates Obligations."

The Hospital will issue the Series 2012 Obligation in the same principal amount as the aggregate principal amount of the Series 2012 Certificates (the "Series 2012 Obligation") pursuant to the Series 2012 Supplement to Master Indenture to secure the Series 2012 Certificates. The Series 2012 Obligation will rank on a parity with the Existing Certificate Obligation, the Series 2008A Obligation, the Series 2008B Obligation, and the Series 2010A Obligation. To

the extent that the principal amounts of Prior Certificates or Series 2012 Certificates are paid by redemption or at maturity, a corresponding amount of principal of the Obligation that secures such Certificates being paid is deemed to have been paid, so that the principal amount of the outstanding Obligations that secure Certificates will always equal the principal amount of the Certificates secured by each. It is expected that PPMH will provide its own funds sufficient to cause the Series 1993 Certificates to be refunded and the Existing Certificates Obligation to be extinguished approximately 30 days after the issuance of the Series 2012 Certificates; however, PPMH is not obligated to refund the Series 1993 Certificates.

The Master Indenture provides for the creation of a group of entities called the Obligated Group, which are jointly and severally liable for the payment of all obligations issued under the Master Indenture. Upon compliance with certain conditions set forth in the Master Indenture, additional members may be added to the Obligated Group and existing members may withdraw from the Obligated Group. The Master Indenture contains certain covenants of and restrictions on the Obligated Group, relating to itself and its assets. The Master Indenture allows members of the Obligated Group to designate certain of their affiliates as "Restricted Affiliates," which are not directly liable for the payment of any obligations issued under the Master Indenture. The Obligated Group has covenanted in the Master Indenture to cause the Restricted Affiliates to comply with certain covenants and restrictions contained in the Master Indenture. There are presently no Restricted Affiliates under the Master Indenture. Upon compliance with certain conditions set forth in the Master Indenture, members of the Obligated Group may designate additional Restricted Affiliates and existing Restricted Affiliates may be released from their obligations and status as Restricted Affiliates.

The Series 2012 Obligation will be a joint and several general obligation of the Obligated Group (subject, in the case of guaranteed obligations, to the Maximum Guaranty Liability (as defined in "DEFINITIONS OF CERTAIN TERMS" in Appendix C hereto)), secured under the Master Indenture by a pledge of the Gross Receipts (as defined in "DEFINITIONS OF CERTAIN TERMS" in Appendix C hereto) of the Obligated Group. The Series 2012 Obligation will be a direct obligation of PPMH guaranteed by each other member of the Obligated Group to the extent of its respective Maximum Guaranty Liability. Although the Obligated Group has covenanted in the Master Indenture to cause each Restricted Affiliate to transfer funds to the Obligated Group to satisfy its obligations under the Master Indenture, there will be no direct recourse against any Restricted Affiliate under the Master Indenture, and no assets of any Restricted Affiliate will be pledged to secure any obligations issued under the Master Indenture.

Under certain circumstances, the Master Indenture permits the Obligated Group to incur additional obligations that will be equally and ratably secured under the Master Indenture on a parity basis with the Series 2012 Obligation, the Series 2010 Obligation, the Series 2008A Obligation, the Series 2010B Obligation, and the Existing Certificates Obligation.

To secure its obligations under the Series 2012 Certificates, the Authority will enter into the Certificate Indenture with the Certificate Trustee, pursuant to which the Authority will assign to the Certificate Trustee all of its right, title, and interest in and to the Series 2012 Obligation, the Loan Agreement (except for certain rights reserved to the Authority), and all moneys and securities held by the Certificate Trustee in any and all of the funds and accounts established under the Certificate Indenture. The Series 2012 Obligation will be registered in the name of the Certificate Trustee and held by the Certificate Trustee for the benefit of the owners of the Series 2012 Certificates. The Certificate Trustee, as the registered owner of the Series 2012 Obligation, will be entitled to the protection of the covenants, restrictions, and other obligations imposed upon the Obligated Group by the Master Indenture.

Under the terms of the Certificate Indenture, the Series 2012 Certificates will be equally and ratably secured on a parity basis, and no obligations other than the Series 2012 Certificates may be issued under or secured by the Certificate Indenture.

For more complete and detailed information, see "SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2012 CERTIFICATES" herein.

Description of the Series 2012 Certificates

Redemption. The Series 2012 Certificates are subject to optional redemption and extraordinary redemption prior to maturity. For more complete information, see "THE SERIES 2012 CERTIFICATES - Redemption" herein.

Denominations. Series 2012 Certificates are issuable in denominations of $5,000 and any integral multiple thereof.

Book-Entry Certificates. Each of the Series 2012 Certificates will be issued as fully registered certificates in the denomination of one certificate per aggregate principal amount of the stated maturity thereof, and, when issued, will be registered in the name of Cede & Co., as nominee for The Depository Trust Company ("DTC"), New York, New York, an automated depository for securities and clearing house for securities transactions, which will act as securities depository for the Series 2012 Certificates. Purchasers will not receive certificates representing their ownership interest in the Series 2012 Certificates purchased. Purchases of beneficial interests in the Series 2012 Certificates will be made in book-entry only form (without certificates), in authorized denominations, and, under certain circumstances as more fully described in this Official Statement, such beneficial interests are exchangeable for one or more fully registered certificates of like principal amount and maturity in authorized denominations. For more complete information, see "THE SERIES 2012 CERTIFICATES - Book-Entry Only System" herein.

Payments. So long as DTC or its nominee, Cede & Co., is the registered owner of the Series 2012 Certificates, payments of the principal of, premium, if any, and interest on the Series 2012 Certificates will be made directly to Cede & Co., which will remit such payments to the DTC participants, which will in turn remit such payments to the beneficial owners of the Series 2012 Certificates.

For a more complete description of the Series 2012 Certificates, see "THE SERIES 2012 CERTIFICATES" herein.

Tax Exemption

In the opinion of Bond Counsel, under existing law and subject to conditions hereinafter described, interest on the Series 2012 Certificates i) excludable from gross income for federal income tax purposes and not treated as an item of tax preference in computing the federal alternative minimum tax (although, it is to be taken into account by corporations as an adjustment to adjusted current earnings in determining alternative minimum taxable income) and (ii) exempt from present State of Georgia income taxation. See Appendix D hereto for the form of the opinion Bond Counsel proposes to deliver in connection with the issuance of the Series 2012 Certificates. For a more complete discussion of such opinion and certain other tax consequences of owning the Series 2012 Certificates, including certain exceptions to the exclusion of the interest on the Series 2012 Certificates from gross income, see "TAX EXEMPTION AND OTHER TAX MATTERS - Opinion of Bond Counsel and Collateral Federal Tax Consequences" herein.

Professionals Involved in the Offering

Certain legal matters pertaining to the Authority and its authorization and issuance of the Series 2012 Certificates are subject to the approving opinion of McKenna Long & Aldridge LLP, Atlanta, Georgia, Bond Counsel. Copies of such opinion will be available at the time of delivery of the Series 2012 Certificates, and a copy of the proposed form of such opinion is attached hereto as Appendix D. Certain legal matters will be passed upon for the Authority by its counsel, Perry & Walters, LLP, Albany, Georgia, for the Obligated Group by its counsel, The Baudino Law Group, Des Moines, Iowa, and Thomas S. Chambless, its Senior Vice President and General Counsel, and for the Underwriters by their counsel, Peck, Shaffer & Williams LLP, Atlanta, Georgia. Hammond Hanlon Camp LLC, Atlanta, Georgia, has been employed as financial advisor to the Obligated Group in connection with the issuance of the Series 2012 Certificates. The consolidated financial statements of the Parent as of July 31, 2011 and 2010 [2012?], and for the years then ended, included in this Official Statement as Appendix B, have been audited by Draffin & Tucker, LLP, Albany, Georgia, independent auditors, as stated in their report thereon, which appears in Appendix B hereto. See "MISCELLANEOUS - Independent Auditors" herein.

Legal Authority

The Series 2012 Certificates are being issued and secured pursuant to the authority granted by the laws of the State of Georgia and pursuant to a resolution of the Authority authorizing the issuance of the Series 2012 Certificates, adopted by the Board of Trustees of the Authority on November 8, 2012. For more complete information, see "THE SERIES 2012 CERTIFICATES - Legal Authority" herein.

Offering and Delivery of the Series 2012 Certificates

The Series 2012 Certificates are offered when, as, and if issued by the Authority and accepted by the Underwriters, subject to prior sale and to withdrawal or modification of the offer without notice. The Series 2012 Certificates in definitive form are expected to be delivered to the Certificate Trustee on behalf of DTC under the DTC FAST system of registration on or about December __, 2012.

Investment Considerations

There are certain considerations relating to an investment in the Series 2012 Certificates which are set forth in this Official Statement under the caption "INVESTMENT CONSIDERATIONS" and which should be carefully reviewed by prospective purchasers of the Series 2012 Certificates. See "INVESTMENT CONSIDERATIONS" herein.

Other Information

This Official Statement speaks only as of its date, and the information contained herein is subject to change.

This Official Statement contains forecasts, projections, and estimates that are based on current expectations but are not intended as representations of fact or guarantees of results. If and when included in this Official Statement, the words "anticipate," "believe," "budget," "estimate," "expect," "intend," "plan," "forecast," and similar words are intended to identify forward-looking statements as defined in the Securities Act of 1933, as amended, and any such statements inherently are subject to a variety of risks and uncertainties, which could cause actual results to differ materially from those contemplated in such forward-looking statements. These forward-looking statements speak only as of the date of this Official Statement. The Authority and the Combined Group disclaim any obligation or undertaking to release publicly any updates or revisions to any forward-looking statement contained herein to reflect any change in the Authority or the Combined Group's expectations with regard thereto or any change in events, conditions, or circumstances on which any such statement is based.

In order to comply with Securities and Exchange Commission Rule 15c2-12, the Obligated Group has agreed pursuant to a Disclosure Dissemination Agent Agreement dated as of December 1, 2012, with Digital Assurance Certification, L.L.C., as dissemination agent, to provide certain financial information and operating data. See "MISCELLANEOUS – Continuing Disclosure" herein.

This Official Statement and the Appendices hereto contain brief descriptions of, among other matters, the Authority, the Combined Group, the System, the Series 2012 Certificates, the Certificate Indenture, the Master Indenture, the Series 2012 Obligation, the Series 2010 Obligation, the Series 2008A Obligation, the Series 2010B Obligation, and the Existing Certificates Obligation, the Loan Agreement, and the security and sources of payment for the Series 2012 Certificates. Such descriptions and information do not purport to be comprehensive or definitive. The summaries of various constitutional provisions and statutes, the Series 2012 Certificates, the Certificate Indenture, the Master Indenture, the Series 2012 Obligation, the Series 2010 Obligation, the Series 2008A Obligation, the Series 2010B Obligation, and the Existing Certificates Obligation, the Loan Agreement, and other documents are intended as summaries only and are qualified in their entirety by reference to such laws and documents, and references herein to the Series 2012 Certificates and the Series 2012 Obligation, the Series 2010 Obligation, the Series 2008A Obligation, the Series 2010B Obligation, and the Existing Certificates Obligation are qualified in their entirety to the forms thereof included in the Certificate Indenture and the Master Indenture. Copies of the Certificate Indenture, the Master Indenture, the Loan Agreement, and other documents and information are available, upon request and upon payment to Phoebe Putney Memorial Hospital, Inc. of a charge for copying, mailing, and handling, from, Kerry L. Loudermilk, Senior Vice President and Chief Financial Officer, 417 Third Avenue, Albany, Georgia 31703, telephone (229) 312-4068. During the period of the offering of the Series 2012 Certificates, copies of such documents are available, upon request and upon payment to the Underwriters of a charge for copying, mailing, and handling, from Merrill Lynch, Pierce, Fenner & Smith, Inc. One Bryant Park, New York, NY 10036, telephone _____.

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PLAN OF FINANCING

Estimated Sources and Applications of Funds

The sources and applications of funds in connection with the issuance of the Series 2012 Certificates are estimated below.

Estimated Sources of Funds*	
Proceeds of Series 2012 Certificates	$[Principal Amount]
[Estimated Interest Earnings during Construction[1]]	_____]
Total Sources of Funds	$_____
Estimated Applications of Funds*	
System Improvements[2]	$
Costs Issuance[3]	_____
Total Applications of Funds	$_____

[1] Based on estimated earnings on the unexpended construction funds at an investment rate of ___% over a period of _____ months.

[2] See "PLAN OF FINANCING - System Improvements" herein.

[3] Includes legal and accounting fees, initial Certificate Trustee's and Master Trustee's fees, printing and engraving costs, validation court costs, underwriting discount, Financial Advisor's fees, and other costs of issuance.

The 2012 Project

The Authority will lend the proceeds of the sale of the Series 2012 Certificates to PPMH pursuant to the terms of the Loan Agreement. PPMH's and the Parent's respective Boards of Directors, together with the Hospital's administrative staff, has developed a multi-year capital improvements program for the System and a plan to finance the program which relies on a combination of proceeds of debt, investment earnings, and System revenues. The Hospital's administrative staff expects that the proceeds of the Series 2012 Certificates, together with investment earnings, will be sufficient to provide for the 2012 Project, consisting of a major portion of the System's capital improvements program into 20__, as set forth in the following general categories:

Estimated Uses of Funds:*

Total

Several of the renovations, expansions, and equipment acquisitions included in the general categories listed above are either substantially completed or currently underway. A portion of the proceeds of the Series 2012 Certificates will be used to reimburse PPMH for costs associated with these projects. The commencement date of some of the System improvements described above was _____, 200_. PPMH has obtained from the Georgia Health Planning Agency all required certificates of need for the capital improvements described above. The improvements described above have been designed and phased so that they will not significantly interfere with daily operations.

For a discussion of restrictions that apply to the use of the proceeds of the Series 2012 Certificates and the amounts held in the Project Fund under the Certificate Indenture, see "THE CERTIFICATE INDENTURE - Project Fund" in Appendix C hereto

* Preliminary, subject to change.

Conversion of Series 2008A and Series 2008B Certificates

On or about the date of issuance of the Series 2012 Certificates, the interest rate on the Series 2008A Certificates and Series 2008B Certificates will be converted from a weekly variable rate with security provided by bank letters of credit to a variable rate based on a percentage of LIBOR plus a credit spread. The converted Series 2008A Certificates and Series 2008B Certificates will be purchased by Bank of America, N.A., and affiliate of Merrill Lynch, Pierce, Fenner & Smith, Inc., one of the Underwriters of the Series 2012 Certificates. The converted certificates are hereinafter referred to as the Series 2012 Bank Certificates. See "INVESTMENT CONSIDERATIONS – Requirements of Swap Counterparties and Holders of Bank Bonds" herein.

Planned Redemption of Series 1993 Certificates

PPMH plans to use its own funds to redeem the Series 1993 Certificates approximately 30 days following the issuance of the Series 2012 Certificates; however, PPMH is not obligated to complete such redemption.

[Remainder of Page Intentionally Left Blank]

	Series 2012 Certificates		Outstanding Certificates[1]		Bank Certificate	
Bond Year Ending December 31	Principal or Sinking Fund Payments	Interest	Principal Payment	Interest[2]	Principal and Interest[3]	Total Debt Service Payments
2013						
2014						
2015						
2016						
2017						
2018						
2019						
2020						
2021						
2022						
2023						
2024						
2025						
2026						
2027						
2028						
2029						
2030						
2031						
2032						
2033						
2034						
2035						
2036						
2037						
2038						
2039						
2040						
2041						
2042						
2043						
TOTAL						

[1] Series 2010 Certificates. See "INTRODUCTION – Security and Sources of Payment for the Series 2012 Certificates" and "PLAN OF FINANCING" herein.

[2] Based on swap rates and based on the assumption that the swaps will be in place throughout the life of the outstanding Series 2010 Certificates.

[3] The Bank Certificate bears interest at a rate equal a percentage of LIBOR plus a credit spread. The interest shown is an assumed rate of ___% per annum; however, there can be no assurance that the interest rate on the Bank Certificate will not increase to rates higher than those shown.

THE SERIES 2012 CERTIFICATES

Description

The Series 2012 Certificates are being issued in the aggregate principal amount of $[Principal Amount]*. The Series 2012 Certificates, as initially issued, will be dated the Closing Date and will mature, subject to prior redemption and acceleration upon the terms and conditions hereinafter described, on December 1 in the amounts and on the dates set forth on the inside cover of this Official Statement. Interest on the Series 2012 Certificates will be payable semiannually on each June 1 and December 1 (each an "Interest Payment Date"), commencing June 1, 2013

The Series 2012 Certificates will bear interest from the Interest Payment Date next preceding the date of authentication thereof to which interest has been paid or duly provided for, unless such date of authentication is an Interest Payment Date to which interest has been paid or duly provided for, in which case from the date of authentication thereof, or unless such date of authentication is prior to the first Interest Payment Date, in which event such Series 2012 Certificates will bear interest from the date of original authentication and delivery of the Series 2012 Certificates, until the entire principal amount of the Series 2012 Certificates is paid; provided, that if at the time of authentication of any Series 2012 Certificate interest is in default or overdue on the Series 2012 Certificates, such Series 2012 Certificate will bear interest from the date to which interest has previously been paid in full or made available for payment in full on Outstanding Series 2012 Certificates.

The Series 2012 Certificates are issuable only as fully registered certificates, without coupons. Series 2012 Certificates are issuable in denominations of $5,000 and any integral multiple thereof. Purchases of beneficial ownership interests in the Series 2012 Certificates will be made in book-entry form and purchasers will not receive certificates representing interests in the Series 2012 Certificates so purchased. If the book-entry system is discontinued, Series 2012 Certificates will be delivered as described in the Certificate Indenture, and Beneficial Owners will become the registered owners of the Series 2012 Certificates. See "THE SERIES 2012 CERTIFICATES - Book-Entry Only System" herein.

Interest on the Series 2012 Certificates

The Series 2012 Certificates will bear interest from and including their dated date until payment of the principal or redemption price thereof has been made or provided for, whether on the Maturity Date, upon redemption or otherwise. Interest will be calculated on the basis of a 360-day year consisting of twelve 30-day months. Payment of interest will be made on each Interest Payment Date for unpaid interest accrued during the Interest Period.

Redemption

Optional Redemption

The Series 2012 Certificates maturing on and after December 1, 20__ are subject to redemption by the Authority, at the option of PPMH, in whole or in part in an Authorized Denomination at any time on or after December 1, 20__, the maturities of Series 2012 Certificates to be redeemed to be selected by PPMH (and within any maturity to be selected by DTC or any successor depository in accordance with its procedures or if the book-entry system is discontinued, by lot or in such other manner as the Certificate Trustee determines), at the redemption price of 100% of the principal amount thereof plus accrued interest to (but not including) the redemption date.

Extraordinary Redemption

The Series 2012 Certificates are subject to redemption in whole by the Issuer, at the option of PPMH, at a redemption price of 100% of the Outstanding principal amount thereof plus accrued interest to (but not including) the redemption date, in the event all or substantially all of the 2012 Project has been damaged or destroyed, or there occurs the condemnation of all or substantially all of the 2012 Project or the taking by eminent domain of such use or control of the 2012 Project as to render it, in the judgment of PPMH, unsatisfactory for its intended use for a period of time longer than one year.

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* Preliminary, subject to change.

Mandatory Sinking Fund Redemption

The Series 2012 Certificates maturing on December 1, 20__ and December 1, 20__ are subject to mandatory redemption prior to maturity, in part with the Series 2012 Certificates to be redeemed to be selected by the Securities Depository in accordance with its procedures or, if the Book-Entry System has been discontinued, by lot, in such manner as may be designated by the Certificate Trustee in its reasonable discretion, reasonably exercised, on the following dates and in the following principal amounts at a redemption price of one hundred percent (100%) of the principal amount thereof plus accrued interest to the redemption date, but without premium:

Series 2012 Certificates Maturing December 1, 20__

December 1 of the Year	Principal Amount

(Leaving $_____ to mature December 1, 20__)

Series 2012 Certificates Maturing December 1, 20__

December 1 of the Year	Principal Amount

(Leaving $_____ to mature December 1, 20__)

On or before 45 days prior to each sinking fund installment, the Certificate Trustee will select for redemption, by lot in such manner as the Certificate Trustee determines, the principal amount of Series 2012 Certificates equal to the applicable sinking fund installment. The amount of the applicable sinking fund installment for any particular date and maturity may be reduced by the principal amount of any Series 2012 Certificates which prior to said date have been redeemed (otherwise than through the operation of the sinking fund) and cancelled and not theretofore applied as a credit against a sinking fund installment. Such reductions, if any, will be applied in such year or years determined by PPMH.

Notice of Redemption

Notice of the call for redemption will be given by the Certificate Trustee by mailing a copy of the redemption notice (a) by first class mail at least 15 days but not more than 60 days prior to the date fixed for redemption to the Owner of each Series 2012 Certificate to be redeemed in whole or in part at the address shown on the registration books and (b) at least 10 days prior to the date fixed for redemption, to the Municipal Securities Rulemaking Board ("MSRB") in electronic format as prescribed by the MSRB (which, as of the date of this Indenture, is the Electronic Municipal Market Access system ("EMMA") of the MSRB. No defect in any notice delivered pursuant to clause (b) above or any failure to give all or any portion of such notice will in any manner defeat the effectiveness of a call for redemption if notice is given as prescribed in clause (a) above. Any notice mailed as described in this paragraph will be conclusively presumed to have been duly given, whether or not the Owner or any other recipient receives the notice. Each notice of redemption given hereunder will contain (i) information identifying the Series 2012 Certificates or portions thereof to be redeemed (ii) the CUSIP numbers of all Series 2012 Certificates being redeemed; (iii) the date of issue of the Series 2012 Certificates as originally issued; (iv) the rate of interest borne by each Series 2012 Certificate being redeemed; (v) the maturity date of each Series 2012 Certificate being redeemed; and (vi) any other descriptive information needed to identify accurately the Series 2012 Certificates being redeemed; provided that no notice will be deemed defective if the information required in clause (i) above is provided in such notice. The redemption of the Series 2012 Certificates may be contingent or subject to such conditions as may be specified in the notice, and if funds for the redemption are not irrevocably deposited with the Certificate Trustee or otherwise placed in escrow and in trust prior to the giving of notice of redemption, the notice will be specifically subject to the deposit of funds by PPMH.

Failure to mail any such notice, or the mailing of defective notice, to any Owner, will not affect the proceeding for redemption as to any Owner to whom proper notice is mailed.

Partial Redemption

If a Series 2012 Certificates is of a denomination larger than $5,000, a portion of such Series 2012 Certificate ($5,000 or any integral multiple thereof) may be redeemed, but only in the principal amount of $5,000 or any integral multiple thereof.

Purchase in Lieu of Redemption

PPMH will have the option to cause the Series 2012 Certificates to be purchased in lieu of redemption on the applicable redemption date at a price equal to the then applicable redemption price, plus accrued interest thereon to, but not including, the date of such purchase. Such option may be exercised by delivery to the Trustee on or prior to the business day preceding the redemption date of a written notice of PPMH specifying the Series 2012 Certificates that will be subject to purchase in lieu of redemption with the moneys provided or to be provided by or on behalf of PPMH. Upon delivery of such notice, the Series 2012 Certificates to which such notice applies will not be redeemed but will be purchased at the redemption price on the date that would otherwise have been the redemption date.

Book-Entry Only System

The information in this section concerning DTC and DTC's book-entry system has been obtained from sources that the Authority and PPMH believe to be reliable, but neither the Authority nor PPMH take any responsibility for the accuracy thereof.

The Series 2012 Certificates initially will be issued solely in book-entry form to be held in the book-entry only system maintained by The Depository Trust Company ("DTC"), New York, New York. So long as such book-entry system is used, only DTC will receive or have the right to receive physical delivery of the Series 2012 Certificates and, except as otherwise provided herein with respect to tenders by beneficial owners of beneficial ownership interests, beneficial owners will not be or be considered to be, and will not have any rights as, owners or holders of the Series 2012 Certificates under the Certificate Indenture.

The following information about the book-entry only system applicable to the Series 2012 Certificates has been supplied by DTC. Neither the Authority nor the Certificate Trustee makes any representations, warranties or guarantees with respect to its accuracy or completeness.

DTC will act as securities depository for the Series 2012 Certificates. The Series 2012 Certificates will be issued as fully-registered securities registered in the name of Cede & Co. (DTC's partnership nominee) or such other name as may be requested by an authorized representative of DTC. One fully-registered Bond certificate will be issued in the aggregate principal amount of the Series 2012 Certificates and will be deposited with DTC at the office of the Certificate Trustee on behalf of DTC utilizing the DTC FAST system of registration.

DTC, the world's largest securities depository, is a limited-purpose trust company organized under the New York Banking Law, a "banking organization" within the meaning of the New York Banking Law, a member of the Federal Reserve System, a "clearing corporation" within the meaning of the New York Uniform Commercial Code, and a "clearing agency" registered pursuant to the provisions of Section 17A of the Securities Exchange Act of 1934. DTC holds and provides asset servicing for over 3.5 million issues of U.S. and non U.S. equity issues, corporate and municipal debt issues, and money market instruments from over 100 countries that DTC's participants ("Direct Participants") deposit with DTC. DTC also facilitates the post-trade settlement among Direct Participants of sales and other securities transactions in deposited securities, through electronic computerized book-entry transfers and pledges between Direct Participants' accounts. This eliminates the need for physical movement of securities certificates. Direct Participants include both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, clearing corporations, and certain other organizations. DTC is a wholly-owned subsidiary of The Depository Trust & Clearing Corporation ("DTCC"). DTCC is the holding company for DTC, National Securities Clearing Corporation and Fixed Income Clearing Corporation, all of which are registered clearing agencies. DTCC is owned by the users of its regulated subsidiaries. Access to the DTC system is also available to others such as both U.S. and non-U.S. securities brokers and dealers, banks, trust companies, and clearing corporations that clear through or maintain a custodial relationship with a Direct Participant, either directly or indirectly ("Indirect Participants"). DTC is rated "AA+" by S&P. The DTC Rules applicable to its Participants are on file with the Securities and Exchange Commission. More information about DTC can be found at http://www.dtcc.com and http://www.dtc.org.

Purchases of the Series 2012 Certificates under the DTC system must be made by or through Direct Participants, which will receive a credit for the Series 2012 Certificates on DTC's records. The ownership interest of each actual purchaser of each Series 2012 Certificate ("Beneficial Owner") is in turn to be recorded on the Direct and Indirect Participants' records. Beneficial owners will not receive written confirmation from DTC of their purchase. Beneficial owners are, however, expected to receive written confirmations providing details of the transaction, as well as periodic statements of their holdings, from the Direct or Indirect Participant through which the Beneficial Owner entered into the transaction. Transfers of ownership interests in the Series 2012 Certificates are to be accomplished by entries made on the books of Direct and Indirect Participants acting on behalf of beneficial owners. Beneficial owners will not receive certificates representing their ownership interests in the Series 2012 Certificates, except in the event that use of the book-entry system for the Series 2012 Certificates is discontinued.

To facilitate subsequent transfers, all of the Series 2012 Certificates deposited by Direct Participants with DTC (or the Certificate Trustee on behalf of DTC utilizing the DTC FAST system of registration) are registered in the name of DTC's partnership nominee, Cede & Co., or such other name as may be requested by an authorized representative of DTC. The deposit of the Series 2012 Certificates with DTC (or the Certificate Trustee on behalf of DTC utilizing the DTC FAST system of registration) and their registration in the name of Cede & Co. or such other DTC nominee do not effect any change in beneficial ownership. DTC has no knowledge of the actual beneficial owners of the Series 2012 Certificates; DTC's records reflect only the identity of the Direct Participants to whose accounts such the Series 2012 Certificates are credited, which may or may not be the beneficial owners. The Direct and Indirect Participants will remain responsible for keeping account of their holdings on behalf of their customers.

Conveyance of notices and other communications by DTC to Direct Participants, by Direct Participants to Indirect Participants, and by Direct Participants and Indirect Participants to beneficial owners will be governed by arrangements among them, subject to any statutory or regulatory requirements as may be in effect from time to time. Beneficial owners of the Series 2012 Certificates may wish to take certain steps to augment the transmission to them of notices of significant events with respect to the Series 2012 Certificates, such as redemptions, tenders, defaults, and proposed amendments to the Bond documents. For example, beneficial owners of the Series 2012 Certificates may wish to ascertain that the nominee holding the Series 2012 Certificates for their benefit has agreed to obtain and transmit notices to beneficial owners. In the alternative, beneficial owners may wish to provide their names and addresses to the Certificate Trustee and request that copies of notices be provided directly to them.

Redemption notices shall be sent to DTC. If less than all of the Series 2012 Certificates are being redeemed, DTC's practice is to determine by lot the amount of the interest of each Direct Participant in such issue to be redeemed.

Neither DTC nor Cede & Co. (nor any other DTC nominee) will consent or vote with respect to the Series 2012 Certificates unless authorized by a Direct Participant in accordance with DTC's Procedures. Under its usual procedures, DTC mails an Omnibus Proxy to the Authority as soon as possible after the record date. The Omnibus Proxy assigns Cede & Co.'s consenting or voting rights to those Direct Participants to whose accounts the Series 2012 Certificates are credited on the record date (identified in a listing attached to the Omnibus Proxy).

Redemption proceeds, distributions, and interest payments on the Series 2012 Certificates will be made to Cede & Co., or such other nominee as may be requested by an authorized representative of DTC. DTC's practice is to credit Direct Participants' accounts upon DTC's receipt of funds and corresponding detail information from the Certificate Trustee, on payable date in accordance with their respective holdings shown on DTC's records. Payments by Participants to beneficial owners will be governed by standing instructions and customary practices, as is the case with the Series 2012 Certificates held for the accounts of customers in bearer form or registered in "street name" and will be the responsibility of such Participant and not of DTC or its nominee, the Certificate Trustee or the Authority, subject to any statutory or regulatory requirements as may be in effect from time to time. Payment of redemption proceeds, distributions, and interest payments to Cede & Co. (or such other nominee as may be requested by an authorized representative of DTC) is the responsibility of the Certificate Trustee, disbursement of such payments to Direct Participants will be the responsibility of DTC, and disbursement of such payments to the beneficial owners will be the responsibility of Direct and Indirect Participants.

DTC may discontinue providing its services as depository with respect to the Series 2012 Certificates at any time by giving reasonable notice to the Authority or the Certificate Trustee. Under such circumstances, in the event that a successor depository is not obtained, Bond certificates are required to be printed and delivered.

The Authority may decide to discontinue use of the system of book-entry transfers through DTC (or a successor securities depository). In that event, Series 2012 Certificates will be printed and delivered.

NEITHER THE AUTHORITY NOR THE CERTIFICATE TRUSTEE WILL HAVE ANY RESPONSIBILITY OR OBLIGATION TO ANY DIRECT PARTICIPANT, INDIRECT PARTICIPANT OR ANY BENEFICIAL OWNER OR ANY OTHER PERSON NOT SHOWN ON THE REGISTRATION BOOKS OF THE CERTIFICATE TRUSTEE AS BEING A HOLDER WITH RESPECT TO: (1) THE SERIES 2012 CERTIFICATES; (2) THE ACCURACY OF ANY RECORDS MAINTAINED BY DTC OR ANY DIRECT PARTICIPANT OR INDIRECT PARTICIPANT; (3) THE PAYMENT BY DTC OR ANY DIRECT PARTICIPANT OR INDIRECT PARTICIPANT OF ANY AMOUNT DUE TO ANY BENEFICIAL OWNER IN RESPECT OF THE PURCHASE PRICE OF TENDERED THE SERIES 2012 CERTIFICATES OR THE PRINCIPAL OR REDEMPTION PRICE OF OR INTEREST ON THE SERIES 2012 CERTIFICATES; (4) THE DELIVERY BY ANY DIRECT PARTICIPANT OR INDIRECT PARTICIPANT OF ANY NOTICE TO ANY BENEFICIAL OWNER WHICH IS REQUIRED OR PERMITTED UNDER THE TERMS OF THE CERTIFICATE INDENTURE TO BE GIVEN TO HOLDERS; (5) THE SELECTION OF THE BENEFICIAL OWNERS TO RECEIVE PAYMENT IN THE EVENT OF ANY PARTIAL REDEMPTION OF THE SERIES 2012 CERTIFICATES; OR (6) ANY CONSENT GIVEN OR OTHER ACTION TAKEN BY DTC AS HOLDER.

Each Beneficial Owner for whom a Direct Participant or Indirect Participant acquires an interest in the Series 2012 Certificates, as nominee, may desire to make arrangements with such Direct Participant or Indirect Participant to receive a credit balance in the records of such Direct Participant or Indirect Participant, to have all notices of redemption, elections to tender the Series 2012 Certificates or other communications to or by DTC which may affect such Beneficial Owner forwarded in writing by such Direct Participant or Indirect Participant, and to have notification made of all debt service payments.

Beneficial owners may be charged a sum sufficient to cover any tax, fee, or other governmental charge that may be imposed in relation to any transfer or exchange of their interests in the Series 2012 Certificates.

The Authority cannot and does not give any assurances that DTC, Direct Participants, Indirect Participants or others will distribute payments of debt service on the Series 2012 Certificates made to DTC or its nominee as the registered owner, or any redemption or other notices, to the beneficial owners, or that they will do so on a timely basis, or that DTC, Direct Participants or Indirect Participants will serve and act in the manner described in this Official Statement.

Limitation

For so long as the Series 2012 Certificates are registered in the name of DTC or its nominee, Cede & Co., the Authority, PPMH and the Certificate Trustee will recognize only DTC or its nominee, Cede & Co., as the registered owner of the Series 2012 Certificates for all purposes, including payments, notices and voting. So long as Cede & Co. is the registered owner of the Series 2012 Certificates, references herein to the Holders or registered owners of the Series 2012 Certificates shall mean Cede & Co. and shall not mean the Beneficial Owners of the Series 2012 Certificates.

Because DTC is treated as the owner of the Series 2012 Certificates for substantially all purposes under the Certificate Indenture, Beneficial Owners may have a restricted ability to influence in a timely fashion remedial action or the giving or withholding of requested consents or other directions. In addition, because the identity of Beneficial Owners is unknown to the Authority, PPMH, the Certificate Trustee or DTC, it may be difficult to transmit information of potential interest to Beneficial Owners in an effective and timely manner. Beneficial Owners should make appropriate arrangements with their broker or dealer regarding distribution of information regarding the Series 2012 Certificates that may be transmitted by or through DTC.

Under the Certificate Indenture, payments made by the Certificate Trustee to DTC or its nominee shall satisfy the Authority's obligations under the Certificate Indenture and PPMH's obligations under the Lease Agreement to the extent of the payments so made.

None of the Authority, PPMH or the Certificate Trustee shall have any responsibility or obligation with respect to:

- the accuracy of the records of DTC, its nominee or any Direct Participant or Indirect Participant with respect to any beneficial ownership interest in any Series 2012 Certificates;

- the delivery to any Direct Participant or Indirect Participant or any other Person, other than a Holder, as shown on the registration books maintained by the Certificate Trustee, of any notice with respect to any Series 2012 Certificate including, without limitation, any notice of redemption with respect to any Series 2012 Certificate;

- the payment to any Direct Participant or Indirect Participant or any other Person, other than a Holder, as shown on the registration books maintained by the Certificate Trustee, of any amount with respect to the principal or redemption price of, or interest on, any Series 2012 Certificate; or

- any consent given by DTC or its nominee as registered owner.

Prior to any discontinuation of the book-entry only system hereinabove described, the Authority, PPMH and the Certificate Trustee may treat Cede & Co. (or such other nominee of DTC) as, and deem Cede & Co. (or such other nominee) to be, the absolute Holder of the Series 2012 Certificates for all purposes whatsoever, including, without limitation:

(i) the payment of the principal or redemption price of and interest on and the Series 2012 Certificates;

(ii) giving notices of redemption and other matters with respect to the Series 2012 Certificates;

(iii) registering transfers with respect to the Series 2012 Certificates; and

(iv) the selection of Series 2012 Certificates for redemption.

The Authority and the Certificate Trustee cannot give any assurances that DTC or the Participants will distribute payments of the principal or redemption price of and interest on the Series 2012 Certificates, paid to DTC or its nominee, as the registered owner of the Series 2012 Certificates, or any redemption or other notices, to the Beneficial Owners or that they will do so on a timely basis or that DTC will serve and act in the manner described in this Official Statement.

So long as Cede & Co. is the registered owner of the Series 2012 Certificates, as nominee of DTC, references in this Official Statement to the Holders of the Series 2012 Certificates shall mean Cede & Co. and shall not mean the Beneficial Owners, and Cede & Co. will be treated as the only Bondholder of Series 2012 Certificates for all purposes under the Certificate Indenture.

The Authority may enter into amendments to the agreement with DTC or successor agreements with a successor securities depository relating to the book-entry system to be maintained with respect to the Series 2012 Certificates without the consent of Beneficial Owners or Bondholders.

Removal From the Book-Entry System

DTC may discontinue providing its services as securities depository with respect to the Series 2012 Certificates at any time by giving written notice to the Authority, the Certificate Trustee and PPMH. The Authority or PPMH, with the consent of the other, may terminate the services of DTC (or a successor securities depository). Upon the discontinuance or termination of the services of DTC, unless a substitute securities depository is appointed, Series 2012 Certificates will be printed and delivered to the Beneficial Owners of the Series 2012 Certificates.

In the event the Series 2012 Certificates are removed from the Book-Entry System, the principal of and the interest on the Series 2012 Certificates shall be payable to the persons in whose names the Series 2012 Certificates are registered on the Bond Register on the applicable Record Date. Payments of interest on the Series 2012 Certificates shall be made to the registered owner of the Series 2012 Certificates (as determined at the close of business on the Record Date next preceding the applicable Interest Payment Date) by check mailed on the Interest Payment Date and the principal amount of any Series 2012 Certificate and premium, if any, together with interest payable other than a regularly scheduled Interest Payment Date, shall be made by check only upon presentation and surrender of the Series 2012 Certificate on or after its maturity date or date fixed for redemption or other payment at the office of the Certificate Trustee; provided, however, that payment of principal of, premium, if applicable, and interest on any Series 2012 Certificate may be made by wire transfer as described above under the heading "Method of Payment."

Legal Authority

The Series 2012 Certificates are being issued and secured pursuant to the authority granted by (i) the Constitution of the State of Georgia, (ii) Article 4 of Chapter 7 of Title 31 of the Official Code of Georgia Annotated, known as the "Hospital Authorities Law" (the "Hospital Authorities Law"), and (iii) Article 3 of Chapter 82 of Title 36 of the Official Code of Georgia Annotated, known as the "Revenue Bond Law."

The issuance, sale, and delivery of the Series 2012 Certificates and the execution, delivery, and performance of the Certificate Indenture and the Loan Agreement by the Authority have been authorized and approved pursuant to a resolution adopted by the Board of Trustees of the Authority on November 8, 2012.

Investments

For a description of how the proceeds of the Series 2012 Certificates are to be invested pending their use, the provisions governing those investments, and other provisions governing the investment of the proceeds of the Series 2012 Certificates and the amounts held to pay debt service on the Series 2012 Certificates, see "THE CERTIFICATE INDENTURE - Security for and Investment or Deposit of Funds" in Appendix C hereto.

SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2012 CERTIFICATES

Certificate Indenture

To secure its obligations under the Series 2012 Certificates, the Authority will enter into the Certificate Indenture with the Certificate Trustee, pursuant to which the Authority will pledge and assign to the Certificate Trustee, for the benefit of the owners of the Series 2012 Certificates, all of its right, title, and interest in and to (1) the Series 2012 Obligation, (2) the Loan Agreement (except for certain rights reserved to the Authority), and (3) all moneys and securities held by the Certificate Trustee in any and all of the funds and accounts established under the Certificate Indenture.

To evidence its obligation to repay the loan of the proceeds of the Series 2012 Certificates made pursuant to the Loan Agreement, PPMH will execute and deliver to the Authority the Series 2012 Obligation issued under the Master Indenture. To secure its obligations under the Series 2012 Certificates, the Authority will irrevocably assign the Series 2012 Obligation to the Certificate Trustee. The Series 2012 Obligation will be registered in the name of the Certificate Trustee and held by the Certificate Trustee for the benefit of the owners of the Series 2012 Certificates. The Certificate Trustee, as the registered owner of the Series 2012 Obligation, will be entitled to the protection of the covenants, restrictions, and other obligations imposed upon the Obligated Group by the Master Indenture. See "SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2012 CERTIFICATES - Master Indenture -- *Series 2012 Obligation*" herein for a description of the Series 2012 Obligation.

The Certificate Indenture establishes with the Certificate Trustee a trust fund known as the Series 2012 Certificate Fund, into which the payments made under the Series 2012 Obligation must be deposited. See "THE CERTIFICATE INDENTURE - Revenues and Funds" in Appendix C hereto.

Under the terms of the Certificate Indenture, no obligations other than the Series 2012 Certificates may be issued thereunder or secured thereby. Additional obligations may, however, be issued under the Master Indenture.

Master Indenture

Parties. The Parent and PPMH have entered into the Master Indenture with the Master Trustee, pursuant to which the Series 2012 Obligation will be issued and secured.

Obligated Group. The Master Indenture provides for the creation of a group of entities called the Obligated Group, which are jointly and severally liable for the payment of all obligations issued under the Master Indenture. The Obligated Group presently consists of the Parent and PPMH. Upon compliance with certain conditions set forth in the Master Indenture, additional members may be added to the Obligated Group and existing members may withdraw from the Obligated Group. See "THE MASTER INDENTURE -Admission into Obligated Group," " - Withdrawal from Obligated Group," and "- Designation and Release of Restricted Affiliates" in Appendix C hereto.

Series 2012 Obligation. Simultaneously with the issuance of the Series 2012 Certificates, in order to evidence its obligation to repay the loan of the proceeds of the Series 2012 Certificates made pursuant to the Loan Agreement, PPMH will execute and deliver to the Authority the Series 2012 Obligation issued under the Master Indenture. The Series 2012 Obligation will be a joint and several general obligation of the Obligated Group (subject, in the case of guaranteed obligations, to the Maximum Guaranty Liability). The Series 2012 Obligation will be a direct obligation of PPMH guaranteed by each of the other members of the Obligated Group to the extent of their respective Maximum Guaranty Liability. See "THE MASTER INDENTURE - Party Obligations," "- Security for Obligations," and "- Cross-Guaranties" in Appendix C hereto. The Series 2012 Obligation will be in the same aggregate principal amount, bear interest at the same rates, mature on the same dates, and be subject to redemption on the same terms as the Series 2012 Certificates. The Series 2012 Obligation will obligate PPMH to make loan repayments directly to the Certificate Trustee for the Authority's account in amounts and at times calculated to be sufficient to pay, when due, the principal of, premium, if any, and interest on the Series 2012 Certificates.

Pledge of Gross Receipts. Under the terms of the Master Indenture, the members of the Obligated Group will pledge their Gross Receipts in order to secure the payment and performance of the obligations created under the Master Indenture. See "DEFINITIONS OF CERTAIN TERMS" in Appendix C hereto for the definition of "Gross Receipts." The Master Indenture creates and establishes a trust fund of the Obligated Group that is required to be held in trust by the Master Trustee. In order further to secure the timely payment of the Outstanding Obligations, the Obligated Group has agreed in the Master Indenture that they will deposit daily, so far as practicable, all of the Gross Receipts into such trust fund to be applied as provided in the Master Indenture. See "THE MASTER INDENTURE - Payment or Principal, Premium, if any, and Interest, - Performance of Covenants," and "- Pledge of Gross Receipts and Establishment of Gross Receipts Account" in Appendix C hereto.

Limitations on Pledge of Gross Receipts. Certain interests and claims of others may be on a parity with or prior to the pledge of the Gross Receipts made in the Master Indenture, and certain statutes and other provisions may limit the Obligated Group's right to make such pledges. Examples of such claims, interests, and provisions are:

(1) statutory liens and rights of set-off,

(2) the Georgia Uniform Commercial Code may not recognize a security interest in future revenues,

(3) rights arising in favor of the United States of America or any agency thereof on failure of the Master Trustee or the members of the Obligated Group to comply with federal or state statutes regarding the assignment of certain claims,

(4) constructive trusts, equitable liens, or other rights impressed or conferred by any state or federal court in the exercise of its equitable jurisdiction,

(5) state and federal bankruptcy or insolvency laws as they affect the enforceability of the security interest in Gross Receipts earned by any member of the Obligated Group within the statutorily prescribed preference period preceding and at any time after any effectual institution of bankruptcy proceedings by or against such member of the Obligated Group,

(6) as to those items in which a security interest, lien, or pledge can be perfected only by possession, including items converted to cash, the rights of third parties in such items not in the possession of the Master Trustee,

(7) prohibitions against assignment contained in federal or state statutes including those governing the Medicaid and Medicare programs,

(8) provisions prohibiting the direct payment of amounts due to health care providers from Medicaid and Medicare programs to persons other than such providers,

(9) certain judicial decisions which cast doubt upon the right of the Master Trustee, in the event of bankruptcy of any member of the Obligated Group, to collect and retain accounts receivable due such member from Medicaid, Medicare, and other governmental programs,

(10) the security interest of third party creditors in "proceeds" of property subject to a Permitted Lien, which "proceeds" may be deemed to constitute Gross Receipts,

(11) items not in possession of the Master Trustee, the records to which are located or moved outside the State of Georgia, which are thereby not subject to or are removed from the operation of Georgia's laws,

(12) claims that might arise if appropriate continuation statements are not filed in accordance with the Georgia Uniform Commercial Code as from time to time in effect,

(13) the absence of an express provision permitting assignment of receivables due members of the Obligated Group under contracts with third-party payors, and present or future prohibitions against assignment contained in any applicable statutes or regulations, and

(14) commingling of Gross Receipts with other moneys of the members of the Obligated Group not so pledged pursuant to the Master Indenture.

The pledge of the Gross Receipts may not be enforceable against third parties unless the Gross Receipts are actually transferred to the Master Trustee.

Restricted Affiliates. The Master Indenture allows members of the Obligated Group to designate certain of their affiliates as "Restricted Affiliates." Initially, there are no Restricted Affiliates. Each member of the Obligated Group has agreed in the Master Indenture to cause, to the extent permitted by law, its Restricted Affiliates to transfer to the Obligated Group such of their property as shall be necessary to enable the Obligated Group to meet all of its joint and several liability in respect of all obligations outstanding under the Master Indenture, in the maximum amount permissible under the applicable fraudulent conveyance or similar laws. The Series 2012 Obligation will not, however, be a direct or guaranteed obligation of any Restricted Affiliate and will not be secured by any pledge of or security interest in any assets of any Restricted Affiliate. The Master Trustee will not have a direct claim upon and will not be able to directly levy upon the assets of any Restricted Affiliate, since its interest in the Restricted Affiliates will be derived solely through the members of the Obligated Group's equity interest in the Restricted Affiliates. Both secured and unsecured creditors of the Restricted Affiliates will be preferred in priority of payment and distribution to the Master Trustee since, by levying upon the equity interest of the members of the Obligated Group in the Restricted Affiliates, the Master Trustee will assume the payment priority of an equity owner of an entity (which is subordinate to the secured and unsecured creditors of the entity) upon the liquidation of the Restricted Affiliates. The Master Indenture allows Restricted Affiliates to be released from their obligations and status as "Restricted Affiliates" under the Master Indenture upon the satisfaction of certain conditions. See "THE MASTER INDENTURE - Membership in and Withdrawal From the Obligated Group," "Designation and Release of Restricted Affiliates -- *Conditions for Designation of Restricted Affiliates*" and "- *Release of Restricted Affiliates*" in Appendix C hereto.

Covenants. The Obligated Group has agreed in the Master Indenture to various operational and financial covenants and restrictions upon the Obligated Group and the Restricted Affiliates, including, but not limited to, limitations on the incurrence of additional indebtedness, maintenance of certain amounts of insurance, limitations on mergers and transfers of assets, limitations on the creation of liens, maintenance of rates and charges at certain levels and financial reporting. See "THE MASTER INDENTURE - General Covenants" in Appendix C hereto. The accounts and financial results of the members of the Obligated Group and the Restricted Affiliates may be combined for financial reporting purposes and for purposes of determining whether the various financial covenants and tests contained in the Master Indenture are met. See "THE MASTER INDENTURE - General Covenants -- *Financial Statements, Etc.*" in Appendix C hereto.

Parity Obligations. Under the terms of the Master Indenture, the Series 2012 Obligation will be equally and ratably secured on a parity basis with the Existing Certificates Obligation, the Series 2008A Obligation, the Series 2008B Obligation, and the Series 2010A Obligation. Upon satisfaction of certain conditions, the Master Indenture permits the members of the Obligated Group, for specified purposes, to issue additional obligations without express limit as to principal amount, which will be equally and ratably secured on a parity basis with the Series 2012 Obligation under the Master Indenture. See "THE MASTER INDENTURE - General Covenants -- *Permitted Additional Indebtedness*" in Appendix C hereto. Any additional parity obligations issued under the Master Indenture may be issued directly to a lender on a taxable basis or may be used to secure tax-exempt obligations issued by the Authority or another governmental body. The Obligated Group expects to issue additional parity obligations in the future to finance part of the cost of ongoing capital improvements to the System. The issuance of additional parity obligations under the Master Indenture may, for a period of time, dilute the security for the Series 2012 Obligation. Upon the issuance of the Series 2012 Certificates, the Certificate Trustee will hold less than a majority of obligations outstanding under the Master Indenture, which may result in conflicts of interest between the Master Trustee and the Certificate Trustee.

Limited Obligations

The Series 2012 Certificates are special limited obligations of the Authority payable from the amounts pledged under the Certificate Indenture.

The Series 2012 Certificates do not and will not constitute a debt, liability, general or moral obligation, or pledge of the faith and credit or taxing power of the City of Albany or Dougherty County. No governmental entity, including the City of Albany and Dougherty County, is obligated to levy any tax for the payment of the Series 2012 Certificates. The Authority has no taxing power.

Enforceability of Remedies

The realization of any rights upon a default will depend upon the exercise of various remedies specified by the Certificate Indenture and the Master Indenture. These remedies may require judicial actions, which are often subject to discretion and delay and which may be difficult to pursue. The enforceability of rights or remedies with respect to the Series 2012 Certificates and the Series 2012 Obligation may be limited by state and federal laws, rulings, and decisions affecting remedies and by bankruptcy, insolvency, or other laws affecting creditors' rights or remedies heretofore or hereafter enacted. Under existing law (including particularly federal bankruptcy law), certain remedies specified by the Certificate Indenture or the Master Indenture may not be readily available or may be limited. A court may decide not to order the specific performance of the covenants contained in the Certificate Indenture or the Master Indenture.

Section 36-80-5 of the Official Code of Georgia Annotated provides that no authority created under the Constitution or laws of the State of Georgia shall be authorized to file a petition for relief from payment of its debts as they mature or a petition for composition of its debts under any federal statute providing for such relief or composition or otherwise to take advantage of any federal statute providing for the adjustment of debts of political subdivisions and public agencies and instrumentalities. Section 36-80-5 of the Official Code of Georgia Annotated also provides that no chief executive or other governmental officer, governing body, or organization shall be empowered to cause or authorize the filing by or on behalf of any authority created under the Constitution or laws of the State of Georgia of any petition for relief from payment of its debts as they mature or a petition for composition of its debts under any federal statute providing for such relief or composition or otherwise to take advantage of any federal statute providing for the adjustment of debts of political subdivisions and public agencies and instrumentalities. Section 36-80-5 of the Official Code of Georgia Annotated does not apply to any members of the Obligated Group.

The joint and several liability assumed by the members of the Obligated Group, other than PPMH, pursuant to the Master Indenture raises questions under federal bankruptcy law and the Georgia fraudulent conveyance statutes as to whether a claim based upon the Master Indenture may be subordinated to the claims of other creditors in the event of bankruptcy or avoided, in the event of insolvency, by other creditors or the Certificate Trustee in bankruptcy. Under the applicable laws, a trustee in bankruptcy or a creditor may avoid any obligation incurred by a related obligor or guarantor if, among other bases therefor, (1) the obligor or guarantor has not received fair consideration or reasonably equivalent value in exchange for the obligation and (2) the obligation renders the guarantor or obligor insolvent or the obligor or guarantor is undercapitalized or unable to pay its debts.

Application by courts of the tests of "insolvency," "fair consideration," and "reasonably equivalent value" has resulted in a conflicting body of case law. It is possible that in an action involving the enforceability of the Master Indenture against a member of the Obligated Group (insofar as it applies to the obligations described above), a court might not enforce the Master Indenture in the event it is determined that sufficient consideration for the member's obligation was not received by such obligor or guarantor or that the incurrence of the obligation represented by the Master Indenture has rendered or will render the obligor or guarantor insolvent or unable to pay its debts.

If any member of the Obligated Group were to file a petition for relief under federal bankruptcy law, the filing would operate as an automatic stay of the commencement or continuation of any judicial or other proceeding against that member of the Obligated Group and its property and as an automatic stay of any act or proceeding to enforce a lien upon its property. If the bankruptcy court so ordered, that member's property, including its Gross Receipts, could be used for the benefit of that member despite the claims of the Master Trustee with respect to the Master Indenture. If a bankruptcy court concludes that the Certificate Trustee has "adequate protection," it may (1) substitute other security for the property subject to the lien of the Master Indenture and (2) subordinate the lien of the Master Indenture (a) to claims by persons supplying goods and services to the particular member of the Obligated Group after bankruptcy and (b) to the administrative expenses of the bankruptcy proceeding.

In a bankruptcy proceeding, the particular member of the Obligated Group could file a plan for the adjustment of its debts which modifies the rights of creditors generally, or any class of creditors, secured or unsecured. The plan, when confirmed by the court, would bind all creditors who had notice or knowledge of the plan and would discharge all claims against the particular member of the Obligated Group provided for in the plan. No plan may be confirmed unless, among other conditions, the plan is in the best interests of creditors, is feasible, and has been accepted by each class of claims impaired thereunder. Each class of claims will have accepted the plan if at least two-thirds in dollar amount and more than one-half in number of the allowed claims of the class that are voted with respect to the plan are cast in its favor. Even if the plan is not so accepted, it may be confirmed if the court finds that the plan is fair and equitable with respect to each class of non-accepting creditors impaired thereunder and does not discriminate unfairly in favor of junior creditors. In addition, federal bankruptcy law permits the adoption of a reorganization plan even though the plan has not been accepted by the owners of a majority in aggregate principal amount of the obligations outstanding under the Master Indenture, if such owners are provided with the value of their claim or the "indubitable equivalent" thereof.

In the event of bankruptcy of a particular member of the Obligated Group, the amount realized by the Certificate Trustee might depend on a federal bankruptcy court's interpretation of "indubitable equivalent" and "adequate protection" under the then existing circumstances. A bankruptcy court may also have the power to prevent the exercise of remedies arising under certain provisions of the Master Indenture that make bankruptcy and related proceedings by any member of the Obligated Group an event of default thereunder.

The various legal opinions to be delivered concurrently with the delivery of the Series 2012 Certificates will be qualified as to the enforceability of the various legal instruments by limitations imposed by state and federal laws, rulings, and decisions affecting remedies and by bankruptcy, insolvency, reorganization, fraudulent conveyance, or other similar laws affecting the enforcement of creditors' rights generally.

INVESTMENT CONSIDERATIONS

Introduction

In analyzing the Series 2012 Certificates and in order to make an informed investment decision, potential investors should carefully consider the following investment considerations prior to making a decision to purchase the Series 2012 Certificates. The following investment considerations are not intended to be exhaustive of the general or specific investment considerations relating to the purchase of the Series 2012 Certificates. Additional investment considerations relating to the purchase of the Series 2012 Certificates are described throughout this Official Statement, whether or not specifically designated as investment considerations.

The following investment considerations do not include a description of issues that may arise with respect to entities that do not comprise the Combined Group, including, without limitation, , Phoebe Worth Medical Center, Inc., Phoebe Sumter Medical Center, Inc., Phoebe Dorminey Medical Center, Inc., Phoebe Putney Health Ventures, Inc., Phoebe Foundation, Inc., Phoebe Putney Indemnity, LLC, and Phoebe Health Partners, Inc. These entities are related to members of the Combined Group and each of their financial health and compliance with applicable laws and regulations may impact the Combined Group.

General

Future revenues and expenses of the Combined Group are subject, among other things, to the capabilities of management of the Combined Group and future economic and other conditions that are not accurately predictable and that may adversely affect revenues and the timely payment of principal of and interest on the Series 2012 Certificates. Conditions that may adversely affect the revenues and expenses include: (a) termination or restriction of governmental financial reimbursement and payments to hospitals, including the Medicare and Medicaid programs; (b) changes in reimbursement and payments made to hospitals by agencies, both governmental and private, that provide such reimbursement and payments; (c) a reduced demand for hospital services arising from, among other things, future medical and other scientific advances, improved health levels, improved occupational health and safety standards, and greater preventive medicine and outpatient care; (d) the failure of the Combined Group to achieve and maintain a sufficient number of patient days and a sufficient occupancy rate at the System; (e) the failure of the Combined Group to contain its operating expenses; (f) changes in the regulation of hospitals by governmental entities, including the regulation of rates and the regulation of facilities and services; (g) the professional and personnel relationships of the staff and employees; (h) changes in the population or economic conditions of the service area of the System; (i) competition arising from other hospitals and other health care facilities, such as skilled care nursing home facilities, and other health care providers in the service area of the System; (j) shortages of nurses and skilled technicians; (k)

community acceptance, adverse publicity, and adverse public relations; (l) the failure of the Combined Group to be able to provide services required or expected by patients; (m) physicians' confidence in and utilization of the facilities of the System; and (n) changes in the number and composition of the medical staff within the System. Many of these conditions, and the effects they could have on the Combined Group, are more fully discussed below.

Impact of Disruption in the Credit Markets and General Economic Factors

General

The domestic and international financial crisis that began in 2008 has had, and is expected to continue to have, negative repercussions upon the national and global economies, including a scarcity of credit, lack of confidence in the financial sector, extreme volatility in the financial markets, increase in interest rates, reduced business activity, increased consumer bankruptcies, and increased business failures and bankruptcies. In response, President Barack Obama, on February 17, 2009, signed the American Recovery and Reinvestment Act of 2009 ("ARRA"), which provided approximately $787 billion in federal spending and tax initiatives. The U.S. Congress, the Federal Reserve Board and other agencies of the federal government, and foreign governments have taken various actions that are designed to enhance liquidity, improve the performance and efficiency of credit markets, and generally stabilize securities markets and stimulate spending. There has been no agreement that these actions have been effective, and there can be no assurance these actions will be effective in the future. Additionally, the enactment of the federal Patient Protection and Affordable Care Act ("PPACA") on March 23, 2010, and its companion amendment, the Health Care and Education Affordability Reconciliation Act of 2010 (the "Reconciliation Amendment") bring significant changes to the healthcare industry. However, the potential change in political control of the executive branch and/or Congress could result in repeal of, or significant changes to, the PPACA. PPACA and the Reconciliation Amendment have come under significant scrutiny during the 2012 presidential campaign and also face strong opposition from House and Senate Republicans. The future of the reforms made by PPACA and the Reconciliation Amendment is therefore highly dependent on the outcome of the November 6, 2012 elections. Republican Presidential Nominee Mitt Romney has pledged to repeal the law upon taking office. House Republicans took multiple votes to repeal the law in the 111th Congress, but the Democrat-controlled Senate declined to take action on House repeal measures. A shift in power in the Senate and in the White House could lead to repeal of many of the changes made by PPACA. It is unclear which, if any, reforms would later be reinstated or what alternatives would be proposed. Thus, the full effects of regulations promulgated pursuant to the PPACA or of the repeal of the PPACA cannot be known at this time.

The current economic environment could have a material adverse effect on the financial condition of many hospitals, including the Combined Group. The financial crisis had a particularly acute impact upon the financial sector and has caused many banks and other financial institutions to seek additional capital, to merge, and in some cases, to fail. Additionally, there have been periods of time in which there has been a lack of liquidity for the purchase of variable rate bonds due to the withdrawal of substantial amounts from tax-exempt money market funds, one of the largest purchasers of variable rate tax-exempt bonds.

The members of the Combined Group have significant holdings in a broad range of investments. Market fluctuations have affected and will continue to affect materially the value of those investments and those fluctuations may be and historically have been material. The market disruption exacerbated the market fluctuations and negatively affected over certain time periods the investment performance of securities in the Combined Group members' portfolios. Investment income (including both realized and unrealized gains on investments) has contributed significantly to the Combined Group members' financial results over recent years. Past market conditions significantly reduced the Combined Group members' investment income and had a material adverse effect on the Combined Group members' financial results during those periods. For specific information about the Combined Group's recent results of operations, see ["_____ - Three Year Operating History"] in Appendix A to this Official Statement.

State Budgets

The general negative economic outlook for states and the resulting budget shortfalls have created significant financial issues for states. Many states face severe financial challenges, including erosion of general fund tax revenues. The financial challenges facing states, including the State of Georgia, may negatively impact hospitals in a number of ways, including but not limited to, a greater number of indigent patients and a greater number of individuals who qualify for Medicaid and/or reductions in Medicaid reimbursement rates. With implementation of the PPACA, it is anticipated that the number of Medicaid eligible enrollees will increase, thus potentially causing additional financial strain on states' budgets.

During the 2010 legislative session of the Georgia General Assembly, the Georgia House and Senate, after much discussion and debate, passed House Bill 307, known as the "Provider Payment Agreement Act" ("H.B. 307"). H.B. 307 became effective July 1, 2010. H.B. 307 provides for a 1.45% provider fee assessed on net patient revenues of hospitals and certain ambulatory surgery centers (also referred to as a "bed tax"). Pursuant to H.B. 307, the bed tax will automatically sunset on June 30, 2013. The bed tax is used to offset Medicaid reimbursement increases to hospitals and for payments for Medicaid services. Management of the Combined Group has determined that H.B. 307 to date has had an insignificant impact on the financial condition and operations of the members of the Combined Group, but there can be no assurance that the impact will not increase materially in the future. It is unclear whether the Georgia General Assembly will allow the tax to sunset or will revise or renew the bed tax.

Changes in Health Care Delivery

Efforts by insurers, Alternative Delivery Systems (as defined below), and governmental agencies to control and reduce the costs of health care services and to reduce utilization of health care facilities by such means as preventive medicine, vigorous utilization review and case management (such as discouraging hospital admissions unless absolutely necessary), increased competition among health care providers, improved standards of occupational health and safety, outpatient care, and support of health maintenance organizations and preferred provider organizations could have an adverse impact upon revenues of the System. In addition, scientific and technological advances, new procedures, drugs and appliances, preventive medicine, occupational health and safety and outpatient health care delivery may reduce utilization and revenues of the Combined Group in the future. Technological advances in recent years have accelerated the trend toward the use of sophisticated and often costly diagnostic and treatment equipment in hospitals, the availability of which may be a significant factor in hospital utilization. The ability of the Combined Group to operate successfully over the life of the Series 2012 Certificates may depend upon its ability to finance, acquire, and support additional capital equipment, replacements, and improvements, which may be affected by the availability of equipment or specialists trained to utilize such equipment, legislation, regulations, and applicable principles of government program reimbursement.

Certificate of Need Law

Under the Georgia State Health Planning and Development Act, a certificate of need ("CON") program is administered by the Georgia Department of Community Health's Office of General Counsel ("DCH"). Georgia's CON program regulates various types of activities and expenditures made by or on behalf of health facilities, including hospitals, to prevent unnecessary duplication of expensive health care services in an effort to contain health care costs. Georgia's CON program requires, among other things, DCH's review prior to construction of a new health care facility, a capital expenditure above certain levels, an increase in bed capacity, the establishment of a new clinical health service, the conversion or upgrade to a specialty hospital, or an expenditure involving the purchase of diagnostic or therapeutic equipment above certain levels. DCH's review is based on a variety of statutory requirements, including a finding of community need for additional health care facilities and services. The Combined Group has received a CON, if required, for all of its current activities other than the proposed renovation of its Medical Intensive Care unit that is included of the 2012 Project. See "PLAN OF FINANCING - The 2012 Project" herein. There can be no assurance that the Combined Group will receive CONs that may be required for future capital expenditures or new services. In addition, the statutory and regulatory requirements under the Georgia CON program may be amended in the future in ways that are adverse to the Combined Group. The Georgia CON program has established CON requirements for multi-specialty ambulatory surgery centers, which often compete or may compete with the Combined Group to provide outpatient surgical services. Such centers currently must obtain a CON from DCH prior to constructing such a center and offering outpatient surgical services. On December 10, 2009, DCH proposed rules that would effectively marginalize the requirement that these centers obtain a CON to offer outpatient surgical services. DCH postponed consideration of these rules, and DCH has indicated that it does not intend to adopt the rules. However, if these rules become final, they would allow competitors of the Combined Group to open such centers after undergoing a substantially simplified CON review process with little possibility of being denied.

In its current form, the CON Law may limit or even prevent the Combined Group from undertaking certain activities and expenditures that are financially advantageous, including the acquisition of new, sophisticated diagnostic and treatment equipment. At the same time, the CON Law may allow competitors to undertake activities or expenditures for which the Combined Group has been denied a certificate of need. In addition, the Combined Group may be required to incur substantial expenditures in order to obtain a certificate of need for any future activities, including consulting fees and legal fees for preparation of applications, review of competing applications, preparation of written comments, and participation in public hearings, administrative hearings, litigation, and appeals. For all of these reasons, the CON Law and regulations could adversely affect the financial condition of the Combined Group.

Competition

The business engaged in by the Combined Group can be highly competitive. For a summary of hospitals which exist in the area of competition of the System, see ["_____- Competition"] in Appendix A to this Official Statement. No assurance can be given that other competitive facilities or services will not be established or that existing competitive facilities will not be expanded or renovated in the System's service area in the future.

The principal methods of competition in the hospital industry include, but are not necessarily limited to, daily rates charged, services available in relation to patient needs, and the quality and attractiveness of physical facilities provided. Management of the Combined Group believes that the System can effectively compete with other facilities currently located in its area of competition. However, investment by the Combined Group in facilities and equipment for capital-intensive services may be lost as a result of rapid changes in diagnosis, treatment, or clinical practice brought about by new technology or new pharmacology. There can be no guarantee that in the future the System will be able to compete with hospitals designed and built with the benefit of advanced technology and services not available at the time the System was constructed and hospitals that are perceived to offer more attractive facilities and services.

Although competition from new hospital facilities will be inhibited to some degree by the operation of the Georgia CON program, such determinations could be erroneous and thus could lead to unnecessary competing facilities. Furthermore, no CONs are required for expansion of the licensed bed capacity of existing facilities which have maintained occupancy rates in excess of 75% for the previous 12 months, by up to 10 beds or 10% of licensed capacity, whichever is greater, in any consecutive two-year period. Also, presently in Georgia no CON is required for ambulatory surgery centers established by single-specialty physician practices, provided total capital costs incurred thereby are below a given threshold amount and/or the practice meets other requirements. In addition, the Georgia CON program is no protection against a reduction in bed need due to demographic or other changes.

The System may also face competition from other forms of health care delivery that could offer comparable health care services at lower prices to the same population served by the System, such as free-standing ambulatory care clinics or surgical centers, private laboratories, radiological service providers or other imaging providers, rehabilitation and therapy centers, home health care, and preventive care agencies. Existing and potential competitors may not be subject to the same restrictions applicable to the Combined Group, and future competition may arise from new sources not currently anticipated or prevalent.

Relations with Alternative Delivery Systems

In recent years, increased sensitivity to the cost of health care and the desire to reduce health care costs have increased enrollment in health maintenance organizations, preferred provider organizations, and other managed care delivery systems ("Alternative Delivery Systems"). Such organizations have become significant purchasers of health care services from hospitals and other providers, often selecting providers that offer the most cost-effective services and hospitals and providers must be able to provide the contracted services without significant operating losses, which may require multiple forms of cost containment. Alternative Delivery Systems have replaced indemnity insurance as the prime source of non-governmental payment for hospital services. Additionally, Medicare and Medicaid now also purchase hospital services using managed care options.

The growth of Alternative Delivery Systems has adversely affected hospitals in a number of ways. Most preferred provider organizations offer financial incentives for subscribers to use only those hospitals that have contracted with the plan. Most health maintenance organizations limit coverage to services provided by hospitals with which they have contracted, effectively directing patients away from hospitals with which they have not contracted. Alternative Delivery Systems have been able to negotiate discounts or more favorable rates for health care services from competing providers and have directed their subscribers to providers that offer the lowest rates for particular hospital services. Additionally, the market for Alternative Delivery Systems has become increasingly competitive and many of the Alternative Delivery Systems are consolidating, while others may not survive. In such instance, if the Combined Group has contracted with an Alternative Delivery System that is either involved in a consolidation or does not survive, the Combined Group may be responsible for providing services for which the Combined Group may not ultimately be compensated. With the passage of the PPACA, which assesses fees and taxes on Alternative Delivery Systems as well as imposes other changes in how Alternative Delivery Systems operate, the relationship between the Combined Group and Alternative Delivery Systems may require renegotiation, but the Combined Group cannot predict the full effects of the PPACA at this time as the law has not yet been fully implemented.

Most Alternative Delivery Systems currently pay hospitals on a discounted fee for service basis or a discounted fixed rate per day of care. A hospital is usually required to discount its charges substantially to obtain a contract to serve

the patients of an Alternative Delivery System. The discounts offered to Alternative Delivery Systems may result in payment at less than actual costs, and the volume of patients directed to a hospital under a contract with an Alternative Delivery System may vary significantly from the anticipated volume. Some health maintenance organizations employ a "capitation" payment method under which the hospital is paid a predetermined periodic rate for each enrollee in the health maintenance organization who is "assigned" to or otherwise directed to receive care at a particular hospital. In a capitation payment system, the hospital assumes a substantial financial risk for the cost and scope of care given to such health maintenance organization's enrollees. If the capitation payment is insufficient to meet the hospital's costs of care, the financial condition of the hospital may erode. Further, pursuant to state insurance regulations, health maintenance organization contracts require that the hospital provide care for health maintenance organization enrollees for a certain period of time regardless of whether the health maintenance organization has funds to make payments to the hospital. In cases where a health maintenance organization is a major purchaser of services from a particular hospital, a contract rate reduction, contract cancellation, inability to pay, business failure, or bankruptcy of the health maintenance organization may have a substantial negative effect on the hospital's financial condition. Hospitals also from time to time have disputes with Alternative Delivery Systems concerning payment and contract interpretation issues.

The Combined Group has a number of contracts with certain Alternative Delivery Systems and receives an increasingly significant portion of its revenues from Alternative Delivery Systems. For its fiscal year ended July 31, 2011 approximately __% of the hospital portion of the System's gross patient service revenue was attributable to patients enrolled by Alternative Delivery Systems. See "[_____– Sources of Combined Gross Patient Service Revenues]" in Appendix A to this Official Statement. Renegotiation of the discount formulas in those contracts may reduce reimbursement to the Combined Group, and there is no assurance that the Combined Group will retain such contracts in the future or obtain other contracts of like kind. Failure to execute and maintain such contracts could have the effect of reducing the System's patient base and gross revenues. On the other hand, although participation may maintain or increase the patient base, it may also result in reduced payments and lower net income.

Dependence on Medicare and Medicaid

Profitable operation of the System is and will be dependent upon a federally funded reimbursement system for the elderly and disabled known as Medicare. Approximately 43.8% of the hospital portion of the System's gross patient service revenue for its fiscal year ended 2012 was attributable to Medicare patients. It is unlikely that the System could ever attract sufficient numbers of private pay patients to become totally self-sufficient without reimbursements from the Medicare program. See "[_____– Sources of Combined Gross Patient Service Revenues]" in Appendix A hereto herein for a discussion of the Medicare reimbursement system.

To a lesser extent, the System also is and will be dependent upon payments made under a cost-related reimbursement system for the medically indigent under the Georgia Medicaid program administered by the Georgia Department of Medical Assistance. Approximately 19.2% of the hospital portion of the System's gross patient service revenue for fiscal year ended 2012 was attributable to Medicaid patients. This program is funded by the State of Georgia, which receives reimbursement for part of its cost from the federal government, provided that the state administered program and the System and its operations meet federally imposed standards for reimbursement. See "THE SYSTEM - Sources of Revenue" herein for a discussion of the Medicaid reimbursement system.

The amount and frequency of payments under the federal Medicare program and the federal-state Medicaid program are subject to legislative changes, administrative rulings, interpretations of policy, determinations and processing delays by intermediaries implementing reimbursement procedures, retroactive payment adjustments, and governmental funding restrictions, any or all of which may materially decrease the revenues and cash flow of the System and the Combined Group.

There can be no guarantee that the federal government or the State of Georgia will not terminate or substantially change or curtail the Medicare and Medicaid reimbursement programs, and such a change could, and any termination or curtailment probably would, have an adverse effect upon the System and the Combined Group. See below for further discussion of the Medicare and Medicaid Programs and their impact on the Combined Group.

Nonprofit Healthcare Environment - Federal and State Actions

General

The Combined Group is subject to regulation by a number of governmental agencies, including those that administer the Medicare and Medicaid programs, federal, state, and local agencies responsible for the administration of health planning programs, and is subject to federal, state, and local laws, regulations, rulings, and court decisions relating

to their organization and operation, including their operation for charitable purposes. There can often be tension between the rules designed to regulate a wide range of charitable organizations and the day-to-day operations of an Integrated Delivery System (as defined below) such as the Combined Group. As a result, the Combined Group is sensitive to legislative and regulatory changes in and limitations on governmental spending for the governmental programs which affect it, and the constant shifts in laws and regulations may be detrimental to the Combined Group and its financial condition. The rapidly rising cost of health care and the consequent drain on the federal budget through federal funding of the Medicare program and through federal participation in the Medicaid program has been a major area of federal executive and Congressional concern, especially in recent years.

While many provisions of the PPACA are already in effect, some aspects of the PPACA and the Reconciliation Amendment will be implemented over the next few years through the issuance of regulations by HHS. It is unclear what form final regulations will take. However, once fully implemented, the PPACA and the Reconciliation Amendment will likely reduce Medicare and Medicaid payments to the Combined Group, increase the Combined Group's expenses, alter the Combined Group's business practices, or otherwise adversely impact its financial performance in a material way.

Recently, an increasing number of operations or practices of health care providers have been challenged or questioned to determine if they are in compliance with the regulatory requirements for nonprofit tax-exempt organizations. These challenges, in some cases, are broader than concerns about compliance with federal and state laws, and instead are examinations of core business practices of the health care organization, such as billing and collection practices, pricing practices, charitable care, executive compensation, and property tax exemption. These challenges have come from state attorneys general, the Internal Revenue Service ("IRS"), labor unions, Congress, state legislatures, other federal and state agencies, and patients. Some of those challenges include the following areas.

Health Care Reform

Comprehensive health care reform was enacted by the federal government in March 2010 through the PPACA and the Reconciliation Act. The PPACA and the Reconciliation Amendment include provisions to reduce the growth in federal spending for health care, including proposals to restrict Medicare and Medicaid spending. Among other things, PPACA restricts the ability of health insurers to design plans, restrict coverage, impose caps, restrict eligibility, and impose other restrictions on covered individuals. Beginning in 2014, individuals will be required to maintain minimal essential health care coverage, and the failure to do so may result in the imposition of a financial penalty upon individuals who fail to maintain such coverage. In addition, not later than 2014, Medicaid coverage will be extended to individuals under the age of 65 having incomes at or below 133% of the federal poverty level. States had the option to accelerate such Medicaid coverage to April 1, 2010 and may opt to extend such coverage to individuals with incomes exceeding 133% of the federal poverty level beginning in 2014. On June 28, 2012, the Supreme Court ruled in *National Federation of Independent Business v. Sebelius* that the requirement for states to expand eligibility to individuals under the age of 65 having incomes at or below 133% of the federal poverty level is optional instead of mandatory. It is uncertain at this time to what extent states will implement this Medicaid coverage expansion in light of the Court's ruling.

Once fully implemented, the PPACA and the Reconciliation Amendment could have a significant impact on the future business and operations of the Combined Group, but management of the Combined Group cannot accurately predict the effect of such implementation at this time.

Other Congressional Hearings and Legislation

In recent years, Congress has focused on tax-exempt hospitals and the community benefit standard for and the charity care provided by such hospitals. For example, in December 2006, the Chairman of the United States House Ways and Means Committee introduced H.R. 6420 (Tax Exempt Hospitals Responsibility Act of 2006) that statutorily mandated the levels of charity care required to be provided by tax-exempt hospitals, and established penalties and taxes for failure to meet such requirements. This bill never became law. As another example, Senator Charles E. Grassley, the ranking Republican on the Senate Finance Committee, continues to take an interest in how tax-exempt hospitals obtain and maintain their charitable status and continue to meet the community benefit standard.

The PPACA establishes requirements for any organization that operates at least one hospital facility to qualify as a section 501(c)(3) organization. In general, new section 501(r) of Internal Revenue Code of 1986, as amended (the "Code") imposes the following new requirements. (1) Each hospital facility is required to conduct a community needs assessment at least every three taxable years and adopt an implementation strategy to meet the community needs identified through such assessment. (2) Each hospital facility is required to adopt, implement, and widely publicize a

written financial assistance policy. The financial assistance policy must indicate the eligibility criteria for financial assistance and whether such assistance includes free or discounted care. (3) Each hospital facility is permitted to bill for emergency or other medically necessary care provided to individuals who qualify for financial assistance under the facility's financial assistance policy to no more than the amounts generally billed to individuals who have insurance covering such care. A hospital may not use gross charges when billing individuals who qualify for financial assistance. (4) A hospital facility (or its affiliates) may not undertake extraordinary collection actions (even if otherwise permitted by law) against an individual without first making reasonable efforts to determine whether the individual is eligible for assistance under the hospital's financial assistance policy.

These requirements were generally effective for taxable years beginning after March 23, 2010, and the requirement for a community needs assessment is effective for taxable years beginning after March 23, 2012.

Failure to complete a community health needs assessment in any applicable three-year period can result in a penalty on the organization of up to $50,000, in addition to possible revocation of status as a section 501(c)(3) organization.

On June 22, 2012, the IRS released for publication a proposed rule that would implement these PPACA provisions with the exception of the community needs assessment requirement. Comments were due by September 24, 2012. It is uncertain at this time when the IRS will finalize these proposals or publish proposals for the community needs assessment requirement.

The PPACA also imposes reporting and disclosure requirements on hospital organizations. The IRS is required to review information about a hospital's community benefit activities at least once every three years. The PPACA requires the Secretary of the Treasury, in consultation with the Secretary of HHS, to submit annually a report to Congress with information regarding the levels of charity care, bad debt expenses, unreimbursed costs of government programs, as well as costs incurred by tax-exempt hospitals for community benefit activities. The Secretary of the Treasury, in consultation with the Secretary of HHS, must conduct a study of the trends in these amounts, and submit a report on such study to Congress not later than five years after the date of enactment. These statutorily mandated requirements for periodic review will increase IRS surveillance over such organizations and may increase the likelihood of IRS examinations challenging their section 501(c)(3) status. In addition, submission of a report to Congress relating to community benefit provided by section 501(c)(3) hospital organizations may increase the likelihood that Congress will consider additional requirements for section 501(c)(3) hospital organizations in the future.

The changes mandated by PPACA, including the requirements imposed by Section 501(r) of the Code described above, may have a material adverse impact on the business and operations of the Combined Group.

Internal Revenue Service Initiatives and the New Form 990

To maintain their status as organizations exempt from federal income taxation, certain members of the Combined Group will be subject to a number of requirements affecting their operations. Failure to satisfy these requirements, the modification or repeal of certain existing federal income tax laws, the change of IRS policies or positions, or a change of such members' methods of operations, purposes, or character could result in the loss by such members of their tax-exempt status. The IRS has been recently scrutinizing the operation of hospitals by nonprofit organizations exempt from federal income taxation. Failure by any such member of the Combined Group to maintain its tax-exempt status or a determination that the operation of any part of the System constitutes an unrelated trade or business could adversely affect the funds available to the Combined Group to make payments under the 2012A Master Note by subjecting income from the System to federal income taxation and by disallowing any deduction to any member of the Combined Group for interest paid on the 2012A Master Note and could result in the inclusion of the interest on the Series 2012 Certificates in gross income for federal income tax purposes.

The obligations of the members of the Combined Group to make payments under the 2012A Master Note may not be enforceable if payments are requested to be made with respect to an Obligation under the Master Indenture that was incurred for a purpose inconsistent with the charitable purposes of the members of the Combined Group from which such payments are requested or that was incurred or issued for the benefit of any entity other than a nonprofit corporation which is exempt from federal income taxation.

Pursuant to the Taxpayer Bill of Rights enacted in July 1996, the IRS has been given added authority to police the activities of tax-exempt organizations. In addition to its authority to revoke an entity's tax-exempt status under Section 501(c)(3) of the Code, the IRS may, pursuant to Section 4958 of the Code, impose intermediate sanctions on "excess benefit" transactions between tax-exempt organizations and disqualified persons, such as organization managers

and other such persons who are in a position to exercise substantial influence over the affairs of the tax-exempt organization. These sanctions may be applied retroactively to any transaction occurring on or after September 14, 1995. On January 23, 2002, the IRS adopted final regulations concerning these intermediate sanctions provisions, pursuant to which an excise tax is imposed on excess benefit transactions, such as excessive compensation arrangements. On September 9, 2005, the Treasury proposed additional regulations under Sections 501(c) and 4958 of the Code which, among other things, illustrate situations involving excess benefit transactions in which the IRS will assert that only an excise tax be imposed and other situations in which the IRS will assert that both excise taxes be imposed and the organization's exempt status revoked. In light of these developments, the number of IRS examinations aimed at excess benefit transactions will likely increase and, in certain circumstances, result in the revocation of the exempt status of the organization.

For tax years beginning on or after January 1, 2008, tax-exempt organizations, such as nonprofit health care organizations, are required to complete a redesigned Form 990. The Form 990 is the annual information return filed by such organizations with the IRS. As a result of the redesigned Form 990, health care organizations, for tax years beginning on or after January 1, 2008, are subject to significantly increased compliance, record-keeping, and reporting obligations with respect to community benefit, billing and collection practices, charity care, tax-exempt bonds, corporate governance, executive compensation, compliance with safe harbor guidance in connection with management contracts and research contracts and other matters. These reporting and record-keeping obligations go beyond what many providers may have done in the past and could result in enhanced enforcement, as the redesigned Form 990 makes available more detailed information on compliance risk areas to the IRS and other stakeholders.

Charitable Purposes Issues - Georgia

There exists common law authority, as well as Georgia statutory authority, for the ability of the Georgia courts to terminate the existence of a Georgia nonprofit corporation or undertake supervision of its affairs on various grounds, including a finding that such corporation has insufficient assets to carry out its stated charitable purpose or has taken some action that constitutes a substantial departure from its stated charitable purpose. Such court action may arise on the court's own motion or pursuant to a petition of the Georgia attorney general or other persons who have interests different from those of the general public pursuant to the common law and statutory power to enforce charitable trusts and require the application of nonprofit corporation funds to their intended charitable uses.

It is possible in the future, therefore, that the Georgia attorney general or the Georgia courts might deem the Master Indenture to constitute obligations of such value as to cause either any or all members of the Combined Group to have liabilities and obligations that exceed their assets, thereby being subject to termination by the attorney general. Moreover, the attorney general or the Georgia courts may deem the performance of the obligation represented by the Master Indenture to constitute a substantial departure from the stated charitable purposes of the members of the Combined Group, and the performance of the Master Indenture as to such members could be enjoined.

An action to enforce a charitable trust and require the application of its funds to their intended charitable uses could also arise if an action to enforce the obligation to make payments under the Master Indenture would result in the cessation or discontinuation of any material portion of health care or related services previously provided by the member of the Combined Group from which payment is requested.

The obligations of a member of the Combined Group to make payments under the Master Indenture may also not be enforceable to the extent such payments are requested to be made from any assets that are donor-restricted or that are subject to a direct, express, or charitable trust which does not permit the use of such assets for such payment. Due to the absence of clear legal precedent in this area, the extent to which the assets of any present or future member of the Combined Group constitute assets that are so restricted or subject to such trusts cannot now be determined. The amount of such assets could be substantial.

Challenges to Real Property Exemptions

Recently, taxing authorities in certain state and local jurisdictions have sought to impose or increase taxes related to the properties and operations of nonprofit organizations, particularly where such authorities have been dissatisfied with the amount of service provided to indigent patients. Illinois courts have recently upheld a decision by the Illinois Revenue Department to revoke the property tax exemption of a tax-exempt hospital in Illinois. While management of the Combined Group is not aware of any challenges to the tax-exempt status of the real property of the Combined Group, it cannot predict whether any such actions would be taken by the State of Georgia or the Georgia Department of Revenue.

Indigent Care

Various congressional committees have held public hearings on the issue of unfair competition between nonprofit and for-profit health care organizations and on the issue of the amount of indigent care that should be provided by nonprofit organizations that have resulted in proposed federal legislation in Congress. Similar hearings have been conducted by certain state legislative bodies. These hearings have focused on the need for changes in the law relating to the taxation of nonprofit organizations in connection with revenue-producing activities in which they are engaged and relating to the amount of indigent care that should be provided to maintain the tax exempt status of nonprofit organizations. On June 30, 2006, the United States Government Accountability Office ("GAO") released to the Ways and Means Committee of the U.S. House of Representatives its survey concerning the level of executive compensation reported by selected hospital systems and concerning related corporate governance issues. Following delivery of the GAO survey several members of Congress, including the Chairman of the Finance Committee of the U.S. Senate, called on the IRS to reconsider terms of the community benefit standard, which health care organizations generally must satisfy in order to qualify as Section 501(c)(3) organizations, with a view to seeing the IRS impose minimum levels of uncompensated indigent care that any such organization must offer as a condition of maintaining its charitable status. Although the IRS has not yet proposed to modify the community benefit standard, there can be no assurance it will not do so in the future or as to the impact such standard, if imposed, would have on the on the business and operations of the Combined Group.

The System provides indigent care without charge or at reduced rates. The amount of this uncompensated care has increased in recent years and is expected to continue to increase in the future. A large portion of this uncompensated care results from emergency room admissions. General economic conditions that affect the number of employed individuals who have health coverage affects the ability of patients to pay for health care. The unemployment rate in the State of Georgia has hit historically high levels and has caused a significant decrease in the number of individuals who have health coverage or have the financial resources to pay for health care. Similarly, changes in governmental policy may increase the frequency and severity of indigent treatment by such hospitals and other providers. It is also possible that future legislation could require that tax-exempt hospitals maintain minimum levels of indigent care as a condition of federal income tax exemption from certain state and local taxes. The Combined Group maintains records to identify and monitor the level of indigent care it provides, which include the amount of charges foregone for services and supplies furnished pursuant to its indigent care policy.

The approximate amounts of indigent care provided by the Combined Group, based upon charges foregone, for its past five fiscal years are set forth below.

Year Ended July 31	Indigent Care (in thousands)
2007	
2008	
2009	
2010	
2011	

Litigation Relating to Billing and Collection Practices

Hospitals have been sued by patients in connection with the tax-exempt status of these facilities. More than 45 lawsuits have been brought against major hospital systems throughout the United States on behalf of uninsured patients. These suits have sought class-action status and included claims that the defendants, by accepting tax-exempt status, entered into agreements with the federal, state, and local governments promising to provide free or reduced cost care to all who need it; that the uninsured patients are beneficiaries of those agreements and entitled to bring suit under them; that the defendants engaged in illegal and oppressive tactics against the uninsured; that the defendants engaged in illegal price discrimination by charging the uninsured rates far in excess of those charged to Medicare and other third-party payors; that the defendants violated state consumer fraud statutes; that they allowed a portion of their properties to be used by for-profit entities at less than fair value and engaged in other inappropriate transactions with doctors and certain "insiders"; that the defendants illegally transferred monies for other than charitable purposes; and that the defendants conspired to charge illegal prices to the uninsured.

Although to date no member of the Combined Group has been named as a defendant in any action of this type, it is possible that this could change in the future. Additionally, there can be no assurance that future changes in the laws,

rules, regulations, and policies relating to the taxation of nonprofit organizations will not force the members of the Combined Group to increase their services to indigent patients at reduced rates or without charge in order to retain their tax-exempt status.

Payment Reform

As part of the general health care reform initiatives described in this Official Statement and with the enactment of the PPACA and the Reconciliation Amendment, the payment structure from payors, including private payors and governmental program payors, may be altered from current methodologies. The PPACA rewards the reorganization of care delivery model in the form of "accountable care organizations" ("ACOs") in which providers would share in any reduction in health care expenditures for a given population. The PPACA gives the Secretary of HHS the flexibility to implement innovative payment models for participating accountable care organizations. In addition, the PPACA directs the Secretary of HHS to develop a national, voluntary pilot program encouraging hospitals, physicians, and post-acute care providers to improve patient care and achieve savings for the Medicare program through bundled payment models. The National Pilot Program on Payment Bundling must be established by January 1, 2013 and run for a period of five years. If the pilot program is found to improve quality and reduce costs, the Secretary of HHS has the authority to expand the pilot program, but the PPACA does not require making a bundled payment model permanent. In addition, the PPACA also provides for a payment bundling model under the Medicaid program through a demonstration program in up to 8 states which began on January 1, 2012 and will end on December 31, 2016. Under this demonstration, the acute care hospital payment is expanded to include post-acute care provided in acute care hospitals and non-hospital settings, and/or hospital and concurrent physician's services. Under this model, hospitals will receive a single bundled payment from Medicaid for such services. While neither of these PPACA initiatives have been implemented, HHS is in the process of implementing a program for testing different models for bundled payments through separate authority granted under the PPACA. The effect of any type of these payment models is uncertain and may result in reduction of net revenue of the Combined Group members.

Conclusion

The foregoing are some examples of the challenges facing nonprofit health care organizations. The legislation and initiatives already enacted, as well as any legislation or initiatives that may be enacted, as a result of any of the challenges discussed above could have a material adverse impact on the business and operations of the Combined Group.

Federal Laws Affecting Health Care Facilities

ARRA

ARRA, which was signed into law in February 2009, includes certain provisions which are intended to provide financial relief to health care providers, such as an increase in the amounts paid by the federal government to the states to fund Medicaid through December 31, 2010. Additionally, Title XIII of ARRA, otherwise known as the Health Information Technology for Economic and Clinical Health Act ("HITECH"), provides for an investment of almost $20 billion in public monies for the development of a nationwide health information technology infrastructure. Among other things, HITECH provides financial incentives, through the Medicare and/or Medicaid programs (the Medicare and Medicaid EHR Incentive Programs), loans, and grants to encourage practitioners and providers to adopt and make meaningful use of certified electronic health records. Beginning in 2015, Medicare payments will be reduced for practitioners and providers who do not make meaningful use of certified electronic health records. HITECH also significantly increased fines and the scope of remedies for violations of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and breaches of privacy and security of protected health information and, if certain procedures and technologies are not in place, requires disclosure to affected individuals, the United States Department of Health and Human Services ("HHS") "), and (in some circumstances) the news media in the event of a breach of protected health information, as that term is defined by HITECH and the implementing regulations. Criminal penalties can be imposed against persons (including employees of covered entities and business associates) who obtain or disclose protected health information without authorization. In addition, a state's attorney general can bring civil actions against a person on behalf of residents adversely affected by violations of either HIPAA or HITECH. The state attorney general can either seek to enjoin further violations or obtain money damages on behalf of the residents harmed. Under HITECH, HHS has begun to perform periodic audits of health care providers to ensure compliance with HIPAA/HITECH requirements and the Privacy, Security and Breach Notification Rules. Additionally, under HITECH, individuals harmed by violations will be able to recover a percentage of monetary penalties or a monetary settlement based upon methods to be established by HHS for this private recovery in the next few years. No determination can be made at this time as to what effect, if any, ARRA may have on the operations or revenues of the Combined Group.

Federal Privacy Laws

When Congress enacted HIPAA, it required HHS to implement national standards to protect the privacy and security of individually identifiable health information (protected health information), as well as adopt standards for electronic claims submission and other healthcare financial and administrative transactions. With respect to the privacy standards, HHS published in December 2000 a set of regulations governing the use and disclosure of protected health information (the "Privacy Rule"). As of April 14, 2003, healthcare providers are required to be fully compliant with the Privacy Rule, as it was amended by HHS on August 14, 2002. The final rule adopting standards for the security of electronic health information (the "Security Rule") was published on February 20, 2003, and, as of April 20, 2005, providers are required to operate in compliance with these regulations.

The standards for electronic healthcare transactions (the "Transactions Rule") were scheduled to go into effect on October 16, 2003. However, due to low compliance levels as that date neared, the Centers for Medicare and Medicaid Services of HHS ("CMS") established a "contingency plan" that permitted electronic claims submission in accordance with electronic formats then currently in use for a one year period. On January 16, 2009, HHS published certain amendments to the transactions standards contained in the Transaction Rule that, among other things, set forth a compliance date of January 1, 2012; after a grace period provided by CMS, covered entities are now expected to be in compliance with the updated transactions standards. On January 16, 2009, HHS also adopted a new generation of diagnosis and procedure codes, commonly known as the ICD-10 code sets, requiring compliance by all covered entities, including hospitals, by October 1, 2013; that compliance date has since been postponed until October 1, 2014. HIPAA implementing regulations also require the adoption and use of a set of new, unique identifiers, the National Provider Identifier (NPI), to identify health care providers in, among other things, claims transactions submitted after May 23, 2007, with a one-year extension applicable to small health plans. On September 5, 2012, CMS published a rule adopting a HIPAA standard for a national, unique health plan identifier (HPID) for HIPAA transactions; the rule requires plans to obtain HPIDs by November 5, 2014 (or November 5, 2015, for small plans), and all covered entities, including health care providers, to use such HPIDs in HIPAA standard transactions where health plans need to be identified beginning November 7, 2016. Under the PPACA, HHS is required to adopt, under the Transactions Rule, a single set of "operating rules" for each of the HIPAA transaction standards, to reduce the variations in how individual health plans and clearinghouses implement the transactions standards; to date, operating rules have been adopted for a number of HIPAA standard transactions and compliance is now required for some, but not all, of the HIPAA/PPACA operating rules. The PPACA also provides for the establishment by HHS of an expedited process for the maintenance and updating of existing HIPAA transaction standards to newer versions

The Privacy Rule prohibits any covered entity, including hospitals and health systems, from using or disclosing an individual's protected health information unless the use or disclosure is authorized by the individual (or his or her personal representative) or is specifically required or permitted under the final regulations. The Security Rule specifies a series of administrative, technical, and physical safe guards that covered entities must implement and follow to ensure that confidentiality, security and integrity of electronic protected health information is not breached or compromised. With respect to the Transactions Rule, electronic claims must be HIPAA compliant or they will not be processed and will be returned to the filing provider for resubmission in the compliant format. Subject to several limited exceptions, claims submitted for Medicare reimbursement must be submitted electronically and, thus, in a HIPAA compliant format. Under the PPACA, as of January 1, 2014, payments for Medicare claims will only be made by electronic funds transfer.

In addition to the provisions noted above, HITECH modified certain provisions of the HIPAA Privacy Rule and Security Rule, and included additional requirements meant to protect the privacy and security of protected health information, including, but not limited to, a new federal breach notification obligation applicable to HIPAA covered entities and their business associates. HHS, as required by HITECH, has issued a regulation setting forth the breach notification obligations applicable to covered entities and their business associates (the "HHS Breach Notification Rule"). On July 14, 2010, HHS published a proposed rule to amend the HIPAA Privacy, Security, and Enforcement Rules to implement other HITECH requirements; as of the date hereof, the final rule has not been published. The various requirements of HITECH and the HHS Breach Notification Rule have different compliance dates. The Combined Group is in compliance with the currently implemented requirements of HITECH and the HHS Breach Notification Rule, but can make no assurances that it is currently in compliance with all elements of the law.

Individually and collectively, the Privacy, Security, Breach Notification and Transactions Rules impose a complex system of requirements that healthcare providers must follow, and covered providers are subject to civil and criminal penalties for failing to do so. Originally under HIPAA, civil penalties of up to $100 per violation could be imposed, with a cap of $25,000 for all identical violations in a calendar year, but with the passage ARRA, a penalty structure was created and the per violation amount and the total penalties per year were increased based on the severity

of the violation; in certain circumstances, penalties of up to $50,000 per violation can be imposed, with a maximum penalty of up to $1,500,000 for all identical violations in a calendar year. Criminal penalties include fines of up to $50,000 and imprisonment of up to one year. Criminal penalties increase substantially if the offense occurs under false pretenses or with the intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm. The administrative and financial burden of complying with the Privacy, Security, Breach Notification and Transactions Rules is expected to be substantial. Even after a healthcare provider has implemented compliance measures, there are expected to be significant, continuing costs associated with compliance. The Combined Group has worked to bring its health information systems into compliance with the Privacy, Security, Breach Notification and Transactions Rules by the applicable deadlines. However, the Combined Group cannot predict the extent to which the costs of maintaining compliance with these regulatory requirements will affect its financial performance.

Medicare and Medicaid Programs

Laws have been enacted from time to time to curb the amount of federal and state expenditures in health care, particularly in the Medicare and Medicaid programs. For example, the Balanced Budget Act of 1997 (the "BBA") made substantial cuts in health care spending that adversely affected many health care providers. In the past, the federal government has curbed health care spending in other ways as well: by reducing the share of federal matching payments paid to the states to subsidize the cost of their Medicaid programs; making program changes that affect reimbursement; and, increasingly, emphasizing the prevention of health care fraud, with a resultant rise in investigation and prosecution of health care providers. There will most likely be a continuing effort to achieve legislative and regulatory reform in these areas on the federal level. According to a report issued in 2012 by the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, the Medicare trust fund, which is used to pay Medicare hospitalization coverage, could be exhausted by 2024.

Health care providers will continue to be significantly impacted by changes in the last several years in federal health care laws and regulations aimed at regulating, controlling, or altering the methods of delivering and financing health care. Further, any additional health care reform legislation that is passed will have a significant impact on health care providers. Bills that have been enacted on the federal level have caused severe reductions in reimbursement from the Medicare program. These laws and regulations have significantly affected health care providers by increasing governmental oversight of health care providers, reducing reimbursement to providers, and increasing the penalties and sanctions for providers who fail to comply with Medicare regulations.

The enactment of HIPAA and the BBA provide evidence of Congress' desire to decrease federal expenditures on Medicare and Medicaid and to reduce Medicare and Medicaid fraud. Congress has also affected reimbursement levels to providers through the enactment of the Medicare, Medicaid and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999 ("BBRA") and the Benefits Improvement and Protection Act of 2000 ("BIPA"). The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the "MMA"), which was signed into law on December 8, 2003, generally increased reimbursement levels. The Deficit Reduction Act of 2005 (the "DRA"), which was signed into law on February 8, 2006, implemented, among other things, cuts in Medicare program benefits while increasing spending to combat waste, fraud, and abuse. The Tax Relief and Health Care Act of 2006 (the "2006 Tax Act") focuses on quality of care. Regulations implementing or further defining the provisions of these aforementioned Acts have been or likely will be enacted, and will likely be subject to future revisions. Therefore, it is not possible at this time to determine all of the effects of such regulations on the Combined Group. Health care legislation has been and continues to be the subject of much debate in Congress, and further health care bills and enactments are likely. No determination can be made at this time as to whether any health care legislation will be enacted into law and, if enacted, what effect, if any, it may have on the operations or revenues of the Combined Group.

Patient Transfers

Federal law requires hospitals that participate in Medicare and Medicaid to comply with the Emergency Medical Treatment and Active Labor Act of 1986 ("EMTALA"), and the Combined Group is therefore required to adhere to EMTALA's requirements. Under EMTALA, any individual, not just a Medicare or Medicaid beneficiary, that comes to the emergency department of a hospital seeking medical examination or treatment must be provided an "appropriate medical screening" examination. The hospital must determine whether an emergency medical condition exists or whether a woman is in active labor. If an emergency medical condition exists or a woman is in active labor, the hospital must provide sufficient examination and treatment to stabilize the patient or must transfer the patient, if the transfer meets EMTALA's requirements for an "appropriate" transfer. EMTALA requires hospitals to provide the medical screening exam and stabilizing treatment regardless of the individual's ability to pay and prohibits hospitals

from inquiring into the individual's method of payment or insurance status before providing the treatment. Additionally, EMTALA prohibits hospitals from delaying treatment in order to obtain prior authorization for treatment from an individual's managed care plan. Because of these prohibitions, the Combined Group may be required to provide substantial amounts of care and services for which they will not receive reimbursement.

Hospitals that knowingly and willfully, or negligently, fail to comply with EMTALA's requirements are subject to termination as a Medicare provider. Additionally, the HHS Office of Inspector General may impose civil monetary penalties of up to $50,000 per violation. EMTALA also provides a private right of action for individuals who suffer harm as a result of a hospital's EMTALA violations.

Management of the Combined Group believes its policies and procedures have been and currently are in material compliance with EMTALA, but no assurance can be given that a violation of EMTALA will not be found. Any sanctions imposed as a result of an EMTALA violation could have a material adverse effect on the business and operations of the Combined Group members.

The Medicare Program and Related Regulations

Introduction

The Medicare program, which is administered by CMS, is funded by the federal government and was created as part of the Social Security Amendments of 1965. Title XVIII of the Social Security Act, officially titled "Health Insurance for the Aged and Disabled," contains the operative provisions. Medicare is a reimbursement program designed primarily for assistance to the aged and disabled and consists of four primary parts, typically referred to as Parts A, B, C and D. Part A provides coverage primarily for inpatient hospital services, post-hospital extended care services, and post-hospital home health services. Part B provides coverage primarily for services provided in an outpatient setting, such as by physicians, other health care practitioners, clinical laboratory and diagnostic tests, ambulatory surgery, as well as for other services or equipment provided by medical suppliers. Part C, once known as "Medicare+Choice" and now referred to as "Medicare Advantage," is intended to provide Medicare beneficiaries with access to private health plan choices and serve as an alternative to the traditional fee-for-service Medicare program. Part D is the prescription drug benefit added to the Medicare program by MMA. The Medicare Part A program is financed primarily out of compulsory taxes paid by employers and employees under the Federal Insurance Contribution Act and by the self-employed under the Self-Employment Contribution Act. An individual may become eligible for Part A benefits in several ways, although as a general rule, an eligible individual must have reached the age of 65 and be entitled to certain benefits under the Social Security program.

CMS delegates to the states the process for certifying hospitals to which CMS will make payment. To achieve and maintain Medicare certification, hospitals must meet CMS's "Conditions of Participation" on an ongoing basis, as determined by the state and/or The Joint Commission. Under the PPACA, as a new Condition of Participation, Medicare providers are required to implement compliance programs that contain core elements established by the Secretary of HHS in consultation with the HHS Office of Inspector General ("OIG"). The requirements for Medicare certification are subject to change, and, therefore, it may be necessary for hospitals to effect changes from time to time in their facilities, equipment, personnel, billing, policies and services. Members of the Combined Group are certified as a provider for Medicare services.

In the last several years, Congress has enacted several laws and federal agencies have promulgated numerous regulations that affect the Medicare Program. The purpose of much of the recent statutory and regulatory activity has been to reduce the rate of increase in health care costs paid under the Medicare Program, and the most sweeping changes in Medicare are contained in the PPACA and the Reconciliation Amendment.

Inpatient Services - Reimbursement

General. In recent years, providers have been reimbursed for most Medicare inpatient services under a prospective payment system ("PPS"), which pays hospitals fixed amounts for specific services based on patient diagnosis. Under the PPS, each Medicare patient discharge has been classified into one of approximately 745 Medicare Severity Diagnosis-Related Group ("MSDRG") categories and the hospital is reimbursed a specific fixed predetermined rate established by Medicare for that particular patient's MSDRG, regardless of the actual costs incurred by the hospital for the treatment of such patient. For each MSDRG category, both an urban and a rural rate has been set for each of nine regions, and a nationwide rate has been set for each MSDRG category. The rate varies based on the particular region's wage rates, and the MSDRG rate for each hospital within a region depends on the weights (based upon the hospital's case-mix) for each MSDRG. If a hospital treats a patient for less than the applicable MSDRG rate, the hospital is

entitled to retain the difference. Although additional payments are made under the present PPS for cases involving unusually high costs in comparison with other discharges in the same MSDRG category (known as "outlier payments"), generally, if a hospital's cost of treating the patient exceeds the MSDRG rate, the hospital will not be entitled to any additional payment, and it will realize a loss. However, if the hospital's costs are less than the prospective payment rate, the hospital will realize a profit. Since payments to hospitals under a MSDRG system have not reflected the actual costs incurred by many hospitals and since such losses have had to be recovered, if at all, from other sources of revenue, many other third-party payors, including Alternative Delivery Systems, have implemented their own prospective payment systems designed to prevent "cost shifting" to such payors and are actively seeking to reduce their payment obligations to hospitals.

MSDRG payments are adjusted each federal fiscal year (which begins October 1) based on input price indexes or so-called "market baskets." For most years since 1983, Congress has modified the increases and given substantially less than the market basket index. CMS has also implemented an adjustment in documentation and coding to account for payments under the MSDRG system that are unrelated to changes in case mix. CMS also has authority to determine retrospectively if the documentation and coding adjustments for these years adequately accounted for payment changes unrelated to changes in case mix. This resulted in additional adjustments for federal fiscal years 2010, 2011, 2012, and 2013. Moreover, the Secretary of HHS is required to annually review the MSDRG categories to account for new procedures, reclassify MSDRGs, and revise DRG relative-value weights to reflect relative resources used by providers with respect to a given MSDRG category. Under PPACA and the Reconciliation Amendment, inpatient hospitals, long-term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals and outpatient hospitals will face changes in the way market basket updates are calculated.

The PPACA instituted an across-the-board payment adjustment through a decrease in the market basket over a ten-year period and, for the first time, starting in fiscal year 2012, incorporates a productivity adjustment into the market basket update. For federal fiscal years 2010 and 2011, the market basket update was generally reduced by 0.25%. (and 0.50% for long term care hospitals in 2011). For 2012 and forward, the market basket update will be reduced by a productivity adjustment. There can be no assurance that any future changes in classification of patient hospitalizations will not adversely affect the Combined Group.

Other Medicare Service Payments. Medicare payments for inpatient rehabilitation services, psychiatric services and general outpatient services are based on regulatory formulas or pre-determined rates. Specific to psychiatric services, CMS published a final rule on November 15, 2004 for converting inpatient psychiatric services to PPS, as mandated under the BBRA. This PPS system applies to both free-standing psychiatric hospitals and certified psychiatric units in general acute-care hospitals. This system became effective for cost-reporting periods from and after January 1, 2005, and rates under this system were phased in over a three-year period. There is no guarantee that any of these rates, as they may change from time to time, will be adequate to cover the actual cost of providing these services to Medicare patients.

Capital Costs; Hospital Wage Index. A hospital's capital-related costs for treating Medicare inpatients, which include interest, depreciation, equipment rentals, amortization of financing costs, taxes, insurance, and similar expenses for plant and fixed and movable equipment are reimbursed on the basis of a prospective capital rate, adjusted for case mix, area wage index, urban location, disproportionate share factors, and outlier cases. There are special exceptions for hospitals financially disadvantaged by the new capital-related cost PPS. A hospital is entitled to additional Medicare capital payments if the total Medicare capital payment it is entitled to receive during any cost reporting period would otherwise be less than the following applicable minimum (floor) payment levels, determined by class of hospital: (1) 90% of total allowable Medicare inpatient capital costs, for sole community hospitals, (2) 80% for urban disproportionate share hospitals with at least 100 beds, and (3) 70% for other hospitals.

Section 3137 of the PPACA required hospital wage index reform. Pursuant to the PPACA, the Secretary of HHS presented to Congress a comprehensive reform plan to calculate relative wages for each geographic area involved. The Secretary recommended the commuting based wage index methodology as a viable alternative to the current methodology used to determine the wage adjustment to payments made under IPPS. If this alternative approach is adopted, each hospital would have a wage index value based on actual employment patterns of the hospital, instead of a value assigned for all hospitals in a specific region.

There can be no assurance that future capital-related payments will be sufficient to cover the actual capital-related costs of the Combined Group's facilities applicable to Medicare patient stays or will provide flexibility for hospitals to meet changing capital needs.

Preventable Medical Errors. The DRA required the HHS Secretary to select at least two conditions that are: (1) high cost, high volume or both; (2) identified through coding as a complicating condition or major complicating condition that, when present as a secondary diagnosis at discharge, results in payment at a higher MSDRG; and (3) reasonably preventable through application of evidence-based guidelines. Such conditions are referred to as "hospital-acquired conditions." The DRA further required hospitals to begin reporting on claims for discharges, beginning October 1, 2007, whether the selected conditions were present on admission. In the fiscal year 2008 Inpatient Prospective Payment System Final Rule, CMS selected eight conditions in furtherance of this mandate. These included seven conditions identified by the National Quality Forum as "never events." In the fiscal year 2009 Inpatient Prospective Payment System Final Rule, CMS finalized several more conditions, within three categories. All of the conditions will have payment implications when acquired during an inpatient stay for discharges on or after October 1, 2008. CMS added two more conditions in the fiscal year 2013 Inpatient Prospective Payment System Final Rule. These events are now referred to as the serious reportable events.

In December 2008, the Office of the Inspector General (the "OIG") issued several broad reports about adverse events in hospitals and the need to improve patient safety, along with a report that presented the findings of a case study that was specific to two counties. The incidence of adverse events and their payment implications continues to be an area of focus for regulators.

The PPACA implements payment adjustments for hospital-acquired conditions. Beginning October 1, 2015, hospitals in the 25th percentile of rates of hospital-acquired conditions for certain high-cost and common conditions would be subject to a payment penalty under Medicare. The PPACA requires the Secretary of HHS to report to Congress on the appropriateness of establishing the same type of policy for other Medicare participating providers, including outpatient hospital departments, ambulatory surgery centers, inpatient rehabilitation facilities and long-term care hospitals.

Value-Based Purchasing. Under PPACA, a value-based purchasing program for hospitals will apply to payments beginning October 1, 2012. Under this program, a hospital is eligible to receive value-based incentive payments that are tied to the hospital's performance on quality measures related to common and high-cost conditions, such as cardiac, surgical and pneumonia care. Quality measures included in this program include clinical process of care measures, patient experience measures, outcome measures, and an efficiency measure. Hospital reimbursements will be reduced to fund these incentive payments. In fiscal year 2013, payments will be reduced by 1.0 percent and will increase to 2.0 percent by fiscal year 2017.

Readmissions. Under the PPACA, CMS is required to implement the Hospital Readmissions Reduction Program in fiscal year 2013. CMS is required to calculate national and hospital-specific data on the readmission rates of Medicare participating IPPS and certain demonstration hospitals for three conditions selected by the Secretary of HHS based on high volume or spending (Acute Myocardial Infarction, (AMI) Heart Failure (HF) and Pneumonia (PN)). Beginning in fiscal year 2015, the four conditions specified in the Medicare Payment Advisory Commission's ("MedPAC") June 2007 report to Congress will be added, as well as other conditions which the Secretary of HHS deems appropriate. Beginning on October 1, 2012, hospitals with readmission rates above a certain threshold will have payments for the original hospitalization reduced if a patient with a selected condition is re-hospitalized with a preventable readmission within 30 days. The maximum reduction in fiscal year 2013 is 1.0 percent and is to increase to 2.0 percent in fiscal year 2014 and 3.0 percent in fiscal year 2015 and beyond.

Outpatient Services - Reimbursement

The BBA established a PPS for outpatient hospital services. Outpatient PPS ("OPPS") became effective August 1, 2000 for hospital outpatient services and October 7, 2000 for provider-based facilities owned by hospitals, and was phased-in over a three-year period ending in 2004. Under OPPS, hospital outpatient services are divided into ambulatory payment classifications ("APCs"). APC groups define the clinically-related and resource-similar items and services that contribute to the cost of a procedure or service. Each APC is assigned a weight, which is based on the median cost of the services in the group. OPPS rates are adjusted annually based on the hospital inpatient market basket percentage increase. Payments to hospitals under OPPS may not reflect the actual costs incurred by many hospitals. The Combined Group cannot predict how future OPPS adjustments that may be made by Congress and CMS may affect the financial condition of the Combined Group.

Provider-Based Standards

Provider-based entities are providers of health care services that are created by, or acquired by, a hospital for the purpose of furnishing health care services of a different type from those furnished by the hospital. Normally, provider-based entities are entitled to additional reimbursement that would not be available if the entity were classified as free-standing. Effective January 10, 2001, CMS issued final regulations including an eight-part test to determine whether an entity qualifies as "provider-based" rather than "freestanding." More recently, CMS has attempted to address, in a Program Memorandum dated April 18, 2003, certain ambiguities present in the January 10, 2001 final regulations in connection with these standards. The current standards make it more difficult to qualify as "provider-based" and are aimed at stemming the proliferation of entities characterized as "provider-based." These standards may lead to the reclassification of entities operating within the System from "provider-based" to "freestanding." Such a reclassification may adversely affect the entity's reimbursement under the Medicare program. In addition, in the event a facility or department that bills for outpatient services is found to be out of compliance with current provider-based regulations, the Combined Group could be liable for Medicare overpayments. It is not possible at this time to predict how the current standards ultimately will affect the Combined Group.

Physician Payments

Under Medicare, physicians may elect to "participate" or enroll in the Medicare program as a provider. Under PPACA, if a physician is not enrolled in the Medicare program, the physician must seek and obtain enrollment before ordering durable medical equipment or home health services that incur any cost to the Medicare program. Medicare Part B provides reimbursement for physician services, including employed and provider-based physicians, based upon a national fee schedule known as the "resource based-relative value scale" ("RBRVS"). Under this system, payments for physician services are based on resource costs. The cost of providing each service is divided into three components (each resource based): physician work, practice expense, and professional liability insurance. This produces so-called relative value units ("RVUs") that are subject to multiplication by a conversion factor and adjustment for geographic differences in resource costs in determining payment rates. The conversion factor is a monetary amount that currently is determined by CMS's Sustainable Growth Rate ("SGR") system. The SGR system annually takes into account changes in the Medicare fee-for-service enrollment, input prices, spending due to law and regulation, and gross domestic product, effectively changing the RBRVS on an annual basis. A reduction in the SGR results in decreased payment rates.

For 2007, CMS issued a final rule that provided for a 5 percent reduction in the SGR, but Congress eliminated this reduction pursuant to 2006 Tax Act, which froze payments at then current levels. For calendar year 2010, CMS has eliminated payments for consultation codes, revised the treatment of malpractice premiums and reduced the Medicare Physician Fee Schedule rate by 21.2%. On November 19, 2009, the House approved the "Medicare Physician Payment Reform Act", which delayed the 21.2% reduction. On December 19, 2009, the Senate approved a freeze on Medicare payment rates, thus delaying the proposed reduction until February 28, 2010. On December 22, 2009, President Obama signed this bill into law, with the expectation that a payment fix would be implemented prior to that date. The House and the Senate, in December 2009 and on March 15, 2010, respectively, passed their version of the "American Workers, State and Business Relief Act of 2010," which among other things, included an extension until October 1, 2010, of the former Medicare payment rates to physicians, who faced a 21.2% rate cut that became effective March 1, 2010. Congress took action in early March 2010 to delay the proposed rate cut until April 1, 2010. Because the House was not likely to act on this bill prior to April 1, 2010, the House passed on March 17, 2010 the "Continuing Extension Act of 2010" that would delay the proposed rate cut through April 30, 2010 to give the House and Senate the opportunity to resolve the differences between the House passed and Senate passed bills. However, the Senate did not act on the bill before it recessed on March 26, 2010, thus allowing the rate reduction for physician payments to take effect as scheduled on April 1, 2010. The CMS instructed its contractors to hold payment of claims submitted for physician services delivered after April 1, 2010 for ten business days while it waits for Congress to act on a "fix" for the physician payment rate. On April 15, 2010, the House and Senate passed, and President Obama signed, the Continuing Extension Act of 2010. This legislation, which was retroactive to April 1, 2010, delayed through May 30, 2010 the reimbursement cut for physician payments. The CMS has instructed its contractors to begin processing "held" claims under the new legislation.

On June 25, 2010, the President signed the "Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010," which increased physician payments by 2.2 percent through November 30, 2010. On November 30, 2010 the "Physician Payment and Therapy Relief Act of 2010" was enacted, which maintained physician payments at these levels through December 31, 2010. On December 15, 2010, President Obama signed into law the "Medicare and Medicaid Extenders Act of 2010," which maintained payments at 2010 levels through December 31, 2011. On December 23, 2011, the Temporary Payroll Tax Cut Continuation Act of 2011 was enacted, which maintained payments at 2011 levels through February 28, 2012, and on February 22, 2012, the Class Tax Relief and Job Creation

Act of 2012 was enacted, which maintained physician payments at these levels through December 31, 2012. In 2013, Medicare physician payments are projected to decrease by around 27 percent. To date, legislation has not been enacted to avert these cuts.

The PPACA directs the Secretary of HHS to develop and implement a budget-neutral payment system that will adjust Medicare physician payments based on the quality and cost of the care they deliver. Those measures will be risk-adjusted and geographically standardized. The Secretary of HHS will phase-in the new payment system over a 2-year period beginning in 2015.

In general, the medical staff members of the Combined Group, including those physicians employed by members of the Combined Group are participating physicians in the Medicare program. There can be no assurance that a legislative solution to the SGR and cuts in physician payments will be enacted by Congress, and if not enacted, payments to physicians participating in the Medicare program could be significantly cut. Such event is likely to have a significant effect on the business and financial operations of members of the Combined Group.

Billing Investigations; Medicare Audits and Withholds

HHS, through the OIG or through fiscal intermediaries of CMS that pay Medicare claims on behalf of HHS, routinely conducts national investigations of hospital Medicare billings for certain types of services. Hospitals participating in Medicare (and Medicaid) are subject to audits and retroactive audit adjustments by Medicare Administrative Contractor ("MAC") or fiscal intermediaries under the Medicare program. From an audit, a MAC or fiscal intermediary may conclude that a patient has been discharged under an incorrect MSDRG, that services may not have been provided under the direct supervision of a physician (to the extent so required), that a patient should not have been characterized as an inpatient, that certain services provided prior to admission as an inpatient should not have been billed as outpatient services or that certain required disclosures or processes were not satisfied. As a consequence, payments may be retroactively disallowed. When such billing investigations occur, members of the Combined Group may be investigated and required to pay penalties, sanctions and other amounts that reimburse the Medicare program for billing deficiencies. Any such repayments could have a material adverse effect on the business, operations and financial condition of the Combined Group. Under certain circumstances, payments may be determined to have been made as a consequence of improper claims subject to the federal False Claims Act (see discussion below) or other federal statutes, subjecting the hospital to civil or criminal sanctions. Medicare regulations also provide for withholding Medicare payment in certain circumstances, and such withholdings could have a substantial adverse effect on the financial condition of the Combined Group. Management of the Combined Group is not aware of any situation in which a Medicare or other payment is being, or may in the future be, withheld that would materially and adversely affect the financial condition or results of operations of the Combined Group.

In accordance with the MMA, CMS designated the use of recovery audit contractors ("RAC") to seek improper Medicare payments in Arizona, Florida, California, Massachusetts, New York, and South Carolina. RACs are paid on a contingency fee basis, receiving a percentage of the improper overpayments and underpayments. Under the RAC program, software "data mining" programs are employed, as well as complex medical record review, to identify potential payment errors to hospitals and other providers. In the demonstration states, the RACs identified significant overpayments in the areas they were authorized to audit. This RAC program was originally part of a demonstration project scheduled to expire in 2008. However, the 2006 Tax Act made the RAC program permanent and mandated its expansion to all 50 states. Additionally, the PPACA extends the RAC program to Medicare Parts C and D and to Medicaid.

Connolly Consulting Associates, Inc. is the RAC for Georgia. On September 1, 2009, the RAC for Region C, which includes Georgia, approved several issues for which it can audit outpatient hospitals and physicians in Georgia. These issues include: blood transfusions, untimed codes, IV hydration therapy, bronchoscopy services, and once in a lifetime procedures. Currently, the RAC has authority to audit more than a hundred issues. The Combined Group cannot anticipate the amount or volume of future Medicare claims that will be reviewed under the RAC program or the results of any such audits.

Also as required by the MMA, CMS has been replacing its current claims payment contractors (fiscal intermediaries and carriers), with new MACs. The MMA amended the Social Security Act to remove the authority for groups or associations and individual providers of services to nominate or appoint their intermediary. It also establishes that all providers and suppliers will generally be assigned to a MAC based on geographic location. The Medicare Part A/B MAC contract for the jurisdiction including Georgia was awarded to Cahaba Government Benefit Administrators, LLC. MACs serve as the primary point of contact for provider enrollment, Medicare coverage and billing requirements,

and processing and payment of Medicare fee-for-service claims for Medicare providers' respective jurisdictions, and also have audit powers with respect to billing and payment matters.

Prepaid Plans

Under current HHS regulations, eligible prepaid medical plans (such as the Medicare Advantage program) may receive payment on a prospective, per capita basis for the cost of services provided to Medicare beneficiaries. The passage of PPACA, which includes significant reimbursement cuts to Medicare Advantage plans over 10 years, will likely impact, the number of these plans and of Medicare beneficiaries enrolled in such plans may decrease, which may result in increases in Medicare admissions and/or payments to hospitals.

Federally Designated Professional Review Organization

The health care facilities of the Combined Group are reviewed by a quality improvement organization ("QIO") (note that QIOs were formerly known as peer review organizations or "PROs"), which reviews the necessity and appropriateness of hospital admissions, the appropriateness of the classifications of discharges, the necessity of patient transfers and the propriety of practices that have the potential to increase hospital payments improperly. The QIO may, subject to appeal by the health care facility under review, recommend sanctions to CMS, including denial of payments, requirements for corrective action or termination from the Medicare program. To date, no member of the Combined Group has been materially adversely affected by any such denial of payment, but there is no assurance that such denial of payment will not increase in the future.

Provider and Employee Screening

The PPACA imposes screening requirements on all providers and suppliers who are either currently enrolled or who are in the process of enrolling in the Medicare program. Under the PPACA, this screening must include a licensure check and may include other procedures such as (1) a criminal background check, (2) fingerprinting, (3) unscheduled and unannounced site visits, (4) database checks, and (5) other screening techniques CMS deems appropriate to prevent fraud, waste and abuse. Medicare providers and suppliers will be required to pay a fee in connection with these screening procedures. In addition, the PPACA requires national and state criminal background checks, including fingerprint checks, by providers including long-term care facilities and providers of their employees and contractors who have, or may have, one-on-one contact with patients. The federal government will also encourage the adoption of similar screening procedures by state Medicaid programs by withholding matching funds of states that fail to create effective screening programs.

Conclusion

Over the last several years, payments to health care providers for inpatient and outpatient services, for capital-related costs, and other care have been subject to numerous statutory and regulatory changes designed to reduce government expenditures for health care. Since implementation of PPS, the costs of providing health care services have outpaced the increases in the amount of reimbursement under the Medicare program. There is no indication either that payment rates will increase more quickly in the future or that hospitals will cease being affected by changes in the Medicare program. As a result of changes to the Medicare and Medicaid reimbursement programs, no assurance can be given that the reimbursement received by the Combined Group will be sufficient to cover costs allocable to Medicare patients for inpatient and outpatient services, debt service and depreciation, or other care provided by the Combined Group. Further, in light of the complexity of the regulations relating to the Medicare program, and the threat of ongoing investigations as described in this Official Statement, there can be no assurance that significant difficulties will not develop in the future.

Medicaid

General

Medicaid is a state-administered medical assistance program which reimburses, among other things, hospital care costs for the medically indigent, primarily including: children, pregnant women, blind and disabled individuals, and the elderly. The Georgia Medical Assistance Program (Medicaid) is administered by the Medicaid Division of the Georgia DCH. The Georgia Medicaid program is jointly funded by the State of Georgia and the federal government. For the State of Georgia to continue to receive funding for the cost of its Medicaid program from the federal government, it must administer its program in accordance with federal statutes and regulations. The federal government has on occasion cut off Medicaid funds to states which were not in compliance with these laws. Any such federal action taken

with respect to the State of Georgia Medicaid program would likely have an adverse effect upon the Combined Group. The Supreme Court's June 28, 2012 ruling limited the federal government's ability to cut off Medicaid funds to states that did not expand their Medicaid population as PPACA provides. Georgia Governor Nathan Deal announced in August, 2012 that the state would not expand the state Medicaid program under PPACA because the state could not afford the cost of such an expansion. The Governor's Office stated that the state would consider an expansion of the program if the state was given flexibility in administering the expansion through a block grant. This concept is not incorporated in the PPACA.

Reimbursement under the Medicaid program is subject to the timely appropriation of sufficient funds by the Georgia legislature, as well as complexities inherent in claims' processing and cost-report settlement under the Georgia Medicaid program. Like most states, the State of Georgia is facing significant budget shortfalls. In the face of a budget shortfall in 2010, the Georgia legislature passed the Georgia Hospital Provider Fee effective for State Fiscal Years 2011, 2012, and 2013. This fee is 1.45 percent of a hospital's net patient revenue (hospitals designated as a trauma center pay a 1.4 percent rate and critical access hospitals are not subject to the fee). The State offset this expense through an increase in hospital Medicaid payments. There can be no assurance that the State of Georgia will not experience budgeting shortfalls in the future with respect to its Medicaid program, or that claims-processing or cost-report settlement problems will not arise under the program which could reduce or delay the payment of Medicaid reimbursements to health care providers.

Increased costs and other factors associated with the Georgia Medicaid program are resulting in its restructuring along the lines of managed care, which could potentially have adverse financial consequences for the Combined Group. Beginning in mid-2006, Georgia implemented Georgia Families, a managed care program for portions of the state's Medicaid program, which provides that Medicaid services to indigent women and children will be provided by care management organizations ("CMOs"). To provide services as an in-network provider, hospitals and physicians must contract with the three CMOs that were selected by the DCH. Members of the Combined Group currently are participating providers in the CMOs network and provide their services to this population of Medicaid recipients pursuant to a contract with one such CMO. The DCH had initiated a process to redesign their Medicaid program that was put on hold after the June 28, 2012 Supreme Court decision on the PPACA and pending the outcome of the November election. Some of the recommendations of this redesign effort would shift members of the state's Medicaid population that remain in a fee for service reimbursement environment into managed care. If these recommendations are implemented, this could potentially have adverse financial consequences for the Combined Group.

The Medicaid Integrity Program ("MIP") was created by the DRA. Audits under the MIP are conducted by Medicare Integrity Contractors. For the MIP, states are primarily responsible for combating fraud in the Medicaid program; however, CMS provides technical assistance, guidance, and oversight. The PPACA requires each state to establish a RAC program for its Medicaid program. Myers and Stauffer LC was awarded the Medicaid RAC contract for Georgia in April 2012. The Medicaid RAC will conduct audits of claims submitted to the state Medicaid program with a look back period of 5 years. At this time, the Combined Group cannot anticipate the number of Medicaid claims to be reviewed under the Medicaid RAC program or the results of any such audit.

Reimbursement Methodology

Under the Georgia Medicaid program, hospital inpatient medical services are reimbursed according to a hybrid diagnosis related group ("DRG") prospective payment system. Hospital outpatient services are reimbursed according to a retrospective determination of allowable and reimbursable costs. There are no patient deductibles, but the patients pay a modest co-payment for inpatient and outpatient services under the Georgia Medicaid program.

Under the current Medicaid reimbursement methodology for inpatient services, inpatient claims are reimbursed for operating cost using one of three payment calculations: (1) inlier DRG, (2) outlier DRG and 3) cost to charge ratio. The DRG-based prospective payment system groups all cases under one of approximately 500 DRGs. In addition, each hospital is assigned to peer groups which are used to establish relative weights that reflect the differences in costs associated with cases in each DRG. Under the Georgia Medicaid program, a case qualifying as an outlier case (a case normally paid as an inlier case but which has an operating cost in excess of the "outlier threshold" established by the DCH) is reimbursed by a different methodology which takes into account the additional cost of providing services to these patients. Certain cases are reimbursed using a cost to charge ratio calculation. In addition to these three payment calculations, hospitals receive hospital-specific add-on rates for capital and other certain expenses.

The rates reimbursed by Medicaid for outpatient services are subject to limits and ceilings. The State of Georgia may periodically audit the reimbursable costs upon which the outpatient Medicaid reimbursements are based. If

the costs on which reimbursements have been based are found to be in excess of those permitted, such costs are subject to being disallowed, and the amounts reimbursed for such disallowed costs are subject to being immediately repayable. Although the Combined Group believes that the rates to be charged Medicaid outpatients will be appropriately premised on allowable costs, no assurance can be given that certain costs for outpatient services will not be disallowed. Any reduction in the services covered by the Georgia Medicaid program or in the payment amounts available for covered services could negatively impact the Combined Group's business. In addition, federal contribution to Medicaid programs could diminish in the coming years if Congress decides to reduce the overall federal deficit by slowing Medicaid spending or making fundamental reforms to the state/federal cost sharing relationship. Any reduction in the federal government's contribution to the Georgia Medicaid program could negatively impact the amount of reimbursement available through the program and could ultimately negatively impact the Combined Group's revenues. Likewise, any cuts in the Georgia Medicaid reimbursement rates by the State of Georgia to offset declining tax revenues and overcome budget shortfalls could negatively impact the amount of reimbursement available through the program and could ultimately negatively impact the Combined Group's revenues.

Under the CMO contracts, the reimbursement arrangements consist primarily of prospectively determined rates per discharge, discounts from established charges, or prospectively determined per diem rates.

Disproportionate Share Payments

The federal Medicare and the state Medicaid laws permit states to include a "disproportionate share" adjustment in payments to hospitals to compensate those hospitals that serve a disproportionate share of indigent patients. CMS published a final rule on December 19, 2008 implementing provisions of MMA to impose additional reporting and auditing requirements on states for Medicaid disproportionate share hospital payments, and the final rule took effect on January 19, 2009. In Fiscal Year 2011, members of the Combined Group received aggregate Medicaid disproportionate share payments of $_____. The PPACA includes changes to the payment methodology for disproportionate share hospitals. Beginning October 1, 2014, hospitals' Medicare and Medicaid disproportionate care payments would be reduced to reflect lower uncompensated care costs relative to increases in the number of insured. Since the enactment of the PPACA, additional changes have been proposed that would reduce further the level of disproportionate share hospital's funding. There is no guarantee that in the future, members of the Combined Group will continue to receive distributions at their current level or at all.

Regulatory and Contractual Matters

State Regulation

Georgia has established statutory and regulatory requirements for health care facilities. In addition, Georgia has passed a state version of the federal False Claims Act and the Georgia Patient Self-referral Act of 1993, a mini-Stark law (see discussion below of each of these laws on a federal level). Failure to comply with laws and rules governing licensure and standards of care would result in the revocation of a hospital's license and operating privileges, including licensure of inpatient facilities and outpatient programs.

Anti-Fraud and Abuse

A number of federal laws, loosely referred to as fraud and abuse laws, are used to prosecute health care providers and physicians that fraudulently or wrongfully obtain reimbursement that increases costs to any federal health care program. The anti-kickback provisions of the Social Security Act (the "Anti-Kickback Law") make it a felony to knowingly and willfully offer, pay, solicit or receive remuneration, directly or indirectly, with the intent to encourage or induce utilization of services payable under a federal health care program. The Anti-Kickback Law has been construed by courts to mean that a financial arrangement will violate the Anti-Kickback Law if one of the purposes of one of the parties is to encourage patient referrals or other Medicare/Medicaid business, even if legitimate purposes also exist for the arrangement. To protect legitimate and cost-effective arrangements among health care providers, the OIG has issued 21 "safe harbor" regulations that specify certain financial arrangements deemed not to violate the Anti-Kickback Law. The safe harbor regulations generally are narrowly drawn and protect very few arrangements. In addition, the OIG asserts the authority to prosecute entities that enter into "sham" transactions that technically comply with a safe harbor if the OIG determines the substance of the transaction is not reflected by its form. Non-compliance with one or more elements of a safe harbor does not make conduct illegal; however, non-compliance with a safe harbor does make it more difficult to determine whether activities in which members of the Combined Group engaged are likely to be considered a violation of the Anti-Kickback Law, and could require members of the Combined Group to incur significant expenses in defending any such arrangement should a challenge of such arrangement ensue.

Penalties for violation of the Anti-Kickback Law are severe. Conviction could result in up to five years imprisonment, a $25,000 fine per offense, exclusion from the federal health care programs, and/or loss of tax-exempt status. In lieu of or in addition to criminal proceedings under the Anti-Kickback Law, violators of the Anti-Kickback Law may also be subject to civil monetary penalties. Civil monetary penalties are civil assessments and fines and can range from $10,000 to $50,000 per offense, as well as damage assessments equal to three times the total amount of the kickback. Under HIPAA, a provider must be excluded from participation in the federal health care programs if convicted of any felony relating to health care fraud under federal or state law. For exclusions related to program abuse, patient abuse, health care fraud or a controlled substance, the minimum period of exclusion is five years. A minimum one-year exclusion was also created for providers sanctioned for failure to comply with statutory obligations related to quality of care. Because of the breadth of the Anti-Kickback Law and the narrowness of the safe harbors, no assurance can be given as to what effect this law will have on the Combined Group.

HIPAA increased the scope of fraud and abuse laws by applying them to prohibit fraudulent conduct against any health care benefit program, not only federal healthcare programs. Under HIPAA, anyone who knowingly and willfully executes or attempts to execute a scheme or artifice to defraud any health care benefit program, or to obtain, by false or fraudulent pretenses, representations or promises, any of the money or property owned or controlled by any health care program in connection with the delivery of or payment for health care items, benefits or services, is subject to criminal penalties or fines or imprisonment for up to ten years, or both. Violations which result in serious bodily harm or death are punishable by more severe criminal penalties.

HIPAA also created a new crime for falsifying, concealing or covering up a material fact in connection with the delivery of or payment for health care benefits, or making any materially false, fictitious or fraudulent statement or representation, or making or using any materially false writing or document knowing the same to contain any materially false, fictitious or fraudulent statement or entry, which is punishable by fines or imprisonment up to five years, or both.

The BBA increased the penalties associated with fraud and abuse. Under the BBA, individuals or entities convicted of three health care related crimes must be permanently excluded from the Medicare and Medicaid programs. The BBA gave CMS the authority to refuse to enter into Medicare agreements with a physician or supplier convicted of a single felony that is determined to be detrimental to Medicare. Additionally, the BBA authorizes civil monetary penalties to be assessed against entities that contract with an excluded individual or entity and established a toll-free number for beneficiaries to report fraud and billing irregularities.

Finally, actions which violate the Anti-Kickback Law or similar laws may also involve liability under the federal civil False Claims Act which prohibits the filing of false claims for payment by Medicare, if the claim is filed with the knowledge that the claim is false or with deliberate ignorance or reckless disregard for the truth or falsity of the claim. Each violation of this prohibition is a felony punishable by a fine and/or imprisonment. In addition, violators may be subject to civil penalties up to $10,000, plus damages of three times amounts paid by Medicare based on false claims. This statute authorizes private persons to file qui tam actions on behalf of the United States.

Pursuant to the mandates of HIPAA and HITECH, and the added tools provided to HHS and the general public under HITECH, increased emphasis is being placed on federal investigations and prosecutions of Medicare and Medicaid "fraud and abuse" cases, and increases in personnel investigating and prosecuting such cases have been reported, which will most likely result in a higher level of scrutiny of hospitals and health care providers, including the members of the Combined Group.

The PPACA strengthens the federal government's ability to investigate and prosecute health care fraud, and increases existing penalties for non-compliance. The PPACA provides that under the Anti-Kickback Law, as well as the federal health care fraud statute (18 U.S.C. § 1347), prosecutors need not prove that a defendant had actual knowledge of the law or specific intent to violate the law. Moreover, claims for reimbursement submitted to federal health care programs that result from illegal kickbacks will be considered false or fraudulent for purposes of civil liability under the Civil False Claims Act, even if the claims are not submitted directly by the wrongdoers themselves. In addition, the PPACA expands the definition of "federal health care fraud offense" to include illegal kickbacks as well as offenses committed in violation of the Federal Food, Drug and Cosmetic Act. This change makes additional enforcement tools available to prosecutors, such as subjecting proceeds from the offenses to criminal forfeiture and authorizing the use of administrative subpoenas for the production of documents.

The health care industry is governed by a complex web of statutes and regulations which are not always clear in their interpretation or application. The Combined Group's policy is to comply with all applicable statutes and regulations, and the Combined Group has adopted and implemented a corporate compliance program to detect, correct

and, if necessary, report deficiencies. In addition, the Combined Group periodically conducts internal compliance reviews regarding the Anti-Kickback Law and other related laws and regulations. Management of the Combined Group believes the members of the Combined Group have used their best efforts to comply with the Anti-Kickback law. However, because of the breadth of these laws and the narrowness of the "safe harbor" regulations, there can be no assurance that regulatory authorities will not take a contrary position or that members of the Combined Group will not be found to have violated the Anti-Kickback Law. At the present time, management of the Combined Group is not aware of any pending or threatened claim, investigation (including any internal review) or enforcement action regarding the Anti-Kickback Law, which, if initiated, and if determined adversely to the members of the Combined Group, taken as a whole and taking into account current reserves, would have a material adverse effect on the financial condition of the Combined Group.

Laws on Patient Referrals - Stark Law

The Ethics in Patient Referrals Act, known as the "Stark Law," also prohibits certain types of referral arrangements between physicians and health care entities. Physicians are prohibited under the original Stark Law enactment and its 1993 amendment, "Stark II," from referring patients for "designated health services" which are reimbursed under the Medicare and Medicaid programs to entities with which they have a financial relationship or in which they have an ownership interest, unless a so-called Stark "exception" applies. "Designated health services" include clinical laboratory services, physician therapy services, occupational therapy services, radiology and other diagnostic services (such as MRIs, CT scans, and ultrasound procedures), durable medical equipment, radiation therapy services, parenteral and enteral nutrients, equipment and supplies, prosthetics, orthotics and prosthetic devices, home-health services, outpatient prescription drugs, as well as inpatient and outpatient hospital services. The Stark Law also prohibits the entity receiving the referral from filing a claim or billing for the services arising out of the prohibited referral. Unlike the Anti-Kickback Law, this proscription applies regardless of whether there has been an intent to violate the statute. Sanctions for violating Stark Law include denial of (or requirement to refund) payment for tainted claims, civil monetary penalties of up to $15,000 per improper referral, a civil penalty of up to $100,000 against parties that enter into a scheme to circumvent Stark Law's prohibitions, and exclusion from the Medicare and Medicaid programs. There are several legal theories that can lead to violations of the Stark Law and may serve as a basis for liability under the False Claims Act.

Stark II has been implemented in phases. Phase I was released on January 4, 2001 and implemented a majority of the provisions of the Stark Law, certain exceptions and related definitions. Phase II was released on March 26, 2004 and implemented issues not addressed in Phase I, such as ownership and investment exceptions and remaining exceptions regarding compensation arrangements. Phase III was released on September 5, 2007, and CMS has continued to modify the physician self-referral regulatory scheme through annual Medicare physician fee schedule and hospital inpatient prospective payment system rulemaking. The combined effect has been to clarify certain exceptions to the Stark Law and to create additional exceptions. The requirements imposed by the Stark Law and the final rules continue to limit the range of acceptable financial relationships with physicians and create situations that could lead to violations of the basic Stark Law prohibition against self-referrals. The types of financial arrangements between a physician and an entity that trigger the self-referral prohibitions of the Stark Law are broad, and include ownership and investment interests and compensation arrangements, both direct and indirect.

The 2009 Inpatient Prospective Payment System Final Rule ("2009 IPPS Final Rule") published on August 18, 2008, revised the Stark Law regulations, certain provisions of which became effective on October 1, 2008, and certain provisions of which had a delayed effective date of October 1, 2009. Management of the Combined Group believes that its arrangements with physicians have been amended or terminated as of the effective date of the applicable provisions in the 2009 IPPS Final Rule to comply with the changes required thereby.

The 2009 IPPS Final Rule also contained the final of CMS's information collection instrument referred to as the Disclosure of Financial Information Relationships Report ("DFRR"). The DFRR, designed to collect information from hospitals concerning the ownership and investment interests and compensation arrangements between hospitals and physicians, was to be sent to around 500 hospitals, which would have 60 days to complete the DFRR and return it to CMS. CMS had stated that it envisioned the DFRR as a one-time information collection instrument. While it was previously thought that, based on the information contained in the DFRR and other factors, CMS may propose future rulemaking to make the DFRR a permanent disclosure requirement, CMS has since postponed the DFRR indefinitely.

Pursuant to the PPACA, the Secretary of HHS developed and implemented a disclosure protocol for use by providers by which they can disclose to CMS actual and potential violations of the Stark Law. CMS released the self-

disclosure protocol on September 23, 2010, which became effective immediately. Additionally, the PPACA expressly authorizes CMS to compromise payment and penalty amounts due and owing for violations of the Stark Law.

Although the Stark Law only applies to Medicare, a number of states, including Georgia, have passed similar statutes pursuant to which prohibitions of physician self-referrals are made applicable to other payors.

The Combined Group attempts to avoid prohibited arrangements with physicians and/or physician groups and to structure and maintain such arrangements in compliance with the Stark Law, but the law and its related regulations are complex and highly technical in nature and are revised by government regulators frequently. As a result, there can be no guarantee that regulatory authorities will not view some arrangements, or the implementation (either initially or ongoing) of its arrangements, with physicians and/or physician groups as violating the Stark Law. Monetary penalties for violations of the Stark Law can be significant and sanctions under the Stark Law, including penalties and exclusion from the Medicare and Medicaid programs, could have a material adverse effect on the financial condition and results of operations of the Combined Group. In this regard, the Combined Group periodically conducts internal reviews of any contracts with referral sources and is presently conducting such a review which is not expected to be finalized before the issuance of the Series 2012 Certificates. At the present time, management of the Combined Group does not anticipate that any of its internal reviews, and is not aware of any pending or threatened claims, investigations, or enforcement actions regarding the Stark Law which, if initiated and determined adversely to the members of the Combined Group, would if taken as a whole and taking into account current reserves, would have a material adverse effect on the financial condition of the Combined Group.

False Claims Laws

There are principally three federal statutes addressing the issue of "false claims." First, the Civil False Claims Act imposes civil liability (including substantial monetary penalties and damages) on any person or corporation that (1) knowingly presents or causes to be presented a false or fraudulent claim for payment to the United States government; (2) knowingly makes, uses, or causes to be made or used a false record or statement to obtain payment; or (3) engages in a conspiracy to defraud the federal government by getting a false or fraudulent claim allowed or paid. Specific intent to defraud the federal government is not required to act with knowledge. This statute authorizes private persons to file qui tam actions on behalf of the United States. Disgruntled or unhappy employees or competitors may become plaintiffs and have a financial incentive to bring suit, as they can recover a portion of the damages awarded.

The Fraud and Enforcement and Recovery Act ("FERA") signed into law on May 20, 2009, has the potential to expand exposure under the Civil False Claims Act for a wide range of business transactions involving federal government funds. Pursuant to FERA amendments, the Civil False Claims Act may impose liability for false claims with more remote connections to the federal government. FERA also potentially has the effect of expanding liability for the retention of money owed to the government. Under recent changes in the law, the knowing retention of overpayments can convert the claims that resulted in overpayments into false claims. FERA makes four other significant amendments to the Civil False Claims Act. First, it expands protection for "whistleblowers" who lawfully attempt to stop a violation of the Act. Second, it permits whistleblower plaintiffs to access information gained from government subpoenas. Third, it authorizes the government to share information provided by whistleblowers with law enforcement authorities from state or local governments. And lastly, it effectively expands the statute of limitations for actions, specifying that government complaints relate back to earlier whistleblower complaints for purposes of the statute of limitations.

In addition to the Civil False Claims Act, the Civil Monetary Penalties Law authorizes the imposition of substantial civil money penalties against an entity that engages in activities including, but not limited to, (1) knowingly presenting or causing to be presented, a claim for services not provided as claimed or which is otherwise false or fraudulent in any way; (2) knowingly giving or causing to be given false or misleading information reasonably expected to influence the decision to discharge a patient; (3) offering or giving remuneration to any beneficiary of a federal healthcare program likely to influence the receipt of reimbursable items or services; (4) arranging for reimbursable services with an entity which is excluded from participation from a federal healthcare program; (5) knowingly or willfully soliciting or receiving remuneration for a referral of a federal healthcare program beneficiary; or (6) using a payment intended for a federal healthcare program beneficiary for another use. The Secretary of HHS acting through the OIG, also has both mandatory and permissive authority to exclude individuals and entities from participation in federal healthcare programs pursuant to this statute.

Finally, it is a criminal federal healthcare fraud offense to: (1) knowingly and willfully execute or attempt to execute any scheme to defraud any healthcare benefit program; or (2) to obtain, by means of false or fraudulent

pretenses, representations or promises any money or property owned or controlled by any healthcare benefit program. Penalties for a violation of this federal law include fines and/or imprisonment, and a forfeiture of any property derived from proceeds traceable to the offense.

It is also significant to note that a number of states, including Georgia, have passed similar statutes expanding the prohibition against the submission of false claims to nonfederal third party payors.

Under the PPACA, Congress provided additional weapons in combating fraud, waste and abuse. The PPACA and the Reconciliation Amendment greatly expand potential liability under the Civil False Claims Act (even more so than FERA) and eliminates several longstanding defenses intended to protect against speculative lawsuits. In particular, the PPACA clarifies the language in the "public disclosure bar" (which until PPACA prohibited a qui tam relator from bringing a complaint that is based on information already available to the public) and now permits the Department of Justice to object when a court dismisses claims because the same allegations were publicly disclosed in federal hearings, congressional reports or investigations, or through the news media. In general, the PPACA expands liability for false claims.

Hospital providers in many states, including Georgia, also are subject to a variety of state laws, related to false claims (similar to the Civil False Claims Act or that are generally applicable false claims laws) and anti-kickback (similar to the federal Anti-Kickback Law or that are generally applicable anti-kickback or fraud laws). These prohibitions are similar in public policy and scope to the federal laws, and could pose the possibility of material adverse impact often for the same reasons as the federal statutes.

At the present time, management of the Combined Group is not aware of any pending or threatened claims, investigations, or enforcement actions regarding the False Claims Act which, if initiated and determined adversely to the members of the Combined Group, taken as a whole and taking into account current reserves, would have a material adverse effect on the financial condition of the Combined Group.

Enforcement Affecting Clinical Research

In addition to increasing enforcement of laws governing payment and reimbursement, the federal government has also heightened enforcement of laws and regulations governing the conduct of clinical trials at hospitals. HHS elevated and strengthened its Office of Human Research Protections, one of the agencies with responsibilities for monitoring federally funded research. In addition, the National Institutes of Health significantly increased the number of facility inspections that these agencies perform. The Food and Drug Administration ("FDA") also has authority over the conduct of clinical trials performed in hospitals when these trials are conducted on behalf of sponsors seeking FDA approval to market the drug or device that is the subject of the research. The FDA's inspection of facilities has increased significantly in recent years. These agencies' enforcement powers range from substantial fines and penalties to exclusions of researchers and suspension or termination of entire research program. Scrutiny of clinical research, including research undertaken by community hospitals (like members of the Combined Group) is increasing, leading to enhanced enforcement activities by various regulatory agencies in this area. At the present time, management of the Combined Group is not aware of any pending or threatened claims, investigations, or enforcement actions regarding its clinical research activities which, if initiated and determined adversely to the members of the Combined Group would have a material adverse effect on the financial condition of the Combined Group.

Licensing, Surveys, Investigations, and Audits

On a regular basis, health facilities, including those of the Combined Group, are subject to numerous legal, regulatory, professional and private licensing, certification and accreditation requirements. These include, but are not limited to, requirements relating to Medicare participation and payment, state licensing agencies, private payors, and The Joint Commission. The PPACA expands reporting requirements and responsibilities under Medicare and Medicaid related to nursing home ownership and management, patient safety and care quality. Currently, the facilities of the Combined Group are licensed under the applicable provisions of federal, State, and local law and are certified for participation in Medicare and Medicaid. Management of the Combined Group believes that the facilities presently comply and will comply with all applicable laws, rules, regulations, and requirements and currently anticipates no difficulty renewing or continuing currently held licenses, certifications or accreditations. These laws, rules, regulations, and requirements, which relate to the construction, fitness, and adequacy of the physical facilities, the qualification and adequacy of personnel, and the quality of medical care, are, however, subject to change, and there can be no guarantee that in the future the Combined Group will not be required to expend substantial sums in order to maintain licensed, certified, and accredited status. The facilities' continued licensure and certification to participate in the Medicare and

Medicaid programs depend upon many factors, including, among other things, accommodations, equipment, services, patient care, safety, personnel, physical environment, and adequate policies, procedures, and controls. Federal, state, and local agencies survey hospital facilities on a regular basis to determine whether such facilities are in compliance with governmental operating and health standards and conditions for participating in governmental reimbursement programs. Such surveys include, but may not be limited to, reviews of patient utilization and inspection of standards of patient care. The Combined Group will attempt to assure that the facilities are operated in compliance with applicable licensing and accreditation standards and that they retain certification to participate in the Medicare and Medicaid programs. However, to the extent these standards are not met, the licenses of the facilities could be limited, suspended, or revoked, decertification proceedings could be commenced against them to exclude them from participating in the Medicare or Medicaid programs, or accreditation could be denied or revised, adversely affecting the revenues and cash flow of the Combined Group.

In addition to the licenses noted above, various health and safety regulations and statutes apply to the System and are enforced by various state agencies. Violation of certain health and safety standards could result in closure or requirements that compliance with such standards be immediately achieved. Management of the Combined Group believes that the System complies and will comply with all such health and safety standards. These health and safety standards are, however, subject to change, and there can be no guarantee that in the future the Combined Group will not be required to expend substantial sums in order to comply with those changed standards.

The availability and cost of health care has become a matter of social and political concern, and a number of states have adopted legislation to establish rate-setting agencies with control over hospitals and hospital rates. There is a risk that the State of Georgia could establish such an agency, and any controls adopted thereby could have an adverse effect on the revenues of the System and the Combined Group. Management of the Combined Group is not aware of any plans to establish such an agency.

Healthcare Professionals and Other Employees

Possible Staffing Shortages

In recent years, the hospital industry has suffered from an increasing scarcity of nurses, pharmacists, and other skilled health care technicians to staff its facilities. Factors underlying this industry trend include a decrease in the number of persons entering these professions. These factors may intensify in years to come, aggravating the shortage of skilled personnel. Nationally, as a result of the growth in the unemployment rate, these shortages have lessened. As economic conditions improve, this shortage of skilled professionals and technicians could eventually reappear and could force the Combined Group to pay higher than anticipated salaries to such personnel or to hire such personnel on a temporary basis through outside agencies at a higher cost, as competition for such employees intensifies, which would have the effect of significantly increasing the Combined Group's personnel costs and which could have a material adverse effect on the financial results of the Combined Group. Although the System has adequate staffing levels to date and has had no problems to date recruiting and employing sufficient qualified staffing, it is uncertain whether qualified candidates will continue to be available to the Combined Group in the future. The Combined Group, like many of its competitors, has significantly increased salaries in recent years and at times has hired temporary personnel through outside agencies at higher costs.

Employment Risks

Health care providers are major employers, combining a complex mix of professional, quasi-professional, technical, clerical, housekeeping, maintenance, dietary, and other types of workers in a single operation. As with all large employers, the members of the Combined Group bear a wide variety of risks in connection with their employees. These risks include strikes and other related work actions, contract disputes, discrimination claims, personal tort actions, work-related injuries, exposure to hazardous materials, interpersonal torts (such as between employees, between physicians or management and employees, or between employees and patients), and other risks that may flow from the relationships between employer and employee or between physicians, patients, and employees. Many of these risks are not covered by insurance, and certain of them cannot be anticipated or prevented in advance.

As of the date of this Official Statement, management of the Combined Group is not aware of any efforts by any labor union to organize employees of the Combined Group, and no employees of the Combined Group are currently represented by unions. As a general matter, health care facilities, however, have been subjected to an increasing number of union organizational efforts. Unionization of all or some of the Combined Group's employees could have an adverse effect on the Combined Group's financial condition.

The Employee Free Choice Act was introduced in Congress in March 2009 with the stated purpose of amending the National Labor Relations Act to establish a system that would make it easier for employees to form or join labor unions and to provide for mandatory injunctions for unfair labor practices during an organizing campaign. Congress has not passed this legislation. The bill was referred to the House Subcommittee on Health, Employment, Labor, and Pensions on April 29, 2009, where it has remained. It is not clear if, or when, or in what form, this legislation may be re-introduced. While this proposed legislation was a central issue in Obama's presidential campaign in 2008, it has not played a central role in the 2012 campaign. Regardless, if reintroduced and passed, this or similar legislation would make it easier for employees of the members of the Combined Group to join and form labor unions.

Wage and Hour Class Actions and Litigation

Federal law and many states impose standards related to worker classification, eligibility and payment for overtime, liability for providing rest periods and similar requirements. Larger employers with complex workforces, such as hospitals, are susceptible to actual and alleged violations of these standards. In recent years, there has been a increase in the number of these "wage and hour" issues, often in the form of large, multi-state class actions. For large employers such as hospitals and health systems, such class actions can involve multi-million dollar settlements, judgments or claims. A major class action decided or settled adversely to any member of the Combined Group could have a material adverse impact on such members and/or the Combined Group's financial condition and operations. Currently, no such class action lawsuits are pending against any of the members of the Combined Group.

Insurance Regulation; Professional Liability; General Liability

The State of Georgia has enacted regulations and adopted policies affecting risk assumptions in the health care industry, including statutes, regulations, and policies that subject hospitals, physicians, and provider networks engaged in risk-based contracting to applicable insurance laws and regulations, which may include, among other things, laws and regulations providing for minimum capital requirements and other safety and soundness requirements. The Combined Group believes that it is currently in compliance with such insurance laws and regulations; however, implementation of additional regulations or compliance requirements could result in substantial costs to the Combined Group. The inability to enter into capitated or other risk-sharing arrangements, or the cost of complying with applicable laws in the future that affect the Combined Group's risk-based contracting activities, could have a material adverse effect on the Combined Group's business, financial condition, and results of operations.

Professional liability and other actions alleging wrongful conduct and seeking punitive damages are often filed against health care providers, and insurance may not provide sufficient coverage or coverage for punitive damages. Litigation also arises from the corporate and business activities of hospitals, from a hospital's status as a property owner, an employer, a contracting party with physicians, vendors or others, or as a result of medical staff peer review or the denial of medical staff privileges. As with professional liability, certain of these risks may not be covered by insurance. For those risks or claims not covered by insurance, they may, in whole or in part, become a direct liability of a member of the Combined Group if determined or settled adversely.

In 2005, Georgia enacted comprehensive tort reform, which among other things, placed caps on non-economic damages in medical liability cases. On March 22, 2010, the Georgia Supreme Court, in *Atlanta Oculoplastic Surgery, P.C. v. Nestlehutt*, 286 Ga. 731, 691 S.E.2d 218 (2010), declared these caps on non-economic damages unconstitutional as violating the state constitutional right to a jury trial, and applied its decision retroactively to the date the law was enacted in 2005. This decision could negatively impact health care providers in a number of ways, including limiting the availability, and increasing the cost, of professional liability insurance, increasing the frequency of medical malpractice claims or suits seeking non-economic damages, and due to the retroactivity of the ruling, making existing reserves and insurance inadequate to cover existing claims and suits.

There is no assurance that the Combined Group will be able to maintain coverage amounts currently in place in the future, that the coverage will be sufficient to cover any malpractice judgments rendered against a member of the Combined Group or that such coverage will be available at a reasonable cost in the future. Additionally, there is no assurance that malpractice claims or suits against members of the Combined Group will not increase as a result of the Court's ruling.

Business Relationships

Integrated Delivery System - Employed Physicians and Physician Groups

Many hospitals and health systems, including the Combined Group, are pursuing strategies with physicians in order to offer an integrated package of health care services, including physician and hospital services, to patients, health care insurers, and managed care providers (an "Integrated Delivery System"). These integration strategies may take many forms, including physician-hospital organizations ("PHOs"), organizations that are typically jointly owned or controlled by a hospital and physician group for the purpose of managed care contracting, implementation, and monitoring. Other integration structures include hospital-based clinics or medical practice foundations, which may purchase and operate physician practices as well as provide all administrative services to physicians, and acquisitions of medical and other provider practices. Many of these integration strategies are capital intensive and may create certain business and legal liabilities for the Combined Group. Another structure is an accountable care organization ("ACO"), which is a provider-run organization in which the participating providers are responsible collectively for the care of an enrolled population of patients, and they also may share in savings associated with the quality and efficiency of the care they provide.

HMCI employs approximately __ primary care and specialty providers either on its own or through its controlled affiliate, Phoebe Putney Health Ventures, Inc., which was formed for the purpose of pursuing certain integrated delivery arrangements. For more information, see "[THE COMBINED GROUP - Other Affiliates]" in Appendix A to this Official Statement.

The start-up capitalization for such arrangements, as well as operational deficits, may be funded, in whole or in part, by the Combined Group. Depending on the size and organizational characteristics of a particular arrangement, these capital requirements may be substantial. In some cases, the Combined Group may be asked to provide a financial guaranty for the debt of a related entity that is carrying out an integrated delivery strategy. In certain of these structures, the Combined Group may have an ongoing financial commitment to support operating deficits, which may be substantial on an annual or aggregate basis.

These types of integrated delivery arrangements are generally designed to conform to existing trends in the delivery of medicine, to implement anticipated aspects of health care reform, to increase physician and other provider availability to the community, or enhance the managed care capability of the affiliated hospital and physicians. However, these goals may not be achieved, and, if the arrangement is not functionally successful, it may produce materially adverse results that are counterproductive to some or all of the above-stated goals.

All such integrated delivery arrangements carry with them the potential for legal or regulatory risks in varying degrees. Such arrangements may call into question compliance with the Medicare anti-referral and other fraud and abuse laws, relevant antitrust laws, and federal or state tax exemption requirements. While the federal government has issued regulatory guidance specific to these issues for ACOs participating in the Medicare Shared Savings Program, for other integrated delivery arrangements, these risks will turn on the facts specific to the implementation, operation, or future modification of any Integrated Delivery System. The ability of hospitals or health systems to conduct integrated physician operations may be altered or eliminated in the future by legal or regulatory interpretation or changes, or by health care fraud enforcement. Integrated Delivery Systems that operate at a deficit over an extended period of time may raise significant risks of investigation or challenge regarding tax-exemption or compliance with the Medicare anti-referral and other fraud and abuse laws. In addition, depending on the type of arrangement, a wide range of governmental billing and reimbursement issues may arise, including questions of the authorization of the entity to bill for or on behalf of the physicians involved. Other related legal and regulatory risks may arise, including employment, pension and benefits, insurance, fee-splitting, vicarious liability for malpractice claims, and corporate practice of medicine, particularly in the current atmosphere of frequent and often unpredictable changes in federal and state legal requirements regarding health care and medical practice. The potential impact of any such regulatory or legal risks on the Combined Group cannot be predicted with certainty. There can be no assurance that such issues and risks will not lead to material adverse consequences in the future.

Joint Ventures

The OIG has expressed its concern in various advisory bulletins and advisory opinions that many types of joint venture arrangements between hospitals and physicians and/or physician groups who are in a referral relationship with the hospitals implicate the Anti-Kickback Law. In its 1989 Special Fraud Alert, the OIG raised concern about certain physician joint ventures where the intent is not to raise investment capital to start a business but rather to "lock up a

stream of referrals from the physician investors and compensate these investors directly for these referrals." The OIG listed various features of suspect joint ventures, but noted that its list was not exhaustive. These features include: (i) whether the physician was chosen because he/she is in a position to refer business to the hospital; (ii) whether physicians are sold interests based on their actual or potential referrals; (iii) whether referrals are tracked and the referral patterns shared with investors; (iv) whether the overall structure represents a new line of business for the investors (e.g., one of the parties is an ongoing entity already engaged in a particular line of business); and (v) whether investors' investment and return are proportional to the risk assumed by such investors.

In April 2003, the OIG issued a Special Advisory Bulletin, which indicated the "contractual joint ventures" (where a provider expands into a new line of business by contracting with an entity that already provides the items or services) may violate the Anti-Kickback Law and that expressed skepticism that existing statutory or regulatory safe-harbors would protect suspect contractual joint ventures. In January 2005, the OIG published its Supplemental Program Guidance for hospitals and reiterated its concerns regarding joint ventures entered into by hospitals.

In addition, federal tax laws governing Section 501(c)(3) organizations, a tax-exempt hospital's participation in a joint venture with for-profit entities must further the hospital's exempt purposes and the joint venture arrangement must permit the hospital to act exclusively in the furtherance of its exempt purposes, with only incidental benefit to any for-profit partners. If the joint venture does not satisfy these criteria, the hospital's tax-exemption may be revoked, the hospital's income from the joint venture may be subject to tax, or the parties may be subject to other sanctions.

Joint ventures with physicians may also implicate the Stark Law. Any evaluation of compliance with the Anti-Kickback Law or Section 501(c)(3) requirements depends on the facts and circumstances, but the Stark Law requires strict compliance with an exception if the prohibition is triggered.

While management of the Combined Group believes that the joint venture arrangements to which members of the Combined Group are parties are in material compliance with the Anti-Kickback Law, OIG pronouncements, the tax laws governing Section 501(c)(3) organizations, and the Stark Law, there can be no assurance that regulatory authorities will not take a different position or that such arrangements will not be found to have violated these laws and regulations, which could have a material adverse effect on the financial condition of the Combined Group.

Physician Medical Staff

The primary relationship between a hospital and the physicians who practice in such setting is through the hospital's organized medical staff. Medical staff bylaws, rules and policies establish the criteria and procedures by which a physician may have his or her privileges or membership curtailed, denied or revoked. Physicians who are denied medical staff membership or certain clinical privileges or who have such membership or privileges curtailed or revoked often file legal actions against hospitals and medical staffs. Such actions may include a wide variety of claims, including antitrust claims, some of which could result in substantial uninsured damages to a hospital. Furthermore, from time to time, actions or decisions of hospital management may cause unrest among certain physician groups or members of the medical staff, which could result in legal or other actions, such as resignation from the medical staff. In addition, failure of the hospital governing body to adequately oversee the conduct of its medical staff may result in hospital liability to third parties.

Worker Reclassification Audits

Employers are required to withhold income taxes from amounts paid to employees. If the employer fails to withhold the tax, the employer becomes liable for payment of the tax imposed on the employee. On the other hand, businesses are not required to withhold federal taxes from amounts paid to a worker classified as an independent contractor. The IRS has established criteria for determining whether a worker is an employee or an independent contractor for tax purposes. Federal and state officials are starting to aggressively pursue worker misclassification cases, and the IRS has recently announced that it is conducting audits to determine if companies are misclassifying workers. It is likely that given the record budget deficits at the federal and the state levels, that enforcement in this area may increase. If the federal or state officials were to reclassify a significant number of hospital independent contractors (e.g., physician medical directors) as employees, back taxes and penalties could be material.

Physician Shortages

Sufficient supply of community-based physicians is important to hospitals and health systems. The shortage of physicians could become a significant issue for hospitals and health systems to face in the coming years, due to factors such as the passage of health care reform legislation and continuing decline in the reimbursement rates paid under

Medicare or Medicaid. CMS annually reviews overall physician reimbursement formulas and any changes to these formulas could lead to physicians locating or relocating their practices in areas with lower Medicare or Medicaid populations. The Combined Group may be required to invest additional resources for recruiting and retaining physicians, or may be required to increase the number of employed physicians to continue serving its population base and maintain market share.

Physician Recruitment and Referrals

The Medicare PPS creates strong financial incentives for hospitals to recruit and retain active physicians who will admit patients and utilize hospital services. The Combined Group's response to these incentives is limited, however, by legal restrictions, including limitations with respect to permitted activities of tax-exempt organizations and federal and state statutes prohibiting fraud and abuse and certain physician self-referrals. See discussion above on the Anti-Kickback Law and the Stark Law. As tax-exempt organizations, the members of the Combined Group are limited in their use of practice income guarantees, reduced rent on medical office space, low interest loans, joint venture programs, and other means of recruiting and retaining physicians. According to certain IRS rulings, a hospital using such means to recruit and retain physicians must demonstrate that the benefits provided to the physicians are incidental to the public benefits derived from such arrangements and that such benefits do not constitute prohibited private inurement. The IRS has focused particular attention on the physician compensation arrangements of tax-exempt organizations in recent years. The Medicare and Medicaid statutes and other laws prohibit the payment of any remuneration, directly or indirectly, in cash or in kind, to encourage or induce physicians to admit patients or order services for patients. Other federal and state statutes generally prohibit physicians from referring patients to health care providers with which they have ownership or other financial interest. Violations of these laws may result in civil and criminal penalties. Civil penalties range from monetary fines to temporary or permanent exclusion from the Medicare program. These laws have been construed to apply to many situations where hospitals and physicians conduct joint business activities, including joint ventures, physician recruitment and retention programs, physician referral services, hospital-physician service and management contracts, and lending and leasing activities between hospitals and physicians. The Combined Group engages in the general types of activities described in the preceding sentence and is not aware of any challenge or investigation of these activities by the Combined Group. HHS has, in recent years, focused particular attention on physician recruitment and compensation arrangements for possible abuses of Medicare and Medicaid fraud and abuse laws. The Combined Group intends to comply with these statutes, regulations, and rulings; such compliance, however, will limit the Combined Group's ability to influence directly the volume of services it provides.

In light of some of the legal restrictions described above, the Combined Group has acquired physician practices and directly employs certain physicians. The Combined Group's direct employment of physicians, however, may implicate the corporate practice of medicine doctrine. The corporate practice of medicine doctrine provides, in general, that neither a corporation nor any other unlicensed person or entity may engage in the practice of medicine. On its face, Georgia law does not expressly prohibit corporations such as the members of the Combined Group from directly employing physicians. As the Georgia legislature has amended the Georgia statutes to remove the language expressly prohibiting the corporate practice of medicine, System management would view any attempt by the Georgia Composite Medical Board or the Attorney General's office to invoke the doctrine in Georgia as contrary to the legislative history and legislative intent of the Georgia statutes.

Antitrust

As described under "THE COMBINED GROUP – Phoebe North, Inc.," a member of the Combined Group is presently involved in litigation with the Federal Trade Commission (the "FTC") in which the FTC alleges that an acquisition would substantially lessen competition or tend to create a monopoly in the market in violation of certain alleged provisions of the Anti-Trust laws. Enforcement of the antitrust laws against health care providers is becoming more common, and antitrust liability may arise in a wide variety of circumstances, including medical staff privilege disputes, third party contracting, physician relations, and joint venture, merger, affiliation, and acquisition activities. In some respects, the application of federal and state antitrust laws to health care is still evolving, and enforcement activity by federal and state agencies appears to be increasing. In particular, the FTC has publicly acknowledged increasing enforcement action in the area of physician joint contracting. Likewise, there has been increased enforcement action relating to hospital mergers. At various times, health care providers may be subject to an investigation by a governmental agency charged with the enforcement of antitrust laws, or may be subject to administrative or judicial action by a federal or state agency or a private party. Violation of the antitrust laws could be subject to criminal and civil enforcement by federal and state agencies, as well as by private litigants.

From time to time, the Combined Group is or will be involved in a variety of activities that could receive scrutiny under antitrust laws, and it cannot be predicted when or to what extent liability may arise. With respect to payor contracting, the Combined Group may, from time to time, be involved in joint contracting activity with other hospitals, providers or) Phoebe Putney Health Ventures, Inc. The precise degree to which this or similar joint contracting activities may expose the participants to antitrust risk from governmental or private sources is dependent on a myriad of factual matters that may change from time to time.

Hospitals, including those of the Combined Group, regularly have disputes regarding credentialing and peer review, and may be subject to liability in this area. In addition, hospitals occasionally indemnify medical staff members who are involved in such credentialing or peer review activities, and may also be liable with respect to such indemnity.

Court decisions have also established private causes of action against hospitals that use their local market power to promote ancillary health care businesses in which they have an interest. Such activities may result in monetary liability for the participating hospitals under certain circumstances where a competitor suffers business damage.

The ability to consummate mergers, acquisitions, or affiliations may also be impaired by the antitrust laws, potentially limiting the ability of health care providers to fulfill their strategic plans. Liability in any of these or other antitrust areas of liability may be substantial, depending on the facts and circumstances of each case.

Affiliation, Merger, Acquisition, and Divestiture

Significant numbers of affiliations, mergers, acquisitions, and divestitures have occurred in the health care industry recently. See "THE COMBINED GROUP" herein. As part of its ongoing planning process, the Combined Group may consider the potential acquisition of operations or properties that may become affiliated with or become part of the Combined Group in the future. As a result, it is possible that the organizations and assets that currently make up the Combined Group may change from time to time. See "[THE MASTER INDENTURE - Conditions for Membership in Obligated Group, - Withdrawal from the Obligated Group, - Conditions for Designation of Restricted Affiliates, and - Release of Restricted Affiliates]" in Appendix C hereto.

Environmental Requirements

The Combined Group is subject to a wide variety of federal, state, and local environmental laws and regulations that address, among other things, health care operations or facilities and properties owned or operated by health care providers. Among the types of environmental requirements faced by health care providers are: air and water quality control requirements; waste management requirements; specific regulatory requirements applicable to asbestos, polychlorinated biphenyls, and radioactive substances; requirements for providing notice to employees and members of the public about hazardous materials handled by or located at the hospital; and requirements for training employees in the proper handling and management of hazardous materials and wastes. In their role as owners and operators of properties or facilities, health care providers may be subject to liability for investigating and remedying any hazardous substances that have come to be located on the property, including any such substances that may have migrated off of the property. Typical health care operations include, in various combinations, the handling, use, storage, transportation, disposal, and discharge of hazardous, infectious, toxic, radioactive, flammable, and other hazardous materials, wastes, pollutants, or contaminants. For this reason, health care operations are particularly susceptible to the practical, financial, and legal risks associated with compliance with such environmental laws and regulations. Violation of such environmental laws and regulations may result in damage to individuals, property, or the environment, may interrupt operations or increase their cost, may result in legal liability, damages, injunctions, or fines, or may trigger investigations, administrative proceedings, penalties, or other government agency actions. At the present time, executive administration of the System is not aware of any pending or threatened claim, investigation, or enforcement action regarding environmental issues which, if determined adversely to the Combined Group, would have material adverse consequences. There can be no assurance, however, that the Combined Group will not encounter such risks in the future, and such risks may result in material adverse consequences to the operations or financial condition of the Combined Group.

Substitution of Security

Under certain circumstances the Bond Trustee is required to accept a substitute promissory note in exchange for the 2012 Master Note, which substitute promissory note would be an obligation of a different obligated group of which the issuer of the 2012A Master Note would be a member. This could, under certain circumstances, lead to the substitution of different security in the form of an obligation backed by an obligated group that is financially and operationally different than the then existing Obligated Group. That obligated group could have substantial debt

outstanding that would rank on a parity with the substitute obligation. See "[THE TRUST INDENTURE - Trustee Authorized to Vote Master Indenture Obligations; Exercise of Remedies; Substitution of Master Note" in Appendix C hereto.

Prepayment Risks

The Series 2012 Certificates are subject to redemption and purchase, without premium, in advance of their stated maturity under certain circumstances. See "THE SERIES 2012 CERTIFICATES -- Redemption." Upon the occurrence of certain events of default, the payment of the principal of and interest on the Series 2012 Certificates may be accelerated. Thus, there can be no assurance that the Series 2012 Certificates will remain outstanding until their stated maturities.

Hedging Transactions

As described in Appendix A under "[OTHER FINANCIAL INFORMATION — *Interest Rate Swaps,*"] under certain circumstances, the Borrower's interest rate swap agreements (the "Existing Swap Agreements") are subject to termination prior to stated maturity. Any additional hedging agreements entered into by the Obligated Group could also terminate prior to their stated termination dates. Therefore, there can be no assurance that they will remain in place for the term of the Indebtedness for which they provide a hedge.

Changes in the market value of the Existing Swap Agreements or any such other agreements could have a negative impact upon the Obligated Group's operating results and financial condition, and such impact could be material. If an existing swap agreement or any other hedging arrangement entered into by the Obligated Group were to be terminated at a future date when such agreement has a negative value to such members of the Obligated Group, the members of the Obligated Group would be obligated to make a termination payment, which could be substantial and could materially adversely affect the financial condition of the Obligated Group.

Under certain circumstances, under the Existing Swap Agreements each of the parties has agreed to collateralize its obligations. Any requirement of the Obligated Group to further collateralize under the Existing Swap Agreements could materially adversely affect the financial condition of the Obligated Group. Certain financial covenants in the Master Indenture, including the liquidity covenant, the covenant limiting dispositions of assets and the covenant limiting certain liens and encumbrances take into account changes in the mark to market value of the Obligated Group's swap transactions and concomitant changes in the collateral requirement. For example, an increase in the amount of collateral posted with respect to all swap transactions reduces Unrestricted cash available to satisfy the liquidity covenant under the Master Indenture, decreases certain amounts that the Obligated Group is entitled to transfer or dispose of, and reduces the dollar value of certain Permitted Encumbrances (as defined in the Master Indenture).

Requirements of Swap Counterparties and Holders of 2012 Bank Certificates

The Master Indenture as well as the Existing Swap Agreements contain and agreements with the holders of the Series 2012 Bank Certificates, and any future credit arrangements entered into by the Obligated Group may contain, certain terms that are more restrictive than those described herein, including, among others, requirements that the Obligated Group generate a greater debt service coverage ratio, maintain a certain level of unrestricted cash and marketable securities and maintain certain credit ratings, as well as certain limitations on the incurrence by the Obligated Group of additional Indebtedness and other obligations and on dispositions of assets, that have been required by banks, municipal bond insurers and swap counterparties providing such credit facilities. Such terms may be waived by the respective banks, bond insurers and swap counterparties without notice to or the consent of the holders of the Series 2012 Certificates. Any default under such terms that is not remedied within any applicable cure period or waived by such bank, bond insurer or swap counterparty could cause an Event of Default under the Master Indenture, which could result in a decline in the market value and acceleration of the Series 2012 Certificates.

Maintenance of Exempt Status

The exclusion of interest on each series of the Series 2012 Certificates from the gross income of the recipients thereof for federal income tax purposes depends upon the maintenance by PPMH of its status as an Exempt Organization. To maintain such status, PPMH must conduct its operations in a manner consistent with current and future IRS regulations and rulings governing exempt organizations and its operations and activities. Although PPMH has covenanted to maintain its status as an Exempt Organization, its failure to do so would likely have a materially adverse effect on PPMH and could result in the inclusion of interest on the Series 2012 Certificates of each series in gross income of the owners thereof for federal income tax purposes retroactive to the date of issuance.