SUPPLEMENT DATED JUNE 15, 2017 TO
OFFICIAL STATEMENT
DATED JUNE 7, 2017

$145,570,000
CITY OF CHILLICOTHE, OHIO
Hospital Facilities Revenue Refunding and Improvement Bonds, Series 2017
(Adena Health System Obligated Group Project)

This Supplement dated June 15, 2017 replaces certain portions of the Official Statement dated June 7, 2017 relating to the captioned bonds. The information contained in this Supplement should be read in conjunction with the information contained in the Official Statement.

Please be advised that the Official Statement is hereby supplemented and amended as follows:

1. On page A-12, the second paragraph under the sub-section entitled "EXECUTIVE MANAGEMENT" is deleted in its entirety and is replaced with the following (new language is underlined):

   Adena Health's Board of Trustees established a Search Committee to steer the selection of the organization's next President and CEO. The Board engaged Witt/Kieffer, a well-regarded national healthcare executive search firm, to manage the CEO search. <u>On June 14, 2017 Adena Health's Board of Trustees announced it had selected Jeffrey J. Graham as its new President and CEO.</u>

2. On page A-13, the following paragraph should be inserted directly after the first paragraph:

   Jeffrey J. Graham, 56, President and CEO. Mr. Graham will rejoin Adena as its new President and CEO on Monday, July 31, 2017. For the past five years, Mr. Graham has been the President and CEO of Mercy Health System's east market in the Cincinnati area. Prior to his time at Mercy Health, Graham served Adena Health from 2002-2012 in various roles, including the CEO and Administrator for AGMC, Adena Health's Chief Operating Officer and Adena Health's Chief Strategy Officer.

3. On page A-13, the second paragraph is deleted in its entirety and is replaced with the following (new language is underlined):

   John Fortney, M.D., 65, Interim President and CEO. Prior to taking the interim role, Dr. Fortney was the Chief Physician Executive at Adena Health from 2015 to 2016, Adena Health's Chief Medical Officer and AMG's President and CEO since 2009. Dr. Fortney served Adena Health in 2003 as Senior Medical Director and previously was the Physician Administator for Adena Health and the Smith & Fleischer Pediatric Groups for 20 years. He has a Master's Degree in Hospital

Administration from Ohio University, a Medical Degree from The Ohio State University School of Medicine and a Bachelor of Science Degree also from The Ohio State University. He holds a lifetime certification from the American Academy of Physicians. As a result of the selection of Jeffrey Graham as the new President and CEO, Dr. Fortney will return to his previous role as Chief Physician Executive.

4. In all other respects, the Official Statement is unchanged. This Supplement, the Appendices and the front portion of the Official Statement together constitute the entire Official Statement.

NEW ISSUE—BOOK-ENTRY ONLY

RATINGS: S&P: A-
MOODY'S: A3
See Ratings

In the opinion of Dinsmore & Shohl LLP, Bond Counsel, under existing laws, regulations, rulings and judicial decisions, and assuming the accuracy of certain representations and certifications, and compliance with certain covenants intended to assure compliance with the applicable provisions of the Internal Revenue Code of 1986, as amended (the "Code"), and the regulations thereunder, interest on the Series 2017 Bonds is excluded from gross income for federal income tax purposes and is not an item of tax preference for purposes of the federal alternative minimum tax. The interest on the Series 2017 Bonds, the transfer thereof, and any profit made on their sale, exchange, transfer, or other disposition are exempt from the Ohio personal income tax and income taxes imposed by certain local political subdivisions in Ohio. Interest on the Series 2017 Bonds, as is the case with most other forms of interest on debt obligations, is not subject to the Ohio commercial activity tax. See ***Tax Matters*** *for additional information.*

$145,570,000
CITY OF CHILLICOTHE, OHIO
Hospital Facilities Revenue Refunding and Improvement Bonds, Series 2017
(Adena Health System Obligated Group Project)

Dated: Date of Delivery

Due: December 1, as shown on inside front cover

The above-captioned bonds (the "Series 2017 Bonds") when, as and if issued, will be special obligations of the City of Chillicothe, Ohio (the "Issuer"), pursuant to an ordinance of its Council and an Indenture of Trust (Bond Indenture) dated as of June 1, 2017 (the "Bond Indenture"), between the Issuer and The Huntington National Bank, as trustee (the "Bond Trustee"). The proceeds of the Series 2017 Bonds, together with other available funds, will be used for the purpose of (1) advance refunding a portion of the outstanding County of Ross, Ohio Hospital Facilities Revenue Refunding Bonds, Series 2008 (Adena Health System) (the "Series 2008 Bonds") issued to refinance certain hospital facilities leased to Adena Health System, an Ohio nonprofit corporation (the "Corporation"), (2) financing the Series 2017 Project described under **The Series 2017 Project and the Refunding of the Series 2008 Bonds**, and (3) paying certain issuance costs in connection with the Series 2017 Bonds. The Series 2017 Bonds will be secured by the Bond Indenture and by a pledge and assignment by the Issuer to the Bond Trustee of the Issuer's interest in Basic Rent under a Sublease dated as of June 1, 2017, between the Issuer, as lessor, and the Corporation, as lessee, of certain real and personal property constituting "hospital facilities" (as defined in Chapter 140, Ohio Revised Code), and in the funds established by the Issuer in the Bond Indenture. The Series 2017 Bonds will also be secured by Corporation's Series 2017A Note (the "Series 2017A Note") dated the date of delivery, delivered by the Corporation to the Bond Trustee, to be issued pursuant to a Master Trust Indenture, dated as of May 1, 1993, between the Corporation, Adena Medical Group, LLC (together with the Corporation, the "Obligated Group"), and The Huntington National Bank, as Master Trustee, as amended and supplemented to date including by the Amended and Restated Master Trust Indenture, dated as of June 1, 2017 (the "Master Indenture").

The Series 2017 Bonds will be issued in book-entry form and, when issued, will be registered initially in the name of Cede & Co., as registered owner and nominee of The Depository Trust Company, New York, New York ("DTC"). DTC will act as securities depository for the Series 2017 Bonds. Purchases of beneficial interests in the Series 2017 Bonds will be made in book-entry form, in denominations of $5,000 or any integral multiple of $5,000. Purchasers will not receive certificates representing their interest in Series 2017 Bonds purchased. So long as Cede & Co. is the registered owner, as nominee of DTC, references in this Official Statement to the registered owners shall mean Cede & Co. and shall not mean owners of beneficial interests in the Series 2017 Bonds. See **The Series 2017 Bonds—Book Entry and Appendix E—Book-Entry System.**

Interest on the Series 2017 Bonds will be payable on June 1 and December 1 of each year, commencing December 1, 2017 (each an "Interest Payment Date"), to the registered owner of record as of the close of business on May 15 or November 15 next preceding such Interest Payment Date. The Bond Trustee will act as Registrar and Paying Agent for the Series 2017 Bonds.

The Series 2017 Bonds are subject to redemption prior to maturity, including optional redemption, mandatory sinking fund redemption, and extraordinary optional redemption as described under **The Series 2017 Bonds—Redemption Prior to Maturity.**

The purchase of the Series 2017 Bonds includes certain risks. See Bondholders' Risks.

The Series 2017 Bonds are special revenue obligations of the Issuer and are not general obligations, debt, or bonded indebtedness of the Issuer, the State of Ohio, or any political subdivision or agency of the State of Ohio. The holders of the Series 2017 Bonds will not have and do not have the right to have excises or taxes levied by the Issuer, the State of Ohio, or any political subdivision of agency of the State of Ohio for the payment of the principal or and premium, if any, and interest on the Series 2017 Bonds.

The Series 2017 Bonds are offered when, as and if issued and accepted by the Underwriter, subject to prior sale and to the approval of legality by Dinsmore & Shohl LLP, Bond Counsel. Certain legal matters will be passed upon for the Underwriter by Vorys, Sater, Seymour and Pease LLP, and for the Obligated Group by Dinsmore & Shohl LLP. The Series 2017 Bonds are expected to be available for delivery through the facilities of DTC on or about June 22, 2017.

MATURITY DATES, PRINCIPAL AMOUNTS,
INTEREST RATES, PRICES, AND YIELDS
(See Inside Front Cover)

This cover page contains information for general reference only. It is not intended as a summary of this transaction. Investors are advised to read the entire Official Statement to obtain information essential to making an informed investment decision.

CAIN BROTHERS

June 7, 2017

$145,570,000
City of Chillicothe, Ohio
Hospital Facilities Revenue Refunding and Improvement Bonds, Series 2017
(Adena Health System Obligated Group Project)

Maturity Schedule

$17,695,000 Serial Bonds

Maturity Date (December 1)	Principal Amount	Interest Rate	Yield	Price	CUSIP†
2021	$1,925,000	5.000%	1.620%	114.428	169203 AA4
2022	2,005,000	5.000	1.790	116.572	169203 AB2
2023	2,080,000	5.000	2.010	117.980	169203 AC0
2024	2,725,000	5.000	2.180	119.273	169203 AD8
2025	2,850,000	5.000	2.380	119.928	169203 AE6
2026	2,985,000	5.000	2.570	120.255	169203 AF3
2027	3,125,000	5.000	2.720	120.602	169203 AG1

$127,875,000 Term Bonds

$41,910,000, 5.000% Term Bond due December 1, 2037, Yield: 3.400%, Price: 113.962[C], CUSIP†: 169203 AH9

$38,355,000, 4.000% Term Bond due December 1, 2042, Yield: 3.900%, Price: 100.849[C], CUSIP†: 169203 AJ5

$47,610,000, 5.000% Term Bond due December 1, 2047, Yield: 3.540%, Price: 112.650[C], CUSIP†: 169203 AK2

[C] Priced to first call date of December 1, 2027 at par.

† Copyright 2017, CUSIP Global Services. CUSIP® is a registered trademark of the American Bankers Association. CUSIP Global Services is managed on behalf of the American Bankers Association by S&P Capital IQ. CUSIP data herein are provided by CUSIP Global Services. The CUSIP numbers have been assigned by an independent company not affiliated with the Issuer or the Corporation and are included solely for the convenience of the Holders of the Series 2017 Bonds. Neither the Issuer, the Corporation nor any other member of the Obligated Group is responsible for the selection or uses of these CUSIP numbers, and no representation is made as to their correctness on the Series 2017 Bonds or as indicated above. The CUSIP number for a specific maturity is subject to being changed after the issuance of the Series 2017 Bonds as a result of various subsequent actions including, but not limited to, a refunding in whole or in part of such maturity or as a result of the procurement of secondary market portfolio insurance or other similar enhancement by investors that is applicable to all or a portion of certain maturities of the Series 2017 Bonds.

REGARDING THIS OFFICIAL STATEMENT

This Official Statement does not constitute an offering of any security, other than the original offering by the City of Chillicothe, Ohio (the "Issuer") of its Hospital Facilities Revenue Refunding and Improvement Bonds, Series 2017 (Adena Health System Obligated Group Project) (the "Series 2017 Bonds"). No person has been authorized by the Issuer, Adena Health System (the "Corporation"), Adena Medical Group, LLC ("Adena Medical Group" and, together with the Corporation, the "Obligated Group"), or the Underwriter to give any information or to make any representations with respect to the Series 2017 Bonds, other than those in this Official Statement. Any other information or representation should not be relied upon as having been given or authorized by the Issuer, any member of the Obligated Group, or the Underwriter. This Official Statement does not constitute an offer to sell or the solicitation of any offer to buy, nor shall there be any sale of, the Series 2017 Bonds by any person in any jurisdiction in which it is unlawful to make such offer, solicitation, or sale.

The information and descriptions in this Official Statement do not purport to be comprehensive or definitive. Statements regarding specific documents (including the Series 2017 Bonds), instruments and statutes are descriptions of selected provisions of and subject to the detailed provisions of such documents, instruments, and statutes, respectively, and are qualified in their entirety by reference to the full text of each such document, instrument, or statute. Copies of the documents will be on file with the Bond Trustee and will be furnished upon request. The information under the headings **Introductory Statement—The Issuer**, **The Issuer**, and **Litigation—Issuer** has been furnished by the Issuer. All other information contained in this Official Statement has been provided by the Obligated Group.

The Underwriter has reviewed the information in this Official Statement in accordance with, and as a part of, its responsibilities to investors under the federal securities laws as applied to the facts and circumstances of this transaction, but the Underwriter does not guarantee the accuracy or completeness of such information. The information and expressions of opinion in this Official Statement are subject to change without notice. Neither the delivery of this Official Statement nor any sale made under this Official Statement will, under any circumstances, give rise to any implication that there has been no change in the affairs of the Issuer, any member of the Obligated Group, or DTC since its date. This Official Statement has been approved by the Obligated Group and its use and distribution for the purposes set forth above have been authorized by the Obligated Group and the Issuer.

The information and expressions of opinion in this Official Statement are subject to change without notice, and neither the delivery of this Official Statement nor any sale made under this Official Statement will, under any circumstances, create any implication that there has been no change in the affairs of the Issuer or the Obligated Group since the date of this Official Statement. This Official Statement does not constitute a contract between the Issuer, the Obligated Group, or any one or more of the purchasers or registered owners of the Series 2017 Bonds.

IN CONNECTION WITH THE OFFERING OF THE SERIES 2017 BONDS, THE UNDERWRITER MAY OVER-ALLOT OR EFFECT TRANSACTIONS THAT STABILIZE OR MAINTAIN THE MARKET PRICE OF SUCH SERIES 2017 BONDS AT A LEVEL ABOVE THAT WHICH MIGHT OTHERWISE PREVAIL IN THE OPEN MARKET. SUCH STABILIZING, IF COMMENCED, MAY BE DISCONTINUED AT ANY TIME.

NEITHER THE SERIES 2017 BONDS NOR ANY OTHER SECURITY RELATING TO THE SERIES 2017 BONDS HAS BEEN REGISTERED UNDER THE SECURITIES ACT OF 1933, AS AMENDED, AND NEITHER THE BOND INDENTURE NOR THE MASTER INDENTURE HAS BEEN QUALIFIED UNDER THE TRUST INDENTURE ACT OF 1939, AS AMENDED, IN RELIANCE UPON EXEMPTIONS CONTAINED IN THOSE ACTS. THOSE EXEMPTIONS FROM

REGISTRATION AND FROM QUALIFICATION UNDER APPLICABLE PROVISIONS OF FEDERAL OR STATE SECURITIES LAWS SHOULD NOT BE REGARDED AS A RECOMMENDATION THEREOF. NO STATE NOR ANY AGENCY THEREOF HAS PASSED UPON THE MERITS OF THE SERIES 2017 BONDS OR ANY RELATED SECURITY OR THE ACCURACY OR COMPLETENESS OF THIS OFFICIAL STATEMENT. ANY REPRESENTATION TO THE CONTRARY MAY BE A CRIMINAL OFFENSE.

CAUTIONARY STATEMENTS REGARDING FORWARD-LOOKING STATEMENTS IN THIS OFFICIAL STATEMENT

Certain statements included or incorporated by reference in this Official Statement constitute "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. Such statements are generally identifiable by the terminology used such as "plan," "expect," "estimate," "anticipate," "budget," or other similar words. Such forward-looking statements include, among others, certain statements under the **Management Discussion and Analysis of Financial Performance** in **Appendix A** to this Official Statement and certain statements under **Bondholders' Risks** in the forepart of this Official Statement.

THE ACHIEVEMENT OF CERTAIN RESULTS OR OTHER EXPECTATIONS CONTAINED IN SUCH FORWARD-LOOKING STATEMENTS INVOLVE KNOWN AND UNKNOWN RISKS, UNCERTAINTIES AND OTHER FACTORS WHICH 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. NEITHER THE OBLIGATED GROUP NOR ANY OTHER PARTY PLANS TO ISSUE ANY UPDATES OR REVISIONS TO THOSE FORWARD-LOOKING STATEMENTS IF OR WHEN THEIR EXPECTATIONS, OR EVENTS, CONDITIONS, OR CIRCUMSTANCES UPON WHICH SUCH STATEMENTS ARE BASED OCCUR.

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OFFICIAL STATEMENT

$145,570,000
City of Chillicothe, Ohio
Hospital Facilities Revenue Refunding and Improvement Bonds, Series 2017
(Adena Health System Obligated Group Project)

INTRODUCTORY STATEMENT

The following statement is subject in all respects to more complete information contained in this Official Statement. The entire Official Statement including cover page, inside cover page, and the Appendices should be read by any prospective purchaser of the Series 2017 Bonds. No person is authorized to detach this Introductory Statement from this Official Statement or to otherwise use it without this entire Official Statement including the attached Appendices. All statements in this Official Statement are qualified in their entirety by reference to each document. Capitalized words or terms not otherwise defined in this Official Statement have the meanings given to them in **Appendix C—Summary of Certain Bond Documents**.

Purpose of this Official Statement

The purpose of this Official Statement, including the cover page, inside cover page, and the appendices, is to provide information in connection with the offering by the City of Chillicothe, Ohio (the "Issuer"), of its $145,570,000 Hospital Facilities Revenue Refunding and Improvement Bonds, Series 2017 (Adena Health System Obligated Group Project) (the "Series 2017 Bonds").

The Issuer

The Issuer is a municipal corporation and political subdivision of the State of Ohio (the "State"). The Issuer has the power, pursuant to Chapter 140, Ohio Revised Code (the "Act"), to issue revenue bonds such as the Series 2017 Bonds to provide funds for the financing and refinancing of costs of "hospital facilities" within the meaning of the Act.

Adena Health Obligated Group

The Adena Health Obligated Group consists of Adena Health System (the "Corporation") and Adena Medical Group, LLC ("Adena Medical Group" and, together with the Corporation, the "Obligated Group"). The Corporation is a private, Ohio nonprofit corporation that current operates an acute care hospital known as Adena Regional Medical Center, and has eleven wholly-owned subsidiaries. The Corporation is a tax-exempt organization as described in Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"). Adena Medical Group is an Ohio limited liability company. The Corporation is the sole member of Adena Medical Group.

The Obligated Group comprises a financing group under a Master Trust Indenture dated as of May 1, 1993, as previously amended and supplemented (the "Original Master Indenture") between each member of the Obligated Group and The Huntington National Bank, as master trustee (the "Master Trustee"). Each member of the Obligated Group is obligated, jointly and severally, with respect to all promissory notes issued and outstanding from time to time under the Original Master Indenture ("Notes") representing, or providing a guaranty of, indebtedness.

On the date of delivery of the Series 2017 Bonds, the Obligated Group and the Master Trustee will enter into an Amended and Restated Master Trust Indenture dated as of June 1, 2017 (the "Amended

and Restated Master Indenture"). The Amended and Restated Master Indenture shall become effective on the date of delivery of the Series 2017 Bonds, at which time the Amended and Restated Master Indenture will replace and supersede the Original Master Indenture in totality. Each holder of a Series 2017 Bond, by purchasing such Series 2017 Bond, will be deemed to consent to the Amended and Restated Master Indenture. The Original Master Indenture, as amended and restated by the Amended and Restated Master Indenture, is referred to as the "Master Indenture."

Certain information about the Obligated Group is summarized in **Appendix A—Adena Health System and the Obligated Group**.

Additional Indebtedness

The Master Indenture permits the members of the Obligated Group to issue Notes to secure related bonds and other indebtedness in accordance with the Master Indenture. All members of the Obligated Group will be jointly and severally liable for payment of all indebtedness evidenced by the Notes issued under the Master Indenture. The Obligated Group will issue the Series 2017A Note under the Master Indenture to secure the Series 2017 Bonds. See **Appendix C—Summary of Certain Bond Documents** for a description of certain provisions of the Master Indenture, the Bond Indenture, the Sublease, and the Lease in connection with the issuance of indebtedness to be secured by the Master Indenture.

Outstanding Bonds

The following outstanding bonds have been issued for the benefit of the Corporation (collectively, the "Prior Bonds"). The following describes the Prior Bonds and their purposes:

Series 1998 Bonds

In 1998, the County of Ross, Ohio (the "County") issued $8,175,000 Adjustable Rate Demand Hospital Facilities Revenue Bonds, Series 1998 (Adena Health System) (the "Series 1998 Bonds") to finance the costs of acquisition and construction of various improvements at the Corporation's hospital facilities, including the expansion of a medical office building, the renovation of the Women's and Maternity Unit, and the installation of equipment and a management information system. The Series 1998 Bonds are currently outstanding in the aggregate principal amount of $3,310,000. The payment of the principal of and interest on the Series 1998 Bonds is secured by a letter of credit issued by PNC Bank, N.A.

Series 2008 Bonds

In 2008, the County issued $142,970,000 Hospital Facilities Revenue Refunding Bonds, Series 2008 (Adena Health System) (the "Series 2008 Bonds") to currently refund (a) the County's $83,830,000 Variable Rate Hospital Facilities Revenue Refunding and Improvement Bonds, Series 2006 (Adena Health System), and (b) the County's $32,850,000 principal amount of its Hospital Facilities Revenue Refunding and Improvement Bonds, Series 2001 (Adena Health System). The Series 2008 Bonds are currently outstanding in the aggregate principal amount of $130,575,000. On the closing date of the Series 2017 Bonds, a portion of the Series 2008 Bonds ($6,975,000 principal amount) will be defeased with the proceeds of a taxable loan in the principal amount of $7,405,000 from PNC Bank, N.A. to the Corporation (the "Taxable Bank Loan"). The Corporation's obligation to make loan payments under the Taxable Bank Loan will be secured by a Note issued under the Master Indenture on a parity with the Series 2017A Note and the Existing Notes. In addition, the Taxable Bank Loan may contain such covenants and provisions as the Corporation and PNC Bank, N.A. determine, including, but not limited

to, a liquidity covenant. The remaining principal amount of the Series 2008 Bonds will be defeased, along with other available money, with a portion of the proceeds of the Series 2017 Bonds.

Series 2010 Bonds

In 2010, the County issued $30,000,000 Adjustable Rate Demand Hospital Facilities Revenue Bonds, Series 2010 (Adena Health System Project) (the "Series 2010 Bonds") to finance the construction of a cancer center and the renovation and equipping of certain other hospital facilities. The outstanding principal amount of the Series 2010 Bonds as of April 30, 2017 is $25,558,338.

After the issuance of the Series 2017 Bonds, the Closing of the Taxable Bank Loan, and the application of the proceeds of a portion of the Series 2017 as described under the **Series 2017 Project and Refunding of Series 2008 Bonds** below, the aggregate outstanding principal balance of the Prior Bonds, the Taxable Bank Loan, and the Series 2017 Bonds will be $181,843,338.

Use of Bond Proceeds

The Series 2017 Bonds are being issued for the purpose of providing funds to (1) advance refund a portion of the outstanding Series 2008 Bonds (the "Refunded 2008 Bonds") issued by the Issuer to refinance certain hospital facilities leased to the Adena Health System, (2) provide the funds to pay costs of acquiring, constructing, reconstructing, equipping, installing, and otherwise providing "hospital facilities," as defined in the Act, and described in more detail under **The Series 2017 Project and Refunding of the Series 2008 Bonds** (the "Series 2017 Project"), and (3) pay certain issuance costs in connection with the Series 2017 Bonds.

Security for the Series 2017 Bonds

The Series 2017 Bonds are not a general obligation, debt, or bonded indebtedness of the Issuer or of the State or any political subdivision of the State and the holders or owners of the Series 2017 Bonds do not have the right to have excises or taxes levied by the Issuer of by the State or any political subdivision of the State for the payment of the principal of and premium, if any, and interest on ("Bond Service Charges") the Series 2017 Bonds.

The Series 2017 Bonds will be secured by a pledge and assignment by the Issuer to the Bond Trustee of the Issuer's interest in Basic Rent under a Sublease dated as of June 1, 2017 (the "Sublease"), between the Issuer, as lessor, and the Corporation, as lessee, and in the funds established under an Indenture of Trust (Bond Indenture) dated as of June 1, 2017 (the "Bond Indenture"), between the Issuer and The Huntington National Bank, as bond trustee (the "Bond Trustee"). The Sublease provides for the payment of Basic Rent sufficient to pay the Bond Service Charges on the Series 2017 Bonds. The obligation of the Corporation to pay the Basic Rent and other amounts payable under the Sublease will be absolute and unconditional, subject only to certain limitations described in this Official Statement. See **Security for the Series 2017 Bonds** and **Bondholders' Risks—Enforceability of the Master Indenture, the Sublease, and the Series 2017A Note**.

The obligation of the Corporation to make payments of Basic Rent under the Sublease will be secured by a promissory note (the "Series 2017A Note") to be issued under the Master Indenture. The Series 2017A Note is a joint and several obligation of each member of the Obligated Group to pay amounts equal to the Bond Service Charges on the Series 2017 Bonds. The Series 2017A Note will entitle the Bond Trustee to the protection of the covenants, restrictions, and other obligations imposed on the Obligated Group by the Master Indenture and to the pledge of the Gross Receipts by the Obligated Group to secure the Series 2017A Note on a parity with the Existing Notes issued under the Master

Indenture. Upon the issuance of the Series 2017 Bonds, the closing of the Taxable Bank Loan, and the refinancing of the Series 2008 Bonds, the aggregate principal amount of all Notes outstanding under the Master Indenture will be $181,843,338. Pursuant to the Master Indenture, the Obligated Group has assigned and granted to the Master Trustee an assignment of and a security interest in all present or future Gross Receipts to secure the prompt payment of the principal of and interest and any premium on any Note issued under the Master Indenture. See **Security and Sources of Payment for the Series 2017 Bonds** and **Appendix A—Adena Health System and the Obligated Group.**

Trustee

The Huntington National Bank is a national banking association and is duly authorized to exercise corporate powers under the laws of the State, with its designated office located in Cincinnati, Ohio and initially serves as the bond trustee under the Bond Indenture and master trustee under the Master Trust Indenture.

Bondholders' Risks

There are risks associated with the purchase of the Series 2017 Bonds. See the information under the **Bondholders' Risks**, for a description of certain of these risks.

Appendices and Underlying Documents

Brief descriptions of the Issuer, the Series 2017 Bonds, the Master Indenture, the Sublease, the Bond Indenture, and the Tax Regulatory Agreement are included in this Official Statement and in **Appendix C—Summary of Certain Bond Documents**. Information concerning the operations and business of the Obligated Group is contained in **Appendix A—Adena Health System and the Obligated Group** and **Appendices B-1** and **B-2—2016 and 2015 Consolidated Financial Report of Adena Health System and Subsidiaries**. The descriptions and summaries of various documents hereinafter set forth do not purport to be comprehensive or definitive, and reference is made to each document for the complete details of all terms and conditions. All statements in this Official Statement are qualified in their entirety by reference to each such document. Copies of the Sublease, the Bond Indenture, the Master Indenture, the Continuing Disclosure Agreement, and the Tax Regulatory Agreement are available in reasonable quantities upon request to the Bond Trustee or Cain Brothers & Company, LLC (the "Underwriter").

AMENDMENT OF MASTER INDENTURE

By purchasing Series 2017 Bonds, the holders of the Series 2017 Bonds are deemed to have directed the Bond Trustee to consent to the amendments of the Original Master Indenture contained in the Amended and Restated Master Trust Indenture. The Bond Trustee will be the holder of more than a majority in aggregate principal amount of all promissory notes issued and outstanding under the Original Master Indenture, upon the issuance of the Series 2017 Bonds and the refunding and retirement or advance refunding of the Refunded 2008 Bonds and the resulting defeasance of the Note securing the Refunded 2008 Bonds. Consequently, the Original Master Indenture will be amended and restated in its entirety as provided in the Amended and Restated Master Trust Indenture, without any further action, upon delivery of the Series 2017A Note. This Official Statement contains a summary of the provisions of the Amended and Restated Master Trust Indenture and does not contain any summary of the provisions of the Original Master Indenture. All references in this Official Statement to the Master Indenture are references to the Amended and Restated Master Indenture.

THE ISSUER

The Issuer is a municipal corporation and political subdivision of the State. Pursuant to the Act, the Issuer has the power to issue revenue bonds, including the Series 2017 Bonds, to provide funds for financing and refinancing of the costs of hospital facilities, as defined in the Act. The City Council of the Issuer enacted an ordinance authorizing the issuance of the Series 2017 Bonds (the "Bond Legislation").

The Series 2017 Bonds will be special revenue obligations of the Issuer. The Bond Service Charges on the Series 2017 Bonds shall not constitute a general obligation, debt, or bonded indebtedness of the Issuer, the State, or any political subdivision of the State within the meaning of any constitutional or statutory provision whatsoever or, except as to the limited sources of payment described in this Official Statement, shall ever constitute or give rise to a pecuniary liability of the Issuer. The Series 2017 Bonds will not constitute no give rise to a general obligation or liability of, or a charge against, the general credit of the Issuer, the State, of a charge against the general credit or taxing powers of the Issuer, the State, or any other political subdivision of the State, and the holders or owners of the Series 2017 Bonds do not have the right to have any excises or taxes levied by the Issuer or the State or any political subdivision thereof for the payment of Bond Service Charges on the Series 2017 Bonds.

THE CORPORATION

The Corporation is an Ohio nonprofit corporation and an organization described in Section 501(c)(3) of the Code. The Corporation owns and operates an acute care general hospital located in Chillicothe, Ohio, two critical access hospitals in Greenfield and Waverly, Ohio, and a number of outpatient medical facilities. The Corporation is a member of the Obligated Group, as such term is defined in the Master Indenture. A description of the facilities and operations of the Corporation is included in **Appendix A—Adena Health System and the Obligated Group** and in **Appendices B-1** and **B-2—2016 and 2015 Consolidated Financial Report of Adena Health System and Subsidiaries**.

All members of the Obligated Group are jointly and severally liable on the Series 2017A Note from the Corporation to the Bond Trustee. Currently, members of the Obligated Group are the Corporation and Adena Medical Group. Certain covenants and restrictions imposed by the Master Indenture upon the members of the Obligated Group are summarized in **Security and Sources of Payment for the Series 2017 Bonds** in the front part of this Official Statement and in **Appendix C—Summary of Certain Bond Documents**.

THE SERIES 2017 PROJECT AND REFUNDING OF SERIES 2008 BONDS

The proceeds from the sale of the Series 2017 Bonds will be used to provide funds for the purposes, together with other available funds, of (1) advance refunding the Refunded 2008 Bonds issued to refinance certain hospital facilities owned and operated by the Corporation, (2) pay costs of financing the acquisition, construction, reconstruction, equipping, and installation of the Series 2017 Project, or to reimburse the Corporation for costs of its Series 2017 Project already incurred, and (3) paying certain issuance costs in connection with the Series 2017 Bonds.

The Series 2017 Project consists of the expansion of Adena Regional Medical Center's Emergency Center from 16,500 square feet to 59,000 square feet, including the addition of six treatment rooms and 32 additional patient-care areas. The Series 2017 Project will also create the capacity to manage patients that are either in transition to inpatient care, transition to home, or under active medical observation. The Series 2017 Project will also include Adena Regional Medical Center parking lot improvements and other capital improvements of the Corporation's facilities in the County.

The proceeds of the Series 2017 Bonds that will be used to advance refund the Refunded 2008 Bonds will be deposited, together with other available funds (including proceeds of the Taxable Bank Loan), into an escrow fund (the "Escrow Fund") established pursuant to the Escrow Deposit Agreement dated as of June, 1, 2017 (the "Escrow Agreement"), between the Corporation and The Huntington National Bank, as escrow trustee (the "Escrow Trustee"). The funds deposited in the Escrow Fund will be held uninvested as cash or invested as provided in the Escrow Agreement. The cash and maturing principal of and interest on investments in the Escrow Fund will be used by the Escrow Trustee to pay (a) the interest on the Refunded 2008 Bonds which is due and payable on June 1 and December 1, in each of the years 2017 and 2018, and the principal of the Refunded 2008 Bonds which is due and payable on December 1, 2017 (each, an "Escrow Payment Date"), and (b) the outstanding principal of the Refunded 2008 Bonds upon optional redemption, at a price of 100% of the principal amount to be redeemed, on December 1, 2018 (the "Redemption Date").

The sufficiency of the amounts deposited in the Escrow Fund, together with interest on those amounts, to provide for the payments due on the Escrow Payment Dates and the Redemption Date will be verified by Dinsmore & Shohl LLP. See **Verification of Mathematical Computations**. Upon the irrevocable deposit of the funds in the Escrow Fund, the Refunded 2008 Bonds will be deemed paid and no longer outstanding.

The funds on deposit in the Escrow Fund will not be available to make payments on the Series 2017 Bonds. The deposit of money into the Escrow Fund will constitute an irrevocable deposit for the benefit of the holders of the Refunded 2008 Bonds.

ESTIMATED SOURCES AND USES OF FUNDS

The following table sets forth the estimated sources and uses of proceeds of the Series 2017 Bonds, the Taxable Bank Loan, and other available funds:

Sources of Funds	
Par Amount of the Series 2017 Bonds	$145,570,000.00
Original Issue Premium on Series 2017 Bonds	15,525,326.25
Par Amount of Taxable Bank Loan	7,405,000.00
Bond Trustee-Held Funds	12,258,266.00
Total Sources of Funds	$180,758,592.25
Uses of Funds	
Advance Refunding of Series 2008 Bonds	$138,924,052.53
Deposit to Project Fund for Costs of Series 2017 Project	40,000,000.00
Costs of Issuance[(1)]	1,834,539.72
Total Uses of Funds	$180,758,592.25

(1) Estimated amount to provide for Underwriter's discount, the advance refunding of the Refunded 2008 Bonds, legal, consulting, escrow bidding agent, placement agent, and printing fees, and other costs related to the issuance of the Series 2017 Bonds and the Taxable Bank Loan.

ESTIMATED ANNUAL DEBT SERVICE REQUIREMENTS

The following table sets forth, for each bond year ending December 1, commencing with the bond year ending December 1, 2017, the total Bond Service Charges with respect to the Series 2017 Bonds and debt service on other indebtedness of the Obligated Group.

	Series 2017 Bonds				
Year	**Principal**	**Interest**	**Total**	**Other Debt Service[2]**	**Total Debt Service Requirements**
2017	$ -	$3,045,269.58	$3,045,269.58	$3,165,899.83	$6,211,169.41
2018	-	6,894,950.00	6,894,950.00	4,437,238.08	11,332,188.08
2019	-	6,894,950.00	6,894,950.00	4,449,927.59	11,344,877.59
2020	-	6,894,950.00	6,894,950.00	4,492,506.09	11,387,456.09
2021	1,925,000.00	6,894,950.00	8,819,950.00	2,327,210.13	11,147,160.13
2022	2,005,000.00	6,798,700.00	8,803,700.00	2,338,778.13	11,142,478.13
2023	2,080,000.00	6,698,450.00	8,778,450.00	2,354,689.50	11,133,139.50
2024	2,725,000.00	6,594,450.00	9,319,450.00	1,804,346.00	11,123,796.00
2025	2,850,000.00	6,458,200.00	9,308,200.00	1,804,345.00	11,112,545.00
2026	2,985,000.00	6,315,700.00	9,300,700.00	1,804,345.00	11,105,045.00
2027	3,125,000.00	6,166,450.00	9,291,450.00	1,804,346.00	11,095,796.00
2028	3,270,000.00	6,010,200.00	9,280,200.00	1,804,345.00	11,084,545.00
2029	3,420,000.00	5,846,700.00	9,266,700.00	1,804,346.00	11,071,046.00
2030	3,585,000.00	5,675,700.00	9,260,700.00	1,804,346.00	11,065,046.00
2031	3,755,000.00	5,496,450.00	9,251,450.00	1,804,346.00	11,055,796.00
2032	3,930,000.00	5,308,700.00	9,238,700.00	1,804,345.00	11,043,045.00
2033	4,110,000.00	5,112,200.00	9,222,200.00	1,804,346.00	11,026,546.00
2034	4,305,000.00	4,906,700.00	9,211,700.00	1,804,345.00	11,016,045.00
2035	4,505,000.00	4,691,450.00	9,196,450.00	1,804,345.00	11,000,795.00
2036	4,720,000.00	4,466,200.00	9,186,200.00	1,804,345.00	10,990,545.00
2037	6,310,000.00	4,230,200.00	10,540,200.00	454,834.00	10,995,034.00
2038	7,085,000.00	3,914,700.00	10,999,700.00	5,000.00	11,004,700.00
2039	7,365,000.00	3,631,300.00	10,996,300.00	5,000.00	11,001,300.00
2040	7,660,000.00	3,336,700.00	10,996,700.00	502,500.00	11,499,200.00
2041	7,965,000.00	3,030,300.00	10,995,300.00	-	10,995,300.00
2042	8,280,000.00	2,711,700.00	10,991,700.00	-	10,991,700.00
2043	8,615,000.00	2,380,500.00	10,995,500.00	-	10,995,500.00
2044	9,045,000.00	1,949,750.00	10,994,750.00	-	10,994,750.00
2045	9,500,000.00	1,497,500.00	10,997,500.00	-	10,997,500.00
2046	9,975,000.00	1,022,500.00	10,997,500.00	-	10,997,500.00
2047	10,475,000.00	523,750.00	10,998,750.00	-	10,998,750.00
TOTAL	$145,570,000.00	$145,400,219.58	$290,970,219.58	$47,990,074.35	$338,960,293.93

[1] Interest and debt service columns contain de minimis rounding adjustments.

[2] Excludes debt service on the Series 2008 Bonds which will be defeased by the Series 2017 Bonds and the Taxable Bank Loan, and includes $3,310,000 of Series 1998 Bonds (variable rate bonds with assumed interest rate of 1.77%), $25,558,338 of Series 2010 Bonds (fixed rate of 2.97% until September 1, 2020), the Taxable Bank Loan, and a $500,000 equipment note (fixed rate of 1%).

THE SERIES 2017 BONDS

General Description

The Series 2017 Bonds are being issued by the Issuer pursuant to the Bond Legislation and the Bond Indenture. The Series 2017 Bonds are scheduled to mature on the dates in the aggregate principal amounts set forth on the inside cover page of this Official Statement. All Series 2017 Bonds will be dated the date of initial delivery and will bear interest from their dated date at the rates set forth on the inside cover page of this Official Statement. Interest on the Series 2017 Bonds will be payable on June 1 and December 1 of each year, commencing December 1, 2017 ("Interest Payment Dates"). The Series 2017 Bonds are issuable as fully registered bonds without coupons in denominations of $5,000 and any integral multiple of $5,000.

Principal of, and premium, if any, on the Series 2017 Bonds will be payable upon presentation and surrender thereof at the designated corporate trust office of the Bond Trustee, currently The Huntington National Bank, Cincinnati, Ohio. Payment of interest on Series 2017 Bonds will be made by check or draft mailed by the Bond Trustee to the registered owners at the addresses shown on the registration books maintained by the Bond Trustee, as of the Record Date, defined as the 15th day of each May and November next preceding the date on which interest or principal and interest are payable on the Series 2017 Bonds, or as of any special record date fixed for the payment of defaulted interest. Holders of at least $1,000,000 aggregate principal amount of Series 2017 Bonds may receive payment of interest by wire transfer, if requested.

Redemption Prior to Maturity

Mandatory Sinking Fund Redemption. The Series 2017 Bonds maturing on December 1, 2037 are subject to mandatory sinking fund redemption prior to maturity, on December 1 in the following years in the following amounts (with the principal amount due on December 1, 2037 being the amount remaining to be paid at the maturity date), at a redemption price of 100% of the principal amount to be redeemed, plus accrued interest to the redemption date:

Year	Principal Amount
2028	$3,270,000
2029	3,420,000
2030	3,585,000
2031	3,755,000
2032	3,930,000
2033	4,110,000
2034	4,305,000
2035	4,505,000
2036	4,720,000
2037*	6,310,000

* *Maturity*

The Series 2017 Bonds maturing on December 1, 2042 are subject to mandatory sinking fund redemption prior to maturity, on December 1 in the following years in the following amounts (with the principal amount due on December 1, 2042 being the amount remaining to be paid at the maturity date), at a redemption price of 100% of the principal amount to be redeemed, plus accrued interest to the redemption date:

Year	Principal Amount
2038	$7,085,000
2039	7,365,000
2040	7,660,000
2041	7,965,000
2042*	8,280,000

* *Maturity*

The Series 2017 Bonds maturing on December 1, 2047 are subject to mandatory sinking fund redemption prior to maturity, on December 1 in the following years in the following amounts (with the principal amount due on December 1, 2047 being the amount remaining to be paid at the maturity date), at a redemption price of 100% of the principal amount to be redeemed, plus accrued interest to the redemption date:

Year	Principal Amount
2043	$8,615,000
2044	9,045,000
2045	9,500,000
2046	9,975,000
2047*	10,475,000

* *Maturity*

Optional Redemption. The Series 2017 Bonds maturing after December 1, 2027 are subject to optional redemption prior to maturity on or after December 1, 2027, in whole or in part on any date, at the option of the Issuer (at the direction of the Corporation), the maturities of such Series 2017 Bonds to be redeemed to be selected by the Corporation, with less than all of a single maturity of Series 2017 Bonds to be selected by the Bond Trustee in any manner as directed by the Corporation, at a redemption price of 100% of the principal amount redeemed, plus interest accrued to the redemption date. date of redemption.

In the event that the Corporation elects to direct the Issuer to redeem Series 2017 Bonds, the Corporation shall notify the Bond Trustee in writing of such election at least 45 days prior to such redemption date.

If optional redemption of any Series 2017 Bonds is to take place as of any applicable mandatory redemption date, the Series 2017 Bonds or portions of Series 2017 Bonds to be optionally redeemed must be selected prior to the selection by the Bond Trustee, in any manner as directed by the Corporation, of the Series 2017 Bonds to be mandatorily redeemed.

Extraordinary Optional Redemption of Bonds. The Series 2017 Bonds are subject to redemption by the Issuer (at the direction of the Corporation) in whole or in part on any date, at a redemption price of 100% of the principal amount redeemed plus interest accrued to the redemption date, if the Corporation elects to prepay Basic Rent under the Sublease upon the occurrence of any of the following:

(a) the Existing Facilities are damaged or destroyed in an amount greater than $500,000, or if the Corporation receives a condemnation or taking award that is greater than $500,000;

(b) the damage or destruction of the Existing Facilities to the extent that (1) they cannot be reasonably expected to be restored within a period of six months from the commencement of restoration to the condition of those Existing Facilities immediately

preceding such damage or destruction, or (2) it is reasonably expected that the Corporation will be thereby prevented from carrying on its normal operations therein or thereon for a period of six months, or (3) the cost of restoration of those Existing Facilities would be greater than twenty percent of the appraised value of the Existing Facilities immediately before the date on which such damage or destruction occurred;

(c) title to, or the temporary use of, all or a significant portion of the Existing Facilities is taken under the exercise of the power of eminent domain by any governmental authority, or person acting under governmental authority (1) to such extent the Existing Facilities cannot be reasonably expected to be restored within a period of six months from the commencement of restoration to a condition of comparable usefulness to that existing before such taking, or (2) it is reasonably expected that the taking will result in the Corporation being thereby prevented from carrying on its normal operations therein or thereon for a period of six months; or

(d) as a result of any changes in the Constitution of the State or the Constitution of the United States of America or of the legislative or administrative action (whether state or federal) or by final decree, judgment or order of any court or administrative body (whether state or federal) entered after the contest thereof by the Issuer or the Corporation in good faith, the Sublease shall have become void or unenforceable or impossible of performance in accordance with the intent and purpose of the parties as expressed in the Sublease.

Selection of Bonds for Redemption. If less than all Series 2017 Bonds outstanding are to be redeemed, the Series 2017 Bonds are to be selected for redemption in the order selected by the Corporation, without regard as to their order of maturities. If less than all the Series 2017 Bonds of a single maturity are to be redeemed, the Series 2017 Bonds from within a maturity are to be selected by the Bond Trustee in any manner as directed by the Corporation.

Notice of Redemption. Notice of the call for redemption of any of the Series 2017 Bonds will be given by electronic means or mailing a copy of such notice at least 30 days before the redemption date to the holders of the Series 2017 Bonds to be redeemed at the address shown on the registration books maintained by the Bond Trustee; provided, however, that failure to so provide any notice of redemption, or a defect in the notice as to any Series 2017 Bond will not affect the validity of the redemption of any other Series 2017 Bond. Interest will not be payable on the Series 2017 Bonds after the redemption date if notice has been given and if sufficient moneys have been deposited with the Bond Trustee to pay the principal of, applicable redemption premium, if any, and interest on the Series 2017 Bonds or portions thereof, to be redeemed, to the redemption date.

Book Entry

The Series 2017 Bonds are originally issued in book-entry form to be held in a book-entry system maintained by The Depository Trust Company ("DTC"), New York, New York. See **Appendix E—Book-Entry System.**

Revision of Book-Entry System; Replacement Series 2017 Bonds.

The Bond Indenture provides for the issuance and delivery of fully registered Series 2017 Bonds (the "Replacement Series 2017 Bonds") directly to owners other than DTC only in the event that DTC determines not to continue to act as securities depository for the Series 2017 Bonds. Upon occurrence of such event, the Issuer may attempt to establish a securities depository book-entry relationship with

another securities depository. If the Issuer does not do so, or is unable to do so, and after the Bond Trustee has notified the owners of book-entry interests with respect to the Series 2017 Bonds by appropriate notice to DTC, the Issuer will issue and the Bond Trustee will authenticate and deliver Replacement Series 2017 Bonds of any one maturity, in the denomination of $5,000 or any integral multiple of $5,000, to or at the direction or any persons requesting such issuance. Such withdrawal, authentication and delivery, including printing and delivery costs, will be at the expense of the Corporation.

In the event that the book-entry only system is discontinued, the principal or redemption price of and interest on the Series 2017 Bonds will be payable in the manner described above under **The Series 2017 Bonds—General Description**, and the following provisions would apply. The Series 2017 Bonds may be transferred or exchanged for one or more Series 2017 Bonds in different authorized denominations upon surrender thereof at the designated office of the Bond Trustee as Registrar or at the designated office of any Authenticating Agent (initially, the Bond Trustee) by the registered owners or their duly authorized attorneys or legal representatives. Upon surrender of any Series 2017 Bonds to be transferred or exchanged, the Issuer will execute, and the Registrar will record the transfer or exchange in its registration books and the Registrar or Authenticating Agent shall authenticate and deliver, new Series 2017 Bonds appropriately registered and in appropriate authorized denominations. Neither the Issuer, the Registrar, nor any Authenticating Agent shall be required to transfer or exchange any Series 2017 Bond during a period beginning at the opening of business 15 days before the day of the mailing of a notice of redemption of the Series 2017 Bonds and ending at the close of business on the day of such mailing, nor any Series 2017 Bond all or part of which has been selected for redemption.

SECURITY AND SOURCES OF PAYMENT FOR THE SERIES 2017 BONDS

General

The Series 2017 Bonds are special obligations of the Issuer and are payable solely from (a) Basic Rent payable by the Corporation under the Sublease, (b) the Series 2017A Note issued under the Master Indenture, and (c) money and investments on deposit in the funds established under the Bond Indenture.

The Series 2017 Bonds and any Bond Service Charges required to be paid on the Series 2017 Bonds will not be general obligations, debt, or bonded indebtedness, and will not constitute a pledge of the faith and credit of the Issuer, the State, or of any other political subdivision of the State, and the holders or owners of any Series 2017 Bonds will not have any right to have excises or taxes levied by the legislative authority of the Issuer, the State, or the taxing authority of any political subdivision of the State for the payment of Bond Service Charges on the Series 2017 Bonds.

The Bond Indenture

Pursuant to the Bond Indenture, the Issuer will assign to the Bond Trustee, as security for the payment of the Series 2017 Bonds, substantially all of the Issuer's rights (except for certain Unassigned Rights) under the Lease and the Sublease, and the Issuer's rights and interest in the Basic Rent with respect to the Series 2017 Bonds payable under the Sublease, and the money and investments held in certain funds established under the Bond Indenture. See **Appendix C—Summary of Certain Bond Documents—Summary of the Bond Indenture—Application of Series 2017 Bond Proceeds and Other Moneys**. There will be no debt service reserve fund securing the Series 2017 Bonds.

The payment of debt service on the Series 2017 Bonds will be secured by the Series 2017A Note issued to the Bond Trustee by the Obligated Group in accordance with the Master Indenture. The Bond

Trustee will agree not to assign or transfer the Series 2017A Note other than to a successor Bond Trustee. The Series 2017A Note will be a joint and several general obligation of the members of the Obligated Group.

The Sublease

The Issuer will lease the Existing Facilities from the Corporation pursuant to the Agreement of Lease dated as of June 1, 2017 (the "Lease") and will sublease the Existing Facilities back to the Corporation pursuant to the Sublease. The Sublease provides for the payment of Basic Rent sufficient to pay the Bond Service Charges on the Series 2017 Bonds. In accordance with the Bond Indenture, the Issuer will pledge to the Bond Trustee all its rights, title, and interest in and to (a) the Lease and the Sublease (except for certain Unassigned Rights), (b) all of the Basic Rent received or to be received under the Sublease, and (c) all money and securities on deposit in the funds established under the Bond Indenture. So long as the Series 2017 Bonds remain outstanding, the obligation of the Corporation to pay the Basic Rent will be absolute and unconditional. See **Bondholders' Risks—Certain Matters Relating to Security for the Bonds—Enforceability of Master Indenture, the Sublease, and the Series 2017A Note.** The obligation of the Corporation to make payments of Basic Rent sufficient to pay the Bond Service Charges with respect to the Series 2017 Bonds will be evidenced by the Series 2017A Note issued to the Bond Trustee pursuant to the terms of the Master Indenture. Each member of the Obligated Group is jointly and severally liable for all Notes issued under the Master Indenture and all Notes are subject to the terms of the Master Indenture.

The Master Indenture

The Obligated Group. Currently, the Corporation and Adena Medical Group are the only members of the Obligated Group. Other persons may join the Obligated Group upon satisfaction of the conditions set forth in the Master Indenture. Any member of the Obligated Group may withdraw from the Obligated Group upon the satisfaction of certain financial and other conditions contained in the Master Indenture. See **Appendix C—Summary of Certain Bond Documents—Summary of the Master Indenture**.

Additional Notes. The Master Indenture permits the members of the Obligated Group to issue Notes to secure related bonds and other indebtedness in accordance with the Master Indenture. All members of the Obligated Group will be jointly and severally liable for payment of all indebtedness evidenced by the Notes issued under the Master Indenture. The Obligated Group will issue the Series 2017A Note under the Master Indenture to secure the Series 2017 Bonds.

The Gross Receipts Pledge. Each member of the Obligated Group has assigned and granted to the Master Trustee an assignment of and a security interest in all present or future Gross Receipts (described below) of that member to secure the prompt payment of the Bond Service Charges on each Note issued under the Master Indenture and the observance and performance by each member of the Obligated Group of all of its covenants, agreements, and obligations under the Master Indenture. Such assignment constitutes an absolute and unconditional present assignment of the Gross Receipts, subject however to the conditional permission given thereby to each member of the Obligated Group to collect and use Gross Receipts during a period while no Event of Default under the Master Indenture shall have occurred and be continuing. Upon such delinquency or Event of Default, that permission will automatically terminate, and the Gross Receipts shall be deposited immediately with the Master Trustee. Gross Receipts generally consist of all cash and other receipts, accounts, receivables, contracts, and general intangibles now owned or acquired in the future by a member of the Obligated Group and the proceeds thereof, excluding, among other things, proceeds of borrowings held in trust by a trustee as

security for a borrowing, and grantor or donor-restricted funds. **Appendix C—Summary of Certain Bond Documents—Definitions of Certain Terms**.

Amended and Restated Master Indenture. Each holder of a Series 2017 Bond, by purchasing such Series 2017 Bond, will be deemed to consent to the Amended and Restated Master Indenture and to have directed the Bond Trustee to consent to the Amended and Restated Master Indenture. Holders of certain specific Notes and certain credit enhancement providers have consented to the Amended and Restated Master Indenture and, accordingly, the Amended and Restated Master Indenture will become effective on the date of the issuance of the Series 2017 Bonds and the Closing of the Taxable Bank Loan.

Replacement of the Series 2017A Note. Under the circumstances described in the Bond Indenture, the Series 2017A Note may be exchanged by the Bond Trustee, without the consent of any of the holders of the Series 2017 Bonds, for an obligation issued under a different master trust indenture securing obligations of a different obligated group that would include among its members the Corporation or any other member of the Obligated Group. 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 from the Obligated Group. Such new obligated group could have substantial debt outstanding that would rank on a parity with the substitute obligation. To exchange the Series 2017A Note, the Obligated Group must meet certain tests and requirements, as described in **Appendix C—Summary of Certain Bond Documents—Summary of the Bond Indenture—Supplemental Indentures Not Requiring the Consent of Owners of Series 2017 Bonds** and **Appendix C—Summary of Certain Bond Documents—Summary of the Master Indenture—Substitution of Notes**.

BONDHOLDERS' RISKS

The following is a discussion of certain risks that could adversely affect payments to be made with respect to the Series 2017 Bonds. This discussion is not, is not intended to be, and cannot be exhaustive. The occurrence of one or more of the following events, or the occurrence of other unanticipated events, could adversely affect the Obligated Group's financial performance. Prospective purchasers of the Series 2017 Bonds should analyze carefully the information contained in this Official Statement, including the Appendices, and additional information in the forms of the complete documents summarized in this Official Statement, copies of which are available as described in this Official Statement.

General

The Series 2017 Bonds are payable from the revenues and other moneys received or derived by the Issuer from the operation, lease, or other disposition of the Existing Facilities, including the Basic Rent, from other money available for payment on the Series 2017 Bonds under the Bond Indenture, and from money payable under the Outstanding Master Notes and the Series 2017A Note. There is no assurance or any representation that the Corporation (or any other operator of the Existing Facilities or the other facilities operated by the Corporation or any other future members of the Obligated Group) will realize receipts and revenues in amounts sufficient to pay Bond Service Charges on the Series 2017 Bonds. These revenues are affected by and subject to conditions which may change in the future to an extent and with effects that cannot be determined at this time. The risk factors discussed below should be considered in evaluating the ability of the Corporation and any other future members of the Obligated Group to make payments in amounts sufficient to meet their obligations under the Series 2017A Note. **While the following discussion will relate primarily to the Corporation and Adena Medical Group, as the current members of the Obligated Group, it should be noted that additional entities may in**

the future become members of the Obligated Group, and as such the following factors could apply to such new Obligated Group members.

The Obligated Group, like all healthcare providers, is subject to a wide variety of federal and state regulatory actions and legislative and policy changes by those governmental and private agencies that administer Medicare, Medicaid, and other payors and is subject to actions by, among others, the National Labor Relations Board, The Joint Commission, the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services, the Ohio Department of Jobs and Family Services ("ODJFS"), and other federal, state, and local government agencies. The future financial condition of the Obligated Group could be adversely affected by, among other things, changes in the method and amount of payments to the Obligated Group by governmental and nongovernmental payors, the financial viability of these payors, increased competition from other health care entities, changes in the demand for health care, other forms of care or treatment, changes in the methods by which employers purchase health care for employees, capability of management, future changes in the economy, demographic changes, availability of physicians and nurses, and malpractice claims and other litigation. These factors and others may adversely affect payment by the Corporation under the Sublease and by the Corporation, and other members of the Obligated Group under the Series 2017A Note and, consequently, of payment of Bond Service Charges on the Series 2017 Bonds.

Nonprofit Health Care Environment

Economic and Business Conditions. The health of the economy has a direct impact on the financial condition and performance of the Obligated Group. Higher unemployment and reduced personal income expectations have tended historically to result in, among other consequences, (a) lower patient volumes as patients defer elective health care services; (b) rising charity care and uncollectable bad debt expense; (c) budget pressure on federal and state governments that intensify scrutiny of Medicare and Medicaid reimbursement rates and incentivize increased regulatory enforcement activity; (d) adverse shifts in payor mix away from commercial payors; (e) decreasing membership in health care plans, contributing to lower commercial rate increases for hospitals; and (f) increased difficulty attracting philanthropy.

Any current domestic and/or international financial uncertainty, upheaval, or crisis has a direct impact on health care providers, potentially creating 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. These potential occurrences, together with ongoing and future regulatory reform, have prompted many banks and other financial institutions to seek additional capital, to merge, and in some cases, to fail, which may reduce the availability of credit and liquidity to health care providers. These general economic conditions have also resulted in volatile fluctuations in the value of investment holdings for individuals and entities. The members of the Obligated Group have significant holdings in a broad range of investments, and market fluctuations may have a material impact on the Obligated Group's financial performance.

For many years, health care providers have been under increasing economic pressure from various third-party payors, both governmental (particularly Medicare and Medicaid) and private (e.g., health insurance companies). These payors have restructured the payment mechanisms and rates for hospital stays and procedures, creating incentives to reduce hospital inpatient utilization, increasing the use of outpatient services, and accessing care through non-hospital providers. Shifts in third-party payor policies and the need for providers to adapt to changing and complex payment arrangements have had, and will continue to have, a significant impact upon the financial performance of the members of the Obligated Group. The financial condition and performance of members of the Obligated Group also could be adversely and materially affected by increased inflation; increased pressure on the federal

government to decrease Medicare funding, on the federal and state governments to decrease Medicaid funding, and on employers to reduce healthcare coverage and increase deductibles; increases in unemployment, uncompensated care, and bad debts; and decreases in return on investments.

Recent Legislation. The financial condition of health care providers, including the Obligated Group members, have been and will continue to be dependent to a large degree on federal and state laws, regulations and policies affecting health care and related industries. Several pieces of recent federal legislation have been enacted or proposed that will have a significant impact on the health care and insurance industries, including members of the Obligated Group, brief descriptions of which follow.

Medicare Access and CHIP Reauthorization Act of 2015 On April 16, 2015, Former President Obama signed the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"). MACRA repeals Medicare's sustainable growth rate ("SGR") formula for physician reimbursement and, beginning in 2019, substitutes a new, "merit-based incentive payment" system which will reward (or penalize) physicians by comparing their aggregate merit-based incentive payment achievement score for the year to the median score for physicians nationwide. The Chief Actuary of the Centers for Medicare Services, in a report issued on April 9, 2015 ("Report on Estimated Financial Effects of the Medicare Access and CHIP Reauthorization Act") noted that, "physician payment rates under MACRA would be lower than scheduled under the pre-existing SGR formula by 2048 and would continue to worsen thereafter. Absent a change in the method or level of update by subsequent legislation, we expect access to Medicare-participating physicians to change significantly, and potentially unfavorably, in the long term under MACRA.

Because Congress may make changes to the budget, Medicare or MACRA in the future, it is impossible to predict whether any reimbursement cuts will actually be implemented, and if so, what impact they may have upon the Obligated Group. Similarly, it is impossible to predict whether any automatic reductions to Medicare may be triggered in lieu of other spending cuts that may be proposed by Congress. Reduction of Medicare or Medicaid spending under either scenario could have a material adverse effect upon the financial condition and performance of the Obligated Group.

American Recovery and Reinvestment Act of 2009. The American Recovery and Reinvestment Act of 2009 ("ARRA") included several provisions that were intended to provide financial relief to the health care sector, including a requirement that states promptly reimburse health care providers. ARRA also established a framework for the implementation of a nationally-based health information technology program, including incentive payments to eligible health care providers to encourage implementation of health information technology and an electronic health record. The incentive payments will be payable annually for a period of up to four years to eligible providers that demonstrate "meaningful use" of electronic health records. Medicare eligible providers that do not demonstrate meaningful use of electronic health records receive a downward adjustment in federal reimbursement.

The Corporation has implemented an electronic health record system. The Corporation has already achieved Stage 1 meaningful use requirements for its facilities and the largest of the corresponding years one and two incentive payments have been realized. A handful of the Obligated Group's facilities have also successfully achieved Stage 2 meaningful use requirements. The intent of the management of the Corporation is to continue meeting the demands of meaningful use requirements for Stages 2 and 3 for its core facilities. While the regulations are continually being refined, management does not anticipate any significant negative reimbursement impact as a result of its plans to remain in alignment with Stage 2 and 3 meaningful use requirements.

Health Care Reform Act. The Patient Protection and Affordable Care Act (the "ACA") and The Health Care and Education Affordability Reconciliation Act of 2010 (collectively, the "Health Care

Reform Act") were signed by Former President Obama on March 23, 2010 and March 30, 2010, respectively. Some of the provisions of the Health Care Reform Act took effect immediately, while others have been and are being phased in over time, ranging from a few months following approval to ten years in certain cases. Because of the complexity of the Health Care Reform Act generally, additional legislation is likely to be considered and enacted over time. The Health Care Reform Act will also require the promulgation of varied regulations with potentially significant effects on the health care industry and third-party payors. In response, third-party payors and suppliers and vendors of goods and services to health care providers have imposed new and additional contractual terms and conditions. Thus, the health care industry has become, and will continue to be, for a substantial period of time, subject to significant new statutory and regulatory requirements and contractual terms and conditions, and consequently to structural and operational changes and challenges.

A significant component of the Health Care Reform Act is reformation of the sources and methods by which consumers will pay for health care for themselves and their families and by which employers will procure health insurance for their employees and dependents and, as a consequence, expansion of the base of consumers of health care services. A primary objective of the Health Care Reform Act was to make available, or subsidize the premium costs of, health care insurance for some of the millions of currently uninsured (or underinsured) consumers who fall below certain income levels, thereby lessening the impact and incidence of uncompensated charity care on the health care system. However, as discussed below, that objective may not be achieved in Ohio, like many states, without action by the state, which may not occur. The Health Care Reform Act intends to accomplish that objective through various provisions, summarized as follows:

(a) The creation of active markets (referred to as exchanges) in which individuals and small employers can purchase health care insurance for themselves and their families or their employees and dependents.

(b) Provision of subsidies for premium costs to individuals and families based upon their income relative to federal poverty levels.

(c) Mandating that American citizens who meet certain income levels, obtain, and certain employers provide, a minimum level of health care insurance, and providing for penalties or taxes on individuals and employers that do not comply with these mandates.

(d) Establishment of insurance reforms that expand coverage generally through such provisions as prohibitions on denials of coverage for preexisting conditions and elimination of lifetime and annual cost caps.

(e) Expansion of access to primary care by increasing payments to providers of such care.

(f) Expansion of preventive health services such as cancer screenings, by eliminating patient cost-sharing under both governmental and private plans.

(g) Expansion of existing public programs including expansion of the Medicaid program to a broader population with incomes up to 138% of federal poverty levels. The State has adopted the Medicaid expansion. From 2014 through 2017, the federal government paid all costs of covering people newly eligible under the Ohio Medicaid program. This percentage will be reduced to 95% in 2017, 94% in 2018, 93% in 2019, and 90% thereafter.

(h) Expansion of the federal "340B" drug discount programs for patients receiving hospital outpatient services to include a wider range of hospital types and other health facilities, including certain cancer hospitals, children's hospitals, Critical Access Hospitals, Sole Community Hospitals and Rural Referral Centers. The 340B program previously applied only to a fairly narrow range of hospitals and health facility types. Most types of hospital facilities must serve a defined "disproportionate share" percentage of medically indigent persons in order to qualify to enroll as 340B entities. A number of the Obligated Group members are already enrolled or now qualify for 340B program participation.

To the extent all or any of those provisions produce the expected result, an increase in utilization of healthcare services by those who are currently avoiding or rationing their healthcare can be expected and bad debt expenses may be reduced. Increased utilization will increase variable and fixed costs of providing healthcare services, which may or may not be offset by increased revenues.

Some of the provisions of the Health Care Reform Act that may affect operations, financial performance, or financial conditions of the Obligated Group members, are described below. This listing is not intended to be comprehensive. The Health Care Reform Act is complex and comprehensive, and includes a myriad of new programs and initiatives and changes to existing programs, policies, practices, and laws. The demographics of the markets in which individual Obligated Group members provide services, the mix of services that any Obligated Group member provides to its community, and other factors that are unique to each Obligated Group member will affect individual outcomes. Moreover, the Health Care Reform Act remains subject to amendment, repeal, lack of implementation, failure to fund, and judicial interpretation.

- Through September 30, 2019, the annual Medicare market basket updates for hospitals will be reduced and subject to productivity adjustments. The reductions in market basket updates and the productivity adjustments will have a disproportionately negative effect upon those providers that are relatively more dependent upon Medicare than other providers. Additionally, the reductions in market basket updates will be effective prior to the periods during which insurance coverage and the insured consumer base will expand, which may have an interim negative effect on revenues and operating income. The combination of reductions to the market basket updates and the imposition of the productivity adjustments may, in some cases and in some years, result in reductions in Medicare payments per discharge on a year-to-year basis.

- Also, through September 30, 2019, payments under the "Medicare Advantage" programs (Medicare managed care) have been and will continue to be restructured, which may result in increased premiums or out-of-pocket costs to Medicare beneficiaries enrolled in Medicare Advantage plans. Those beneficiaries may terminate their participation in those plans and opt for the traditional Medicare fee-for-service program. The reduction in payments to Medicare Advantage programs may also lead to decreased payments to providers by managed care companies operating Medicare Advantage programs. All or any of these outcomes will have a disproportionately negative effect upon those providers with relatively high dependence upon Medicare managed care revenues.

- Commencing October 1, 2012, a value-based purchasing program was established under the Medicare program that is designed to provide incentive payments to hospitals based on performance, quality and efficiency measures. These incentive payments are being funded through a pool of money collected from all hospital providers. Depending on its performance, the Obligated Group's revenues could decrease under a value-based purchasing program.

- State Medicaid disproportionate share hospital ("DSH") allotment from federal funds has also been reduced.

- Medicaid programs have been expanded to a broader population with incomes up to 133% of federal poverty levels. This has the impact of lowering the number of uninsured patients treated by the Obligated Group.

- Medicare payments to hospitals ranking high in the number of hospital-acquired conditions have been reduced. Effective July 1, 2011, federal payments to states for Medicaid services related to health care-acquired conditions are prohibited.

- Commencing October 1, 2013, Medicare DSH payments were reduced initially by 75%. DSH payments will be increased thereafter to account for the national rate of consumers who do not have health care insurance and are provided uncompensated care. Between 2015 and 2020, Medicaid DSH payments will be reduced by several billion dollars based on a complicated methodology.

- Commencing October 1, 2012, Medicare payments that would otherwise be made to hospitals that have a high rate of potentially preventable readmissions of Medicare patients for certain clinical conditions were reduced by specified percentages to account for those excess and "preventable" hospital readmissions.

- Under the Health Care Reform Act, health care insurers are required to include quality improvement covenants in their contracts with hospital providers, and are required to report their progress on such actions to the Secretary of Health and Human Services ("HHS"). Health care insurers will not be allowed to participate in the health insurance exchanges; unless, their contracting providers have implemented programs designed to ensure patient safety and enhance quality of care. The effect of these provisions upon the process of negotiating contracts with insurers or the costs of implementing such programs cannot be predicted.

- With varying effective dates, the Health Care Reform Act enhances the ability to detect and reduce waste, fraud and abuse in public programs through provider enrollment screening, enhanced oversight periods for new providers and suppliers, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. The Health Care Reform Act requires the development of a database to capture and share health care provider data across federal health care programs and provides for increased penalties for fraud and abuse violations and increased funding for anti-fraud activities. The changes have already resulted in increased enforcement activity by state and federal agencies and regulators.

- Under the Health Care Reform Act, additional requirements for tax-exemption are imposed upon tax-exempt hospitals, including obligations to adopt and publicize a financial assistance policy; limit charges to patients who qualify for financial assistance to the lowest amount charged to insured patients; and control the billing and collection processes. Additionally, tax-exempt hospitals must now conduct a community needs assessment and adopt an implementation strategy to meet those identified needs. Failure to satisfy these conditions may result in the imposition of fines and the loss of tax-exempt status.

- The Health Care Reform Act provides for the establishment of an Independent Payment Advisory Board (the "Board") to develop proposals to improve the quality of care and limitations on cost increases. Beginning January 15, 2019, if the Medicare growth rate exceeds the target, the Board is required to develop proposals to reduce the growth rate and require the Secretary of HHS to implement those proposals, unless Congress enacts legislation related to the proposals.

The Health Care Reform Act established a Medicare Shared Savings Program that seeks to promote accountability and coordination of care through the creation of Accountable Care Organizations ("ACOs"). The program will allow hospitals, physicians, and others to form ACOs and work together to invest in infrastructure and redesign integrated delivery processes to achieve high quality and efficient delivery of services. ACOs that achieve quality performance standards will be eligible to share in a portion of the amounts saved by the Medicare program. HHS has significant discretion to determine key elements of the program, including what steps providers must take to be considered an ACO, how to decide if Medicare program savings have occurred and what portion of such savings will be paid to ACOs. Nevertheless, it is anticipated that private insurers may seek to establish similar incentives for providers, while requiring less infrastructural and organizational change. The potential impacts of these initiatives are unknown, but introduce greater risk and complexity to healthcare finance and operations.

Additional Requirements for Federal Tax Exemption Pursuant to the Health Care Reform Act. The ACA added new Section 501(r) to the Code, which provides additional requirements that must be met by each tax-exempt hospital facility operated by a tax-exempt hospital organization (in addition to those required under Section 501(c)(3) of the Code), in order for the organization to maintain its tax-exempt status under Section 501(c)(3) of the Code. The requirements are related to community needs assessments, written policies regarding financial assistance and emergency medical care, limits on charges for care provided to patients eligible for financial assistance, and procedures related to billing and collections.

Effective for tax years commencing after March 23, 2010, additional requirements were authorized to be imposed upon tax-exempt hospitals (such as those operated by the Corporation) as a condition of maintaining their tax-exempt status. These requirements include, without limitation, the need to adopt and publicize a financial assistance policy; to limit charges to patients who qualify for financial assistance to the lowest amount charged to insured patients; and to control the billing and collection processes (the "Financial Rules"). Additionally, effective for tax years commencing after March 23, 2012, tax-exempt hospitals (such as those operated by the Corporation) must conduct a community needs assessment and adopt an implementation strategy to meet those identified needs at least once every three years (the "Needs Rules"). Noncompliance with the Needs Rules may result in the levy of an excise tax.

Effective for tax years beginning after December 29, 2015, the Treasury Department implemented final regulations (the "Final Regulations, regarding the Financial Rules and the Needs Rules. The Final Regulations provide that certain minor, inadvertent noncompliance with the Financial Rules and the Needs Rules due to reasonable cause will not result in the loss of the tax-exempt status of hospitals, while certain noncompliance that is neither willful nor egregious will not lead to the loss of tax-exempt status of the hospital if such non-compliance is publicly disclosed and corrected. The Final Regulations also provide that certain failures with respect to the Needs Rules will not result in an excise tax if such failure is minor and either inadvertent or due to reasonable cause; otherwise failure to comply with the Needs Rules will result in an excise tax. Other failures to satisfy the Financial Rules and the Needs Rules may result in the imposition of fines and the loss of the tax-exempt status of the hospital. The loss by the Corporation of its tax-exempt status could cause the loss of the tax-exemption of the interest on the Series 2017 Bonds.

The Final Regulations provide that the Financial Rules and the Needs Rules must be satisfied with respect to each individual hospital facility operated by a tax-exempt hospital organization. The Final Regulations provide that while a tax-exempt hospital organization will not lose its tax-exempt status solely because one of the hospital facilities it operates does not comply with the Financial Rules and the Needs Rules, the tax-exempt hospital organization will have to pay a facility-level tax with respect to any of its income derived from its non-compliant hospital facility. Additionally, the Final Regulations provide that the application of a facility-level tax to a noncompliant hospital facility will not, by itself, affect the tax-exempt status of bonds issued to finance such noncompliant hospital facility.

Management of the Corporation has taken appropriate measures to ensure that each applicable member of the Obligated Group is in compliance with the Financial Rules and the Needs Rules.

Federal Legislative and Regulatory Initiatives. Several of the federal statutes and regulations described under this heading **Bondholders' Risks** may be substantially modified or repealed in whole or in part. During the November 2016 elections, several successful candidates for election to the U.S. Congress and President Trump campaigned on promises to effect modification or repeal of statutes and regulations, some of which are described in this heading.

On May 4, 2017, the United States House of Representatives passed H.R. 1628, the American Health Care Act (the "AHCA") through a budget reconciliation process, which aims to amend or eliminate certain provisions of the Health Care Reform Act. For example, starting in 2020 the AHCA would end the Health Care Reform Act's enhanced federal funding for Medicaid expansion for new enrollees. See **Bondholder's Risks—Payment for Health Care Services—Medicaid**. It has been reported that it instead provides for the federal government to provide states with a fixed amount of money per Medicaid enrollee or a block grant under which states that opt in would get a fixed amount of federal funding per year regardless of how many enrollees are in the program. It is uncertain whether, as a result of the implementation of the AHCA, states, like Ohio, will be able to fund the difference between actual Medicaid costs and the federal funding they receive and whether they will choose to make up the difference by reducing Medicaid eligibility, curtailing certain Medicaid benefits or cutting payments to healthcare providers. Although the AHCA proposes to cut some current Medicaid funding, it does provide for the restoration of Medicaid disproportionate share hospital payments in 2018 for states that didn't expand Medicaid coverage under the Health Care Reform Act and in 2020 for states that did expand coverage under the Health Care Reform Act. Any decrease in federal or State Medicaid funding as a result of the AHCA may have a material adverse impact on the Obligated Group's operations, financial condition, and financial performance. See **Appendix A—Adena Health System and the Obligated Group—Key Financial Ratios of the Health System—Payor Mix**.

Other provisions in the AHCA may result in consumers paying more for their health insurance, which may lead to consumers not maintaining health insurance or foregoing comprehensive coverage for a plan that covers only certain heath care services at a lower consumer cost. This may cause an increase in uninsured and uncompensated care by health care providers, which may have a material adverse impact on the Obligated Group's operations, financial condition, and financial performance.

It is uncertain whether and when the AHCA will pass the United States Senate and become law. The Congressional Budget Office has not reviewed H.R. 1628, which it will need to do and to analyze its financial impact before the Senate can vote on it. If it does pass the Senate, it is uncertain whether the provisions in the AHCA passed by the Senate will be the same or different than those passed by the House of Representatives in H.R. 1628. If those provisions are different, it may require another vote from the House of Representatives.

Future legislative or regulatory action to modify or repeal additional portions of the Health Care Reform Act may be likely. It is also expected that legislation to effect tax reform and financial services reform, including rollback of the Dodd-Frank Wall Street Reform and Consumer Protection Act, is likely to be introduced during the current congressional term. It is not certain whether or when legislation relating to such key areas will be introduced or passed. Reform legislation, if introduced and passed, could have a material impact on the Obligated Group's operations, financial condition, and financial performance. In addition, regulatory changes through adoption or repeal and executive actions taken by the Trump administration could materially impact the Obligated Group's operations, financial condition, and financial performance, even in the absence of statutory changes.

Uncertainty of Revenues

As noted elsewhere, except to the extent that the holders of the Series 2017 Bonds are secured by proceeds of insurance, sale, or condemnation awards, the Series 2017 Bonds will be payable solely from payments or prepayments to be made by the Corporation under the Sublease and by the Obligated Group members on the Series 2017A Note. The ability of the Corporation to make payments of Basic Rent under the Sublease and by the Obligated Group to pay Bond Service Charges on the Series 2017A Note is dependent upon the generation by the Obligated Group members of revenues in the amounts necessary for the Obligated Group to pay Bond Service Charges on the Series 2017 Bonds, as well as other operating and capital expenses. The realization of future revenues and expenses is subject to, among other things, the managerial capability of the Corporation's management, government regulation, and future economic and other conditions that are unpredictable and may affect revenues and payment of debt service on the Series 2017 Bonds. No representation can be made or assurance can be provided that revenues will be realized by the Obligated Group at times or in amounts sufficient to make the required payments of Bond Service Charges on the Series 2017 Bonds.

Payment for Health Care Services

A substantial portion of the patient service revenues of the Obligated Group are derived from third-party payors, which reimburse or pay for the services and items provided to patients covered by such third parties for such services, including the federal Medicare program, state Medicaid programs and private health plans and insurers, health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), and other managed care payors. See **Appendix A—Adena Health System and the Obligated Group—Health System Financial and Operational Information—Payor Mix**. Many of these programs make payments to Obligated Group members at rates other than the direct charges of such Obligated Group members. Rates may be determined on a basis of other than actual costs incurred in providing services and items to such patients. Accordingly, there is no assurance that payments made under these programs will be adequate to cover the Obligated Group's actual costs of furnishing health care services and items. In addition, the financial condition and performance of the Obligated Group could be adversely affected by the insolvency of, or other delay in receipt of payments from, third-party payors.

Medicare and Medicaid Programs; General. Medicare and Medicaid are the two most common programs for government-reimbursed healthcare governed by certain provisions of the federal Social Security Act. Health care providers have been and will be affected significantly by changes in the last several years in federal and state health care laws and regulations, particularly those pertaining to Medicare and Medicaid. The purpose of much of the recent statutory and regulatory activity has been to reduce the rate of increase in health care costs, particularly costs paid under the Medicare and Medicaid programs.

Medicare. Medicare is a federal governmental health insurance system under which physicians, hospitals and other health care providers are reimbursed or paid directly for services provided to eligible elderly and disabled persons. Medicare is administered by the Centers for Medicare and Medicaid Services ("CMS") of HHS. To achieve and maintain Medicare certification, a health care provider must meet CMS's "Conditions of Participation" on an ongoing basis, as verified by the state in which the provider is located and/or one of the accreditation organizations having CMS deemed status, e.g. The Joint Commission, the Healthcare Facilities Accreditation Program, or DNV Healthcare Inc.

For the fiscal years ended December 31, 2015 and December 31, 2016, Medicare represented approximately 43.4% and 43.5%, respectively, of the Corporation and subsidiaries' gross patient service revenue before the provision for doubtful accounts. See **Appendix A— Adena Health System—Health System Financial and Operational Information—Payor Mix**. As a consequence, changes in the Medicare program may have a material effect on the Obligated Group. The cost of providing a unit of care may potentially exceed the compensation realized from Medicare for providing that service. Additionally, the aggregate costs to a provider of providing care to Medicare beneficiaries may potentially exceed aggregate Medicare payments received during the relevant fiscal year period. Reductions in Medicare reimbursement, or increases in Medicare reimbursement in amounts less than increases in the costs of providing care, may have a material adverse financial effect on the Obligated Group.

Under the Medicare hospital inpatient prospective payment system ("IPPS"), the amount paid to the provider for an episode of care is established by federal regulation and is not related to the provider's charges or costs of providing that care. Presently, hospital inpatient and outpatient services, skilled nursing care, and home health care are paid on the basis of a prospective payment system ("PPS"). Under the hospital IPPS, fixed payment amounts per inpatient discharge are established based on the patient's assigned diagnosis related group, or DRG. DRGs classify treatments for illnesses according to the estimated intensity of hospital resources necessary to furnish care for each principal diagnosis.

The Secretary of HHS is required to review annually the DRG categories to take into account any new procedures, reclassify DRGs, and recalibrate the DRG relative weights that reflect the relative resources used by hospitals with respect to discharges classified within a given DRG category. The Obligated Group may not be paid amounts that will adequately reflect changes in the cost of providing health care or in the cost of health care technology being made available to patients. CMS may only adjust DRG weights on a budget-neutral basis.

From time to time, the factors used in calculating the prospective payments for units of service are modified by CMS, which may change revenues for particular services. Additionally, as part of the federal budgetary process, Congress has regularly amended the Medicare law to reduce increases in payments that are otherwise scheduled to occur, or to provide for reductions in payments for particular services. Similarly, federal legislation is regularly passed that affects payments made under the IPPS. For example, such legislation may add or eliminate categories of funding. These actions could adversely affect the revenues of the Obligated Group.

Similar to PPS for inpatient operating costs, CMS has been implementing a prospective system in order to reimburse hospitals for their capital costs (including depreciation, interest, taxes, and similar expenses) related to the provision of inpatient services to Medicare beneficiaries. Inpatient capital costs are reimbursed exclusively on the basis of a standard federal rate, which is based on the weighted average capital costs per discharge incurred by all hospitals. Capital cost payments will be based on the federal rate times the DRG weight for the particular discharge, subject to certain adjustments and add-on amounts which are specific to the particular hospital. There can be no assurance that the inpatient capital cost prospective payments will be sufficient to cover the actual capital costs to the Corporation allocable to

Medicare beneficiary stays, or will provide adequate flexibility in meeting the Corporation's future capital needs.

Hospital outpatient services, including hospital operating and capital costs, are reimbursed under an outpatient prospective payment system ("OPPS") basis. Several services are specifically excluded from this rule, including certain physician and non-physician practitioner services, ambulance, clinical diagnostic laboratory services and non-implantable orthotics and prosthetics, physical and occupational therapy, and speech pathology services. Under the OPPS, predetermined amounts are paid for designated services furnished to Medicare beneficiaries. CMS classifies outpatient services and procedures that are comparable clinically and in terms of resource use into Ambulatory Patient Classification ("APC") groups. Using hospital outpatient claims data from the most recent available hospital cost reports, CMS determines the geometric mean costs for the services and procedures in each APC group. Subsequently, a payment rate is established for each APC. Depending on the services provided, a hospital may be paid for more than one APC for a patient visit.

OPPS rates are adjusted annually (on a calendar year schedule) based on the hospital inpatient market basket percentage increase. In the final 2017 OPPS rule, CMS authorized a 1.65% increase in payment rates, reflecting a market basket increase of 2.7%, a 0.3% offset for multifactor productivity, and an additional reduction of 0.75% required by the Health Care Reform Act. Hospitals that fail to report data related to numerous required quality measures will have their market basket percentage increase reduced by 2.0%, resulting in a negative adjustment of 0.35% for calendar year 2017. There cannot be any assurance that the hospital OPPS rate, which bases payment on APC groups rather than on individual services, will be sufficient to cover the actual costs of the Obligated Group allocable to patient care.

In addition to the APC rate, there is a predetermined beneficiary coinsurance amount for each APC group. CMS projects the overall beneficiary coinsurance for OPPS services to be 18.5% in 2017. There cannot be any assurance that the beneficiary will pay this amount.

The OPPS final rule for calendar year 2011 also implemented several provisions of the Health Care Reform Act that may impact the reimbursement and operations of hospitals across the country. These provisions continue to be implemented by CMS in the 2017 OPPS final rule.

Various additional payments may be made to individual providers. Hospitals that treat a disproportionately large number of low-income patients (Medicaid and Medicare patients eligible to receive supplemental Social Security income) currently receive additional payments in the form of disproportionate share payments. See the discussion on DSH payments above. Additional payments are made to hospitals that treat patients who are costlier to treat than the average patient; these additional payments are referred to as "outlier payments." Eligible hospitals are paid for a portion of their direct and indirect medical education costs. Providers may also apply for certain additional payments relating to new technology. Any and all additional payments described in this Official Statement are subject to reductions and modifications or other changes.

The Bipartisan Budget Act of 2015 (the "BBA 2015") changes the reimbursement available for off-campus hospital outpatient departments ("HOPDs") and will likely result in reduced Medicare payments for non-emergency services performed at certain HOPDs. Specifically, Section 603 of the BBA 2015 provides that, starting January 1, 2017, off-campus HOPDs established on or after November 2, 2015, will no longer be eligible for payment under the OPPS for non-emergency services. Instead, non-emergency services performed at these facilities will be paid under the Ambulatory Surgical Center Payment System or the Physician Fee Schedule. Notably, while HOPDs that currently bill under the OPPS are "grandfathered" for purposes of these provisions, and while BBA 2015 does not affect the ability of on-campus facilities to continue to be paid under OPPS, off-campus HOPDs that are currently

under development, but not yet billing under the OPPS, will not be protected from the change in reimbursement. The reimbursement changes implemented under Section 603 will likely have a significant impact on the financial performance of many HOPDs which are not located on a hospital's main campus.

Medicare Audits. Hospitals participating in Medicare are subject to audits and retroactive audit adjustments with respect to reimbursement claimed under the Medicare program. The Obligated Group members receive payments for various services provided to Medicare patients based upon charges or other reimbursement methodologies that are then reconciled annually based upon the preparation and submission of annual cost reports. Estimates for the annual cost reports are reflected as amounts due to/from third-party payors and represent several years of open cost reports due to time delays in the fiscal intermediaries audits and the basic complexity of billing and reimbursement regulations. These estimates are adjusted periodically based upon correspondence received from the fiscal intermediary. Medicare regulations also provide for withholding Medicare payment in certain circumstances if it is determined that an overpayment of Medicare funds has been made. In addition, under certain circumstances, payments may be determined to have been made as a consequence of improper claims subject to the Federal False Claims Act or other federal statutes, subjecting the Obligated Group Members to civil or criminal sanctions. Management of the Corporation is not aware of any situation in which the withholding of a Medicare payment from any Obligated Group member would have a material adverse effect on the financial condition or performance of the Obligated Group.

Management of the Corporation does not anticipate that Medicare audits or cost report settlements for the Medicare program will materially adversely affect the financial condition or performance of the Obligated Group; however, in light of the complexity of the regulations relating to the Medicare program, and the threat of ongoing investigations as described above, there cannot be any assurance that significant difficulties will not develop in the future.

The Health Care Reform Act amended certain provisions of the Federal False Claims Act and added provisions regarding the timing of the obligation to reimburse overpayments. The effect of these changes on existing programs and systems of the members of the Obligated Group cannot be predicted, although management of the Corporation does not believe that the effect on the financial condition or performance of the Obligated Group will be materially adverse.

RAC Reviews. The federal Recovery Audit Contractor ("RAC") program seeks to identify and recover overpayments made by Medicare to medical providers, including hospitals. Under the RAC program, reviews look for Medicare overpayments to hospitals and require immediate repayment to Medicare. Since their inception, the audits have advanced to include reviews of medical necessity. Under the Health Care Reform Act, recovery audits were expanded to include Medicaid by requiring states to contract with RACs to conduct such audits.

Management of the Corporation is not aware of a situation in which a Recovery Audit, if conducted and resulting in a payment to be made by the Obligated Group, would materially adversely affect the financial condition or performance of the Obligated Group. However, in light of the complexity of the regulations relating to the Medicare program and the ongoing threat of audits, there cannot be any assurance that an audit would not materially adversely affect the financial condition or performance of the Obligated Group.

Physician Payment. Physicians may elect to "participate" or enroll in the Medicare program as a provider. Medicare Part B provides reimbursement for physician services, including employed and provider-based physicians, based upon a national fee schedule called the Resource-Based Relative Value Scale ("RBRVS"). Under the RBRVS system, payments for services are determined by the "resource

costs" necessary to provide such services. Payments also are adjusted for geographical differences. The costs have three components: physician work, practice expense, and professional liability insurance. Payments are calculated by multiplying the combined costs of a service by a conversion factor. 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-services enrollment, input prices, spending due to law and regulation, and gross domestic product over a 10-year period, effectively changing the RBRVS on an annual basis.

The RBRVS system encourages a shift towards greater reimbursement for the provision of primary care, and a reduction of technology-based diagnostic procedures and surgical procedures. This continued shift in payment emphasis may affect the relationship between the Obligated Group members and their medical staff and may increase pressure on the Obligated Group members to enter into bundled or global payment models, risk-based delivery models, or increase demands by physicians for payment from hospitals. Currently, it is projected that RBRVS will have negative updates for the next few years. There is no guarantee that reimbursement under RBRVS will cover the Obligated Group's actual costs of providing physician services to Medicare beneficiaries.

The Health Care Reform Act included several changes to Medicare and Medicaid payments for physician services, including the following:

- Making grants to and contracting with interdisciplinary "health teams" that support primary care practices who agree to serve as their patients' "medical home" by being accountable for providing integrated, accessible services that meet a large majority of the patient's health needs through a sustained partnership with patients.

- Reporting to physicians their costs of utilization of resources per episode of care in comparison to their peers.

- Integrating reporting requirements concerning the meaningful use of electronic health records into the Physician Quality Reporting System ("PQRS").

- Establishing payment penalties for physicians who fail to file PQRS reports.

- Developing a system of "value-based payment modifiers" for physicians.

- Requiring state Medicaid programs to pay primary care physicians not less than 100% of the Medicare payment rate, for 2013 and 2014. Congress did not extend this requirement beyond 2014.

Although most of the provisions of the Medicare Physician Fee Schedule ("MPFS") directly affect payments provided under the physician fee schedule, the MPFS final rules also typically address a number of policies that are not directly related to that payment system. Each year the MPFS contains provisions implementing new legislative initiatives, including implementing the Health Care Reform Act, which may impact the reimbursement levels of hospitals, such as: (a) identification and review of potentially misvalued codes; (b) expansion of the multiple procedure payment reduction policy for advanced imaging services; (c) methodology for determining the productivity adjustment for ambulatory surgical centers, clinical laboratory services, and the durable medical equipment fee schedule; (d) revisions to the practice expense methodology; (e) bundling of payments for services provided to outpatients who are later admitted as inpatients and limiting payments for office visits in physician offices owned by hospitals or their subsidiaries to the amount that would be paid if those services were furnished in a hospital, without any compensation for overhead costs (i.e., the 3-day payment window policy); (f)

hospital discharge care coordination; (g) developing two new post-discharge transitional care management codes; (h) adding and removing new CPT payment codes; and (i) continuing to tweak the Physician Quality Reporting System.

Physicians who opt not to participate in the Medicare program also may provide care to Medicare beneficiaries, but will be reimbursed at a lower fee schedule. Regardless of physician enrollment status, physicians who furnish health care services to Medicare beneficiaries must meet all applicable federal coding, documentation, and other compliance requirements.

Medical Education Payments. Medicare currently pays for a portion of the direct and indirect costs of medical education (including the salaries of residents and teachers and other overhead costs directly attributable to approved medical education programs). Payment for the direct costs of medical education ("GME") is made on a "pass-through" basis, not a prospective payment system basis, based on a formula that reflects the hospital's base year per-resident costs adjusted by inflation and the number of current-year reimbursable resident positions. Payment for indirect costs of medical education ("IME") is based on the ratio of a hospital's number of full-time equivalent residents to its number of available beds. Due to budget-balancing and entitlement program reduction efforts at the Congressional level, these payments may be vulnerable to reduction or elimination in the future. Further, there is no explicit assurance that payments to the Obligated Group Members for providing medical education will be sufficient to cover the costs associated with their medical education programs.

Medicaid. Medicaid, a health insurance program for certain low-income and needy individuals, is jointly funded by the federal government and the states. Pursuant to broad federal guidelines, each state establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the payment rates for services; and administers its own programs.

For the fiscal years ended December 31, 2015 and December 31, 2016, the Corporation and its subsidiaries received approximately 26.7% and 27.0% per year, respectively, of gross patient service revenues from the Ohio Medicaid program and Medicaid managed care. See **Appendix A—Adena Health System and the Obligated Group—Health System Financial and Operational Information—Payor Mix**.

Under the Medicaid program, the federal government supplements funds provided by the various states for medical assistance to the medically indigent. Payment for medical and health services is made to providers in amounts determined in accordance with procedures and standards established by state law under federal guidelines. Fiscal considerations of both federal and state governments in establishing their budgets will directly affect the funds available to the providers for payment of services rendered to Medicaid beneficiaries.

Payment for Medicaid patients is subject to appropriation by the respective state legislatures of sufficient funds to pay the incurred patient obligations. The federal government continues to explore options for a long-term solution to the funding difficulties with Medicaid. Certain additional proposals being examined may ultimately result in reduced federal Medicaid funding to the states, which could adversely impact the amount of revenue received by the Obligated Group.

The Health Care Reform Act made changes to Medicaid funding and substantially increased the potential number of Medicaid beneficiaries (thereby bringing potential reduction to the amount of charity care expense to providers), as well as temporary federal financial support for that increased enrollment, and expanded the RAC Medicare program to include Medicaid, using state-based RAC contracts. Due to the varied complexities and interrelations among these changes, management cannot predict the effect of

these changes to the Medicaid program on the financial condition, performance or operations of the Obligated Group.

Ohio Medicaid. The Medicaid program is administered in Ohio by its Department of Job and Family Services ("ODJFS"). Payments made to health care providers under the Medicaid program are subject to change as a result of federal or State legislative and administrative actions, including changes in the calculation methods for payments, the amount of payments made for covered services and the types of services covered under the program. Such changes have occurred in the past and may be reasonably expected to occur in the future, particularly in response to federal and State budgetary constraints. The Ohio Medicaid program provides comprehensive primary and acute care medical services through a managed care system or, for certain statutorily-excluded individuals, a fee-for-service system. Both the managed care and fee-for-service delivery system provide all medically necessary primary care, specialty and emergency care, and preventive services. Ohio Medicaid also provides both home health care and facility-based services for eligible parties requiring long-term care.

Ohio has implemented a Medicaid managed care program (the "MCP") that is mandatory for most Ohio Medicaid enrollees. The MCP has three service regions and five managed care plans to provide services to Ohio Medicaid beneficiaries. As a result of the implementation of the MCP and other Ohio Medicaid reimbursement methodologies limiting or reducing payments to providers of Medicaid services and continuing Ohio budgetary cutbacks reducing the levels of benefits paid, there cannot be any assurance that the payments for services provided by the Obligated Group to Ohio Medicaid patients will be sufficient to cover the actual costs of providing such services.

In Ohio, the federal backed Medicaid expansion has become the subject of a legal dispute between the Governor and the General Assembly. After the General Assembly failed to pass legislation authorizing the expansion of Medicaid, Ohio's Medicaid administration approved the expansion of Medicaid, and on October 21, 2013, Ohio's seven-member Controlling Board voted to accept federal money to pay for such expansion. Six members of the General Assembly subsequently filed a lawsuit challenging the authority of the board to accept federal money for the Medicaid expansion. On December 20, 2013, the Ohio Supreme Court held that the Controlling Board acted lawfully in approving the Ohio Department of Medicaid's request to accept the federal match funds to expand Medicaid.

Reimbursement for care provided to Ohio Medicaid patients is subject to appropriation by the Ohio legislature of sufficient funds to pay incurred patient obligations. With respect to the MCP, managed care plans are paid a premium by the State for each enrollee to direct their care. While managed care plans are required to cover the same medically necessary services that the Medicaid fee for service program offers, managed care plans reimbursement rates are negotiated and established between the managed care plans and the provider as opposed to fee-for-service systems, under which Ohio hospitals are reimbursed for Medicaid inpatient services under a DRG prospective payment system on a per discharge basis. Under that system, payments vary depending on the DRG and peer group to which the case is assigned, the size and cost of a hospital's medical education program, if applicable, and certain other factors. With respect to nursing facilities, prospective rates are established based upon the sum of the allowable per diems for: direct care, other projected costs, indirect care, and capital costs. As a result of the implementation of the MCP in Ohio, other Ohio Medicaid reimbursement methodologies limiting provider payments and continuing Ohio budget cuts reducing the benefit payment levels, there cannot be any assurance that the payments for services provided by Obligated Group members to Ohio Medicaid patients will be sufficient to cover the actual costs of providing such services to such Medicaid beneficiaries.

Capitated Payments. Under the traditional fee-for-service method of health care delivery, hospitals, physicians, and other providers are reimbursed on a per-service basis and thus have a financial

incentive to provide more services, which, in turn, generate more revenue. Under a capitated payment arrangement, in contrast, providers are reimbursed on a "per member, per month" basis; the provider bears some or all of the risk if the cost of services provided exceeds the amount of the capitation payments. This creates an incentive to control utilization of services.

Capitated contracts may cover hospital and professional services separately, or together as "full-risk" contracts. In either case, the provider assumes financial responsibility for the provision of covered health care services to enrollees under such contracts. The financial risk of such arrangements for a hospital is increased by a variety of factors, including, but not limited to, the following: utilization of facilities and services by enrollees above expected levels; increases in the hospital's cost of providing health care services; increases in the cost of emergency care provided by out-of-area providers; increases in the cost of tertiary care provided by providers other than the hospital; and the size or demographic makeup of the enrollee pool. Insufficient information regarding historical costs, utilization, or other factors or inability to manage care jointly with other providers (including physicians) may adversely affect a network's ability to manage the risks of a capitated payment arrangement. Any hospital or healthcare provider that elects to participate in a capitated contract will bear some or all of the financial risk that the capitated payments may not be sufficient to fully cover the cost of covered health care services of the enrollees.

Children's Health Insurance Program

The Children's Health Insurance Program ("CHIP") is a federally funded insurance program for families which are financially ineligible for Medicaid, but cannot afford commercial health insurance. CMS administers CHIP, but each state creates its own program based upon minimum federal guidelines. CHIP insurance is provided through private health plans contracting with the state. Each state must periodically submit its CHIP plan to CMS for review to determine if it meets the federal requirements. If it does not meet the federal requirements, a state can lose its federal funding for the program.

Commercial Insurance and Other Third-Party Plans

Managed Care. For the fiscal years ended December 31, 2015 and December 31, 2016, managed care accounted for approximately 27.9% and 27.4%, respectively, of the gross patient revenues of the Corporation and its subsidiaries. See **Appendix A—Adena Health System and the Obligated Group—Health System Financial Operational Information—Payor Mix**. Commercial insurance plans generally negotiate payment rates that are substantially less than facility charges. There cannot be any assurance that the members of the Obligated Group will maintain commercial contracts or obtain other similar contracts in the future. Failure to maintain contracts could reduce the market share of an Obligated Group member and its net patient services revenues.

The Obligated Group member's ability to develop and expand their services and, therefore, profitability, is dependent upon their ability to enter into contracts with third-party payors at competitive rates. However, recent economic conditions have resulted in lower rate increases from commercial health care insurers. In addition, there cannot be any assurance that Obligated Group members will be able to attract third-party payors, or that, if they do, the Obligated Group members will be able to contract with such payors on advantageous terms. If the Obligated Group members are unable to contract with a sufficient number of such payors on advantageous terms, it could have a material adverse effect on the Obligated Group members' financial condition and performance.

The Health Care Reform Act imposes, over time, increased regulation of the insurance industry, the use and availability of state-based exchanges in which health insurance can be purchased by certain groups and segments of the population, the extension of subsidies and tax credits for premium payments

by some consumers and employers, and the imposition upon commercial insurers of certain terms and conditions that must be included in contracts with providers. In addition, the Health Care Reform Act imposes many new obligations on states related to health care insurance. Due to the uncertainty surrounding the Health Care Reform Act as previously described, there is no guarantee that it will be implemented as described in this Official Statement. It is unclear how the increased federal oversight of state health care may affect future state oversight or affect the Obligated Group. The effects of these changes on the financial condition of any third-party payor that offers health care insurance, the rates paid by third-party payors to providers such as Members of the Obligated Group, and upon the financial condition and performance of the Obligated Group cannot be predicted.

In many markets, including those in which members of the Obligated Group operate, managed care organizations ("MCOs"), such as health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), point of service providers ("POS"), and consumer-driven care and similar arrangements for health care payment have largely replaced indemnity insurance as the prime source of nongovernmental payment for hospital services. MCOs generally use discounts, risk-transfer mechanisms, and other economic incentives to reduce or limit the cost and utilization of health care services, including inpatient hospital care. Payments to the Obligated Group from MCOs typically are lower than those received from traditional indemnity/commercial insurers. There is no assurance that the Obligated Group will maintain managed care contracts or obtain similar contracts in the future. Failure to maintain such contracts could reduce the Obligated Group's market share and net patient services revenues and have a material adverse effect on the financial condition and performance of the Obligated Group. Conversely, participation may maintain or increase the Obligated Group's patient base but could result in lower net operating income or operating losses if the Obligated Group is unable to adequately contain costs.

Under a PPO arrangement, there generally are financial incentives for subscribers to use only those hospitals or providers which contract with the PPO. Under most HMO plans, private payors limit coverage to those services provided by selected hospitals. With this contracting authority, private payers, including health plans and HMOs, may direct patients away from non-selected hospitals by denying coverage for services they provide.

Under a POS arrangement, there are financial incentives for subscribers to use a closed panel of hospitals or providers, but subscribers also are able to use hospitals or providers that do not contract with the network. Use of such non-contracting hospitals or providers requires increased financial contribution from the subscribers, typically in the form of increased coinsurance or deductible payments. Nationally, the popularity of POS and PPO plans has increased while the traditional closed panel HMO has lost popularity.

Under a consumer-directed care arrangement, the consumer generally purchases a high deductible health insurance policy that provides coverage only after the consumer has expended several thousand dollars personally on care. Under federal income tax rules, health savings accounts provide substantial tax relief for those funds actually spent by consumers on their health care. Therefore, patients and not payors or employers determine where to obtain care, and how much to spend on such care. This may lead to a lessening of importance of private commercial payors.

Obligated Group Members have entered into contractual arrangements with PPOs and HMOs pursuant to which the Obligated Group agrees to perform certain health care services for eligible participants at discounted rates. Most PPOs and HMOs currently pay hospitals on a discounted fee-for-service basis or on a fixed rate or episode per day of care. The Obligated Group may not have complete information about its actual costs of providing specific types of care, particularly since each patient presents a different mix of services and length of stay. Consequently, the discounts offered to HMOs and

PPOs may result in payment at less than actual cost and the volume of patients directed to a hospital may vary significantly from projections. Changes in utilization of certain services may be dramatic and unexpected.

As MCOs become more prevalent, hospitals must be capable of attracting and maintaining managed care business, often on a regional basis. There cannot be any assurance that contracts entered into by members of the Obligated Group with MCO payors will be renewed by such payors upon expiration thereof or will not be terminated prior to expiration thereof. As a consequence of such factors, the effect of managed care on the Obligated Group's future financial condition and performance is difficult to predict and not necessarily indicated by the effect in recent periods.

Regulatory Environment

Enforcement Activity. Enforcement activity against health care providers has increased, and enforcement authorities have adopted aggressive approaches. In the current regulatory climate, it is anticipated that many hospitals and physician groups will be subject to an audit, investigation, or other enforcement action regarding the health care fraud laws mentioned below.

Enforcement authorities are often in a position to influence settlements by providers charged with, or being investigated for, false claims violations by withholding or threatening to withhold Medicare, Medicaid, and/or similar payments and/or by instituting criminal action. In addition, the cost of defending such an action, the time and management attention consumed, and the facts of a case may strongly influence the decision to enter into a settlement. Because of the leverage available to enforcement authorities and the reputational and business damage of a prolonged or publicized investigation, whatever the outcome, and regardless of the merits of a particular case, a hospital could experience materially adverse settlement costs, as well as materially adverse costs associated with implementation of a settlement agreement.

Certain acts or transactions may result in violation or alleged violation of a number of the federal health care fraud laws described below, and therefore penalties or settlement amounts often are compounded. Generally these risks are not covered by insurance. Enforcement actions may involve multiple hospitals in a health system, as the government can, under certain circumstances, expand enforcement actions regarding health care fraud to other hospitals in the same organization. Therefore, Medicare fraud-related risks identified as being materially adverse as to a hospital could have materially adverse consequences to a health system taken as a whole. The Obligated Group is not on notice of any such adverse incidents or investigations.

Medicare Conditions of Participation; Utilization Review. Hospitals must comply with standards called "Conditions of Participation" in order to be eligible for Medicare and Medicaid reimbursement. CMS is responsible for ensuring that hospitals meet these regulatory Conditions of Participation. Failure to comply with any of the Conditions of Participation could result in the loss of monies received pursuant to the Medicare and Medicaid program or loss of eligibility to participate in the Medicare and Medicaid programs. Such losses could have a negative effect on the financial condition and results of operations of the Corporation.

The Secretary of HHS is required to exclude from program participation for not less than five years any individual or entity who has been convicted of a criminal offense relating to the delivery of any item or service reimbursed under Medicare or a state healthcare program; any criminal offense relating to patient neglect or abuse in connection with the delivery of healthcare; a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other misdemeanor in connection with the delivery of healthcare services financed or with respect to any act or omission in a healthcare program (other than

Medicare or a state healthcare program) operated by or financed in whole or in part by a governmental agency; or a felony offense relating to the illegal manufacture, distribution, prescription, or dispensing of a controlled substance. The Secretary also has permissive authority to exclude individuals or entities under certain other circumstances, such as a misdemeanor conviction for fraud in connection with delivery of healthcare services or conviction for obstruction of an investigation of a healthcare violation. The minimum period of exclusion for certain permissive exclusions is three years.

To participate in the federal Medicare program, the Corporation is required to be reviewed by a utilization and quality improvement organization ("QIO"). Unlike previous review procedures by other professional-standards-review organizations, QIO reviews may not be delegated to hospitals, and certain non-emergency procedures are subject to preadmission review. The QIO may recommend denial of payment, and in certain circumstances, suspension or termination of participation in Medicare, for unnecessary, substandard, or inappropriate medical care. See also **Licensing, Surveys, Investigations, and Audits** below.

Licensing, Surveys, Investigations and Audits. Health facilities, including those of the Obligated Group, are subject to numerous legal, regulatory, licensing, professional certification, and private accreditation requirements. These include, but are not limited to, requirements relating to Medicare Conditions of Participation, requirements for participation in Medicaid, state licensing agencies, private payors, and the accreditation standards of various organizations, including The Joint Commission, the Healthcare Facilities Accreditation Program, and DNV Healthcare, Inc. Renewal and continuation of certain of these licenses, certifications, and accreditations are based on inspections, surveys, audits, investigations, or other reviews, some of which may require affirmative action.

Management of the Corporation does not currently anticipate any difficulty in renewing or continuing currently held licenses, certifications, and accreditations, nor does management of the Corporation anticipate a reduction in third-party payments from events that would materially adversely affect the financial condition or performance of the Obligated Group. Nevertheless, adverse actions in any of these areas could result in the loss of utilization or revenues or the ability to operate all or a portion of its health care facilities and, consequently, could have a material and adverse effect on financial condition and performance of the Obligated Group.

Negative Rankings Based on Clinical Outcomes, Cost, Quality, Patient Satisfaction, and Other Performance Measures. Health plans, Medicare, Medicaid, employers, trade groups, and other purchasers of health services, private standard-setting organizations, and accrediting agencies increasingly are using statistical and other measures in efforts to characterize, publicize, compare, rank, and change the quality, safety, and cost of health care services provided by hospitals and physicians. Published rankings such as "score cards," "pay for performance," "never events," and other financial and non-financial incentive programs are being introduced to affect the reputation and revenue of hospitals and the members of their medical staffs and to influence the behavior of consumers and providers. Currently prevalent are measures of quality based on clinical outcomes of patient care, reductions in costs, patient satisfaction, and investment in health information technology. Measures of performance set by others that characterize a hospital negatively may adversely affect its reputation and financial condition and performance.

Civil and Criminal Fraud and Abuse Laws and Enforcement. Federal and state health care fraud and abuse laws regulate both the provision of services to government program beneficiaries (and sometimes to individuals insured by private payors) and the methods and requirements for submitting claims for services rendered to such beneficiaries. Under these laws, individuals and organizations can be penalized for submitting claims for services that are not provided, billed in a manner other than as actually provided, not medically necessary, provided by an improper person, accompanied by an illegal

inducement to utilize or refrain from utilizing a service or product, or billed in a manner that does not otherwise comply with applicable legal requirements.

Federal and state governments have a range of criminal, civil and administrative sanctions available to penalize and remediate health care fraud and abuse, including exclusion of the provider from participation in the Medicare/Medicaid programs, criminal fines, civil monetary penalties, and suspension of payments and, in the case of individuals, imprisonment. Fraud and abuse cases may be prosecuted by one or more government entities and/or private individuals, and more than one of the available penalties may be imposed for each violation. Based upon the prohibited activity in which the provider has engaged, governmental agencies and officials may bring actions against providers under civil or criminal False Claims Acts, the Anti-Kickback Statute, and state statutes prohibiting referrals for compensation or fee-splitting. The civil and criminal monetary assessments and penalties arising out of such investigations and prosecutions may be substantial. Additionally, the provider may be denied participation in federal health care programs. The Health Care Reform Act significantly increased funding for enforcement efforts under these laws, and authorized the Secretary of HHS to suspend payments to a provider pending an investigation of a credible allegation of fraud against the provider.

Laws governing fraud and abuse apply to all individuals and health care enterprises with which a hospital does business, including other hospitals, home health agencies, long term care entities, infusion and pharmaceutical providers, insurers, health maintenance organizations, preferred provider organizations, third party administrators, physicians, physician groups, and physician practice management companies. Fraud and abuse prosecutions can have a materially adverse effect on a provider and on the financial condition of other entities in the health care delivery system of which that entity is a part.

The Obligated Group has internal policies and procedures and a compliance program that management of the Corporation believes will effectively reduce exposure liability for violations of these laws. However, because these laws are complex, enforcement efforts presently are widespread and expanding within the industry, and because those efforts may vary from region to region, there cannot be any assurance that the compliance program will not significantly reduce or eliminate the exposure of the Obligated Group to civil or criminal sanctions or adverse administrative determinations.

Federal Self-Referral Law. The federal physician self-referral law (commonly known as the "Stark Law") prohibits referrals by a physician for Medicare-covered "designated health services" ("DHS") to certain organizations in which such physician, a physician's immediate family or an applicable physician organization has a financial relationship, unless an exception applies. DHS include the following: clinical laboratory services; physical therapy services; occupational therapy services; certain radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services; radiation therapy services and supplies; durable medical equipment and services; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. The Stark Law also prohibits the furnishing entity from submitting a claim for reimbursement or otherwise billing Medicare or any other person or entity for improperly referred DHS. Ohio also has a state physician self-referral law.

An entity that submits a claim for reimbursement in violation of the Stark Law must refund any amounts collected and may be (1) subject to a civil penalty of up to $15,000 for each prohibited self-referred service, and (2) excluded from participation in federal health care programs. In addition, a physician or entity that has participated in a "scheme" to circumvent the operation of the Stark Law is subject to a civil penalty of up to $100,000 and possible exclusion from participation in federal health care programs.

The Stark law has a significant influence on the structure and operation of hospital systems through its regulation of physician financial relationships. While the Stark law was intended to provide bright lines on how to structure physician arrangements, the law's complexity and breadth has instead created some unclear boundaries. Thus, it is challenging for even the most sophisticated health care providers to remain completely compliant with the Stark law in all circumstances. And since the government does not need to prove intent by a provider to violate the law, a technical violation of the Stark law can trigger significant financial penalties.

CMS, the federal agency with primary responsibility for enforcement of the Stark Law has, over the years, published a number of regulations interpreting the Stark Law. CMS, on September 23, 2010, published a self-referral disclosure protocol ("SRDP") pursuant to Section 6409(a) of the Health Care Reform Act. The SRDP sets forth a process to enable providers of services and suppliers to voluntarily self-disclose actual or potential violations of the Stark Law. Additionally, Section 6409(b) of the Health Care Reform Act gives the Secretary of HHS the authority to reduce the amount due and owing for violations under the Stark Law.

The Stark statute is a "strict liability" statute, and, because of its complexity, is relatively easy to violate, even if such violation is inadvertent and unintentional. For example, an arrangement may be deemed to violate the Stark statute by virtue of relatively minor technical issues, such as a lack of appropriate signatures. Matters of technical noncompliance may lead a provider to choose to self-disclose such noncompliance and may subject the provider to fines and penalties.

The Corporation provides for monitoring of the agreements that members of the Obligated Group enter into with physicians and physician organizations. Those types of agreements entered into throughout Adena Health System are routinely reviewed and audited, and those reviews and audits have resulted occasionally in the voluntary, self-disclosure by a member of the Obligated Group to federal authorities of unintentional, non-compliance with federal regulatory requirements. The number of non-compliant agreements identified and self-disclosed is a small percentage of the total number of agreements reviewed, and any potential claims associated with non-compliant agreements either have been settled, or, in the case of any agreements known to management of the Corporation to be non-compliant, but as to which a settlement has not yet occurred, in the view of the Corporation's management, after consultation with legal counsel, will be settled, on terms that do not have a material adverse effect on the operations or condition, financial or otherwise, of the Obligated Group.

Anti-kickback Laws. The federal Anti-Kickback Statute prohibits knowingly and willfully offering, paying, soliciting, or receiving, directly or indirectly, anything of value if the purpose is "to induce" the recipient to (1) refer, order, recommend, or purchase an item or service for which payment may be made under a federal health care program such as Medicare or Medicaid, or (2) arrange for someone else to do so. Unlike the Stark Law, this statute is not limited to physicians. An arrangement that is intended to induce referrals violates this statute even when the payment is not directly related to the volume or value of referrals and there is no agreement to make referrals. The law contains certain exceptions. One of the exceptions is for payments to bona fide employees for employment in the provision of Medicare and Medicaid-covered items and services.

Anyone convicted of violating the federal Anti-Kickback Statute can be imprisoned for up to five years, fined up to $25,000 for each offense, and lose status as a Medicare/Medicaid provider. The fine may be increased to $250,000 for individuals and $500,000 for organizations. The State has a similar law applicable to items and services covered by commercial insurance or other private health benefit plans. In addition, the Office of Inspector General ("OIG") of HHS has the authority to impose civil assessments and fines and to exclude hospitals engaged in prohibited activities from the Medicare, Medicaid, TRICARE (a healthcare program providing benefits to dependents of members of the uniformed

services), and other federal healthcare programs for not less than five years. In addition to certain statutory exceptions to the Anti-Kickback Statute, the OIG has promulgated a number of regulatory "safe harbors" under the Anti-Kickback Statute designed to protect certain payment and business practices.

The Obligated Group maintains a compliance program for these types of arrangements, and has an established process in place to analyze any such relationships that the Obligated Group enters into, including an evaluation of the fair market value of the arrangement as well as evaluation by counsel of the legal and regulatory risks of the arrangement, and board committee approval. The process, which was set up with the assistance of outside counsel, also mandates additional checks and balances for more important relationships, including the requirement of prospective determination of fair market value by an independent valuation firm and analysis of legal and regulatory risks by outside counsel.

False Claims Laws. The federal criminal false claims law prohibits anyone from knowingly causing any bill or other information to be submitted to Medicare or Medicaid that is false or misleading. Violators can be imprisoned for up to five years. A similar law prohibits knowing and willful attempts to defraud in connection with any health care benefits (not merely governmental benefits). Violators can be imprisoned for up to 10 years (20 years if serious bodily injury results). Violators of either law can be fined up to $250,000 per violation ($500,000 for corporations) or double the amount of any resulting loss, whichever is greater, and/or excluded from federal programs.

The federal civil False Claims Act ("FCA") makes it illegal to knowingly or willingly submit or present a false, fictitious or fraudulent claim to the federal government. Violators are liable for a civil penalty ranging from $5,500 to $11,000 per claim. Pursuant to Civil Monetary Penalties Inflation Adjustment which became effective August 1, 2017, the penalty range will be based on the Bureau of Labor Statistics' Consumer Price Index and will increase to $10,781 to $21,562 per claim for violations occurring after November 2, 2015 whose penalties are assessed on or after August 1, 2017. In addition to the civil penalty, violators are liable for three times the amount of damages sustained by the government. A person is deemed to have acted knowingly if he or she acted in "deliberate ignorance" or "reckless disregard" of the falsity of the claim. If an individual or entity becomes aware that it was paid any amount under the Medicare or Medicaid programs to which it was not entitled under program rules, it must disclose and repay the amount within 60 days; failure to do so violates the FCA. FCA investigations and cases have become common in the health care field and may cover a range of activity from intentionally inflated billings, to highly technical billing infractions, to allegations of inadequate care, and to potential violations of the Stark Law. Violation or alleged violation of the FCA most often results in settlements that require multi-million dollar payments and mandatory compliance agreements. The FCA also permits individuals to initiate civil actions on behalf of the government in lawsuits called "qui tam" actions. Qui tam plaintiffs, or "whistleblowers," share in the damages recovered by the government or recovered independently if the government does not participate. The FCA also empowers and provides incentives to private citizens (commonly referred to as a qui tam relator or whistleblower) to file suit on the government's behalf. The qui tam relator's share of the recovery can be between 15% and 25% in cases in which the government intervenes, and 25% to 30% in cases in which the government does not intervene. The government may use the FCA to prosecute Medicare and other government program fraud in areas such as coding errors, billing for services not provided, and submitting false cost reports. The FCA has become one of the government's primary weapons against health care fraud. FCA violations or alleged violations could lead to settlements, fines, exclusions, or reputational damage that could have a material adverse impact on a hospital. Amendments to the FCA in the Fraud Enhancement and Recovery Act of 2009 ("FERA") and the Health Care Reform Act amend and expand the reach of the FCA. FERA expanded the FCA's reverse false claims provision, imposing liability on any person who "knowingly conceals" or "knowingly and improperly avoids or decreases" an "obligation to pay or transmit money or property to the Government," whether the person uses a false record or statement to do so or not. FERA also clarified that an "obligation" can arise from the retention of an overpayment. Section 6402 of the

Health Care Reform Act further addresses the retention of overpayments by defining the term overpayment and the circumstances and timing under which an overpayment must be returned to the government before it becomes an "obligation" under the FCA.

The Program Fraud Civil Remedies Act ("PFRCA") allows HHS to impose administrative penalties for false claims relating to federal healthcare programs. Under PFRCA, "knowingly" filing a false claim triggers fines of up to $5,000 for each claim and an assessment by the United States for up to twice the amount of the false claim if the government has made payment. As under the FCA, "knowingly" includes actual knowledge, deliberate ignorance, or reckless disregard of the falsity of the claim.

The Federal Civil Money Penalty Law imposes substantial monetary penalties for certain actions, including submitting (or causing someone to submit) bills or other information that the person knows or "should know" may result in payments in violation of the many rules of the Medicare and Medicaid programs. A person "should know" something if they acted with reckless disregard of, or in deliberate ignorance of, its truth or falsity. Such penalties can also be imposed for other conduct, such as financial inducement to patients. Examples of prohibited conduct include:

- Billing for services not rendered.

- Misrepresenting the services actually rendered (such as "upcoding" the level of a service, misrepresenting the qualifications of the person rendering the service or representing that supervision requirements were met when they were not).

- Falsely certifying that certain services were medically necessary. Both the CMS Form 1500 and the UB-04 billing forms contain statements by which the provider of service affirms that the services provided to the patient were medically necessary.

- Submitting (or causing someone to submit) a claim for payment that is inconsistent with or contrary to Medicare or Medicaid payment requirements.

- Failing to repay an amount received under Medicare or Medicare programs to which the person was not entitled within 60 days of learning of the overpayment.

The Ohio False Claims Law prohibits any person from knowingly making a false statement to secure payment or other benefit administered by a government agency. Ohio's Medicaid law includes civil penalties for engaging in "deception" with respect to Medicaid claims, and defines "deception" to include acting in deliberate ignorance or reckless disregard of the truth or falsity of facts that make a claim false. Ohio law also imposes criminal penalties for knowingly making (or causing to be made) a false or misleading statement or representation for use in obtaining Medicaid payments or fraudulently obtaining money from third parties for items or services rendered to Medicaid recipients in violation of program rules or to obtain eligibility for Medicaid benefits.

The Obligated Group has internal policies and procedures and maintains a compliance program that audits and monitors billing operations that the management of the Corporation believes will effectively reduce the risk associated with possible violations of federal and state false claims laws. However, given the breadth and scope of federal and state compliance enforcement activities, coupled with increasingly serpentine and complicated regulatory oversight, risk of non-compliance remains.

Healthcare Fraud. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") added additional healthcare fraud statutes. These statutes impose fines under the Federal Sentencing

Guidelines or imprisonment for up to 10 years for anyone who is convicted of federal healthcare offenses. These offenses include violations of, or a criminal conspiracy to violate, a variety of activities involving fraud, theft, or embezzlement perpetrated with regard to any healthcare-benefit program. Healthcare-benefit programs include not only Medicare and Medicaid but any public or private health-benefit plan. As such, prosecutors will no longer need to rely only upon the False Claims Act, or use the mail and wire fraud or similar federal criminal statutes, in order to attack healthcare fraud. The Health Care Reform Act enhances the Federal Sentencing Guidelines by providing for escalating increases in the offense levels for any defendant convicted of a federal health care offense above $1,000,000.

Review of Outlier Payments. CMS is reviewing health care providers that are receiving large proportions of their Medicare revenues from outlier payments. Health care providers found to have obtained inappropriately high outlier payments will be subject to further investigation by the CMS Program Integrity Unit and potentially the OIG. Management of the Corporation does not believe that any potential review of a member of the Obligated Group would materially adversely affect the financial condition or performance of the Obligated Group.

Patient Records and Patient Confidentiality. HIPAA requires certain entities and providers to protect the privacy and security of individuals' health information. Disclosure of certain broadly defined protected health information is prohibited unless expressly permitted under the provisions of the HIPAA statute and regulations or authorized by the patient, and a variety of safeguards must be used to protect against privacy or security breaches. HIPAA's confidentiality provisions extend not only to patient medical records, but also to a wide variety of health care clinical and financial settings where patient privacy restrictions often impose communication, operational, accounting, and billing restrictions. These requirements add costs and potentially create unanticipated sources of legal liability.

The Secretary of HHS (the "Secretary") and the Secretary's designees have the authority to conduct compliance reviews to determine whether any covered entity is complying with HIPAA requirements, and to investigate complaints filed by any person who believes a covered entity is not complying with those requirements. HIPAA requires the Secretary of HHS, to the extent practicable, to seek cooperation in obtaining compliance prior to formal action for civil monetary or criminal penalties.

HIPAA imposes civil monetary penalties for violations and criminal penalties for knowingly obtaining or using individually identifiable health information. The penalties for violating HIPAA's administrative simplification requirements range from $100-$50,000 per violation and an annual maximum of $1.5 million for the first tier of sanctions to a highest-tier sanction minimum of $50,000 per violation and an annual maximum of $1.5 million for the identical violation. Criminal penalties also may be imposed on any person who knowingly obtains or discloses protected health information in violation of HIPAA.

The ARRA includes broad, sweeping changes to the HIPAA provisions regarding confidentiality of patient medical records. In general, the ARRA expanded the enforcement of violations of patient medical record confidentiality.

Violations of HIPAA, or of comparable state privacy and security laws, may result in significant costs, liability and reputational harm. The members of the Obligated Group maintain a formal plan for compliance with all applicable HIPAA requirements, have trained their staff and employees in these requirements and maintain a specified HIPAA Compliance Officer who has been provided the authority to supervise, update and enforce policies and procedures designed to assure HIPAA compliance. While the Corporation's management believes that members of the Obligated Group have taken reasonable and appropriate steps in the design of HIPAA policies and procedures and in their supervision so as to maintain HIPAA compliance, it cannot be predicted when or to what extent complaints may be filed or

investigations undertaken, which could involve the expenditure of possibly substantial sums to defend, and the possibility of fines or other penalties should HHS determine that a member of the Obligated Group is not in compliance with HIPAA requirements.

Security Breaches and Unauthorized Releases of Personal Information. Federal and state authorities are increasingly focused on the importance of protecting the confidentiality of individuals' personal information, including patient health information. The Health Information Technology for Economic and Clinical Health Act ("HITECH"), which is part of the ARRA, requires health care providers and some of their vendors to notify individuals, and in some cases, the media, when their unsecured protected health information is subject to a breach of security. The HITECH Act provides for three tiers of penalties with maximum penalties of $50,000 per violation up to a maximum of $1,500,000 for all identical violations during a calendar year. The Act also established programs under Medicare and Medicaid to provide incentive payments for the "meaningful use" of certified electronic health record ("EHR") technology. The Medicare and Medicaid EHR incentive programs provide incentive payments to eligible professionals and eligible hospitals for demonstrating meaningful use of certified EHR technology. Health care providers demonstrate their meaningful use of EHR technology by meeting objectives specified by CMS for using health information technology and by reporting on specified clinical quality measures. Hospitals and physicians who have not satisfied the performance and reporting criteria for demonstrating meaningful use have their Medicare payments significantly reduced.

In addition, many states have enacted laws requiring businesses to notify individuals of security breaches that result in the unauthorized release of personal information. In some states, notification requirements may be triggered even where information has not been used or disclosed, but rather has been inappropriately accessed. State consumer protection laws may also provide the basis for legal action for privacy and security breaches and frequently, unlike HIPAA, authorize a private right of action. In particular, the public nature of security breaches exposes health organizations to increased risk of individual or class action lawsuits from patients or other affected persons, in addition to government enforcement. Failure to comply with restrictions on patient privacy or to maintain robust information security safeguards, including taking steps to ensure that contractors who have access to sensitive patient information maintain the confidentiality of such information, could consequently result in material liability and damage to a health care provider's reputation and could materially adversely affect its financial condition and performance.

The Obligated Group has established formal policies and procedures to comply with the HITECH Act requirements. Additionally, the Obligated Group maintains a cyber insurance policy which will provide coverage of certain expenses which may result from a security breach. However, while the Corporation's management believes that members of the Obligated Group have taken reasonable and appropriate steps in the design of HITECH policies and procedures and in their supervision so as to maintain HITECH compliance, it cannot be predicted when or to what extent complaints may be filed or investigations undertaken, which could involve the expenditure of possibly substantial sums to defend, and the possibility of fines or other penalties, or damages from suits arising out of private rights of action, should the government or a court determine that a member of the Obligated Group is not in compliance with HITECH requirements.

Emergency Medical Treatment and Labor Act. The federal Emergency Medical Treatment and Active Labor Act ("EMTALA") imposes certain requirements on hospitals and facilities with emergency departments. Generally, EMTALA requires that hospitals and other facilities with emergency departments provide "appropriate medical screening" to patients who come to the emergency department to determine if an emergency medical condition exists. If so, the hospital must stabilize the patient within the capabilities of the hospital and the patient cannot be transferred unless stabilization has occurred and the transfer is done pursuant to EMTALA requirements. There are limited exceptions, such as cases in

which the physician documents that the benefits of transfer outweigh the risks. In such cases, appropriate steps must be taken to minimize the risks of transfer.

Failure to comply with EMTALA may result in a hospital's exclusion from the Medicare and/or Medicaid programs, as well as the imposition of civil monetary penalties. As such, failure of a member of the Obligated Group to meet its responsibilities under EMTALA could adversely affect the financial condition and performance of the Obligated Group. Management of the Corporation believes the policies and procedures adopted by members of the Obligated Group 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 or asserted. Any sanctions imposed as a result of an EMTALA violation could have a material adverse effect on the financial condition and performance of the Obligated Group.

Environmental Laws and Regulations. Hospitals are subject to a wide variety of federal, state, and local environmental and occupational health and safety laws and regulations. These include, but are not limited to: (a) air and water quality control requirements; (b) waste management requirements; (c) specific regulatory requirements applicable to asbestos, polychlorinated biphenyls, and radioactive substances; (d) requirements for providing notice to employees and members of the public about hazardous material handled by or located at the hospital; (e) requirements for training employees in the proper handling and management of hazardous materials and wastes; and (f) other requirements.

Hospitals may be subject to requirements related to investigating and remedying hazardous substances located on their property, including such substances that may have migrated off the property. Typical hospital operations include the handling, use, storage, transportation, disposal, and discharge of hazardous, infectious, toxic, radioactive, flammable, and other hazardous materials, wastes, pollutants, and contaminants. As such, hospital operations are particularly susceptible to the practical, financial, and legal risks associated with compliance with such laws and regulations. Such risks may result in damage to individuals, property, or the environment; may interrupt operations and/or increase their cost; may result in legal liability, damages, injunctions, or fines; and may result in investigations, administrative proceedings, civil litigation, criminal prosecution, penalties, or other governmental agency actions; and may not be covered by insurance. Although the management of the Corporation is not aware of any pending or threatened claim, investigation or enforcement action regarding such environmental issues, which, if determined adversely, would have a material adverse effect on the financial condition or performance of the Obligated Group, there cannot be any assurance that a member of the Obligated Group will not encounter such risks in the future. The occurrence of those risks could have a material adverse effect on the financial condition and performance of the Obligated Group.

Physician Recruitment. The IRS, CMS, and OIG have issued various pronouncements that could limit physician recruiting and retention arrangements. In IRS Revenue Ruling 97-21, the IRS ruled that tax-exempt hospitals that provide recruiting and retention incentives to physicians risk loss of tax-exempt status unless the incentives are reasonably necessary to address a community need and accordingly provide a community benefit; improvement of a charitable hospital's financial condition does not necessarily constitute such a purpose. With respect to physician service contracts, the IRS takes the position that the compensation paid must be consistent with the value of services actually provided by the physician. The OIG also has taken the position that any arrangement between a federal health care program-certified facility and a physician that is intended even in part to encourage the physician to refer patients may violate the federal Anti-Kickback Statute unless a regulatory exception applies. Physician service, recruitment, and retention arrangements may also implicate the Stark Law. While the OIG has promulgated a practitioner recruitment safe harbor to the Anti-Kickback Statute, it is limited to recruitment in areas that are health professional shortage areas ("HPSAs"). The OIG also requires consistency with fair market value for certain other exceptions that may apply to service contracts and may allege that any amount paid above fair market value implies an intent to induce referrals. The Stark

Law exception for practitioner recruitment is not limited to HPSAs, rather it applies to the recruitment of physicians who are relocating their practices to the geographic area served by the hospital, if certain requirements are met. The Stark Law also contains an exception pertaining to retention arrangements that allows hospitals, in limited circumstances, to pay incentives to retain a physician in underserved areas. In addition, the Stark Law includes certain exceptions that may apply to service contracts, many of which also require (among other things) that payments to the physician are consistent with fair market value for services actually performed.

The sanctions that could be imposed by the IRS or other regulatory authorities or the courts for violations of IRS regulations, the Stark Law, and the Anti-Kickback Statute and for false claims under the FCA and other similar federal or state laws include, among other things, the loss of tax-exempt status of one or more of the Obligated Group members, repayment of up to three times the amount of claim payments related to services provided or referred by affected physicians, exclusion of one or more Obligated Group members from federal health care programs, including the Medicare and Medicaid programs or additional monetary penalties.

Management of the Corporation believes that the physician recruitment arrangements of the Obligated Group members are in material compliance with these laws and regulations to the extent applicable, but no assurance can be given that regulatory authorities will not take a contrary position or that the Obligated Group members will not be found to have violated applicable law, or that future laws, regulations, or policies will not have a material adverse impact on the ability of the Obligated Group to recruit and retain physicians.

Joint Ventures. The OIG has expressed its concern in various advisory bulletins that many types of joint venture arrangements involving hospitals may implicate the Anti-Kickback Statute, since the parties to joint ventures are typically in a position to refer patients of federal health care programs. In addition, under the 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 another sanction. Many hospital joint ventures with physicians may also implicate the federal Stark Law.

Any evaluation of compliance with the Anti-Kickback Statute or tax laws governing Section 501(c)(3) organizations depends on the totality of the facts and circumstances, while the Stark Law requires strict compliance with an exception if the prohibition is triggered. While management of the Corporation believes that any joint venture arrangements to which the Obligated Group is a party are in material compliance with the Anti-Kickback Statute and OIG pronouncements, the tax laws governing Section 501(c)(3) organizations and the Stark Law, there cannot be any assurance that regulatory authorities will not take a contrary position or that such transactions will not be found to have violated these laws and related regulations. Any determination that a member of the Obligated Group is not in compliance with these laws and related regulations could have a material adverse effect on the financial condition and performance of the Obligated Group.

The Obligated Group members may enter into joint ventures with physicians. The ownership and operation of certain of these joint ventures may not meet safe harbors under the Anti-Kickback Law. Management of the Corporation would proceed with such transactions related to the joint ventures only after consultation with its legal counsel and receipt of advice to the effect that each transaction related to the joint ventures is in compliance with the Stark Law and the tax laws governing Section 501(c)(3) organizations, and is otherwise generally in compliance with the Anti-Kickback Law. However, there

cannot be any assurance that regulatory authorities will not take a contrary position or that such transactions will not be found to have violated the Stark Law, the tax laws governing Section 501(c)(3) organizations, and/or the Anti-Kickback Law. Any such determination could have a material adverse effect on the financial condition and performance of the Obligated 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 responsibility 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 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 programs.

State Law Concerns

Generally. States are increasingly regulating the delivery of health care services. Much of this increased regulation has centered on the managed care industry. State legislatures have cited their right and obligation to regulate and oversee health care insurance and have enacted sweeping measures that aim to protect consumers and, in some cases, providers.

Due to this increased state oversight, the Obligated Group members could become subject to or impacted by a variety of state health care laws and regulations affecting health care providers. In addition, the Obligated Group members could be subject to state laws and regulations prohibiting, restricting, or otherwise governing PPOs, third party administrators, physician-hospital organizations, independent practice associations or other intermediaries, selective contracting, "any willing provider," and "freedom of choice" laws, coinsurance and deductible amounts, insurance agency and brokerage, quality assurance, utilization review, and credentialing activities, provider and patient grievances, mandated benefits, rate increases, and many other practices.

Ohio Healthcare Simplification Act. In 2008, Ohio adopted The Healthcare Simplification Act (the "HSA"), imposing new regulations on health care contracts between health plans and providers. The regulations included instituting a moratorium on the use of "most favored nation" clauses in certain contracts, subjecting certain contractual disputes to binding arbitration and restricting the use of rental networks. Additionally, the HSA required the Ohio Department of Insurance to establish standard credentialing forms for providers. The prohibition on "most favored nation" clauses was made permanent in the 2011 budget legislation. It is possible that the regulations promulgated under the HSA could impose, among other things, material adverse operational, financial and legal burdens, costs and risks to the Obligated Group.

Ohio Licensure. The Licensure Department within the Ohio Department of Health ("ODH") is responsible for licensure and registration of health care facilities. All hospitals in Ohio must be Medicare certified or accredited by a CMS-deemed accrediting organization. ODH prescribes licensing requirements for certain other health care facilities including, among others, ambulatory surgical facilities and freestanding dialysis centers, inpatient rehabilitation facilities, birthing centers, radiation therapy centers, and diagnostic imaging centers and mobile diagnostic imaging centers. Adverse determinations by the ODH regarding these certification, accreditation, or licensing matters could adversely affect members of the Obligated Group and the financial condition and performance of the Obligated Group.

Ohio Hospital Franchise Fee. The Ohio Hospital Franchise Fee Program is intended to allow Ohio to draw down additional enhanced federal matching funds in order to avoid significant cuts to providers' Medicaid reimbursements or cuts to beneficiary eligibility. On May 21, 2014, CMS issued approval notices to Ohio for two state plan amendments (SPAs) that extend the ability of the Ohio Department of Medicaid (ODM) to make supplemental Upper Payment Limit (UPL) payments to hospitals for the state's fiscal years 2014 and 2015. The Ohio Hospital Association estimates that in Ohio's 2014 fiscal year, hospitals paid over $513 million in franchise fees to the state to help fund UPL payments, Medicaid managed care inpatient incentive payments and the continuation of a one-time rate increase to Medicaid base payments. The financial impact varies by year, but management of the Corporation estimates that the franchise fee yielded a net benefit of approximately $6.9 million for the fiscal year ended December 31, 2016.

Ohio HCAP Program. Ohio currently has in place a program known as the "Hospital Care Assurance Program" ("HCAP") that imposes an assessment on hospitals to create a pool of funds for redistribution to hospitals based upon an indigent care factor. Under the HCAP, ODJFS helps hospitals pay for uncompensated costs relating to the treatment of indigent people. ODJFS accomplishes this by levying a provider tax against hospitals which is subsequently joined with matching federal Medicaid funds and redistributed to hospitals based on the relative level of each hospital's indigent care services. The pool of funds available to hospitals under the HCAP is therefore expected to decrease in the future. In the fiscal year ended December 31, 2016, the Obligated Group received HCAP fund net distributions of approximately $6.4 million. There is no guarantee that, in the future, the Obligated Group will continue to receive distributions at this or any level.

Professional Liability Claims and Liability Insurance

The Ohio General Assembly enacted legislation in 2003 that limits the amounts of money patients may recover in medical malpractice lawsuits. The key feature of this reform legislation was a complex cap on non-economic damages in medical malpractice cases. The basic cap is the larger of $250,000 or three times economic damages, subject to a maximum of $350,000 per plaintiff and a maximum of $500,000 per occurrence. These maximum amounts increase to $500,000 per plaintiff and $1 million per occurrence if the plaintiff has suffered permanent and substantial physical deformity, loss of use of a limb, loss of a bodily organ system, or permanent physical functional injury that prevents the plaintiff from being able to independently care for himself or herself and to perform life sustaining activities. While it does not limit the non-economic damages that family members can recover in a wrongful death case, it does limit the right of a decedent's estate to recover for damages such as pain and suffering that a decedent may have experienced prior to death. Additionally, in 2005, many of the medical malpractice reforms discussed above were extended to other areas of tort law, and, among other things, established caps for non-economic damages in non-catastrophic cases and on punitive damages.

In recent years, due to the number of professional and general liability suits and the dollar amounts of damage recoveries nationwide, there have been substantial increases in malpractice insurance premiums. Professional liability and other actions alleging wrongful conduct and seeking punitive damages often are filed against health care providers. Litigation may also arise from the corporate and business activities of the Obligated Group members, employee-related matters, medical staff and provider network matters, and denials of medical staff and provider network membership and privileges. As with professional liability, many of these risks are covered by insurance, but some are not. For example, some antitrust claims, business disputes, and workers' compensation claims are not covered by insurance or other sources and, in whole or in part, may be a liability of the Obligated Group Members if determined or settled adversely. In addition, claims for punitive damages may not be covered by insurance under certain state laws. See **Appendix A—Adena Health System and the Obligated Group—Other Information—Insurance**.

Corporate Compliance Program

The Obligated Group has a compliance program that includes a compliance plan to assist all employees in understanding and adhering to the legal and ethical standards that govern the provision of patient care (the "Compliance Plan"). The Compliance Plan has been designed to (a) comply with the standards set forth in the OIG Compliance Guidelines for Hospitals and in the Federal Sentencing Guidelines for Organizational Defendants and (b) help ensure that the Obligated Group Members act in accordance with their mission, values, and known legal duties.

Antitrust

Enforcement of antitrust laws against health care providers has become more common. 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. While the application of federal and state antitrust laws to health care is still evolving, enforcement activities by federal and state agencies appear to be increasing. Violators of antitrust laws could be subject to criminal and civil liability by both federal and state agencies as well as by private litigants.

Affiliations, Merger, Acquisition and Divestiture

Management of the Corporation evaluates and pursues potential acquisition, merger, and affiliation candidates as part of the overall strategic planning and development process. Management of the Corporation also reviews the use, compatibility, and business viability of operations of the Obligated Group members and other affiliates of the Corporation as part of its ongoing planning and property management functions. From time to time, the Obligated Group members and other affiliates of the Corporation may pursue changes in the use of, or disposition of, their facilities. Likewise, the Obligated Group and the Corporation's affiliates occasionally receives offers from, or conducts discussions with, third parties about joint ventures, the potential acquisition of operations and properties, or about the potential sale of some of the operations or property that are currently conducted or owned by Obligated Group members. Discussions with respect to affiliation, merger, acquisition, disposition, or change of use of facilities, including those that may affect the Obligated Group members, are also held from time to time with other parties. As a result, it is possible that the current organization and assets of the Obligated Group members may change from time to time.

In addition to relationships with other hospitals and physicians, the Obligated Group members may consider investments, ventures, affiliations, development, and acquisition of other health care-related entities. These may include home health care, long-term care entities or operations, infusion providers, pharmaceutical providers, and other health care enterprises that support the overall operations of the Obligated Group. In addition, Obligated Group members and their affiliates may pursue transactions with health insurers, HMOs, preferred provider organizations, third-party administrators, and other health insurance-related businesses. Because of the integration occurring throughout the health care field, management of the Corporation will consider these arrangements if there is a perceived strategic or operational benefit for the Obligated Group. Any initiative may involve significant capital commitments and capital or operating risk (including, potentially, insurance risk) in a business in which the Obligated Group members and their affiliates may have less expertise than in hospital operations. There can be no assurance that any of these projects, if pursued, will not ultimately have a material adverse effect on the financial condition or performance of the Obligated Group.

Issues Related to the Health Care Market of the Obligated Group

Proliferation of Competition. Hospitals may face increased competition in the future from other general hospitals, specialty hospitals, skilled nursing facilities, home health agencies, rehabilitation and therapy centers, ambulatory surgery centers, increasingly sophisticated physician group practices, and from other health care providers that offer comparable health care services. This may cause hospitals to lose essential inpatient or outpatient market share. Competition may be focused on services or payor classifications where hospitals realize their highest margins, thus negatively affecting programs that are economically important to hospitals. Specialty hospitals may attract specialists as investors and may seek to treat only profitable classifications of patients, leaving full-service hospitals with higher acuity and/or lower paying patient populations. Likewise, ambulatory surgery centers may increase competition for outpatient hospital services. The growth of e-commerce may also result in a shift in the way that healthcare is delivered. Persons residing in the Obligated Group's service area may be able to receive certain health services from remote providers. These new sources of competition may have a material adverse impact on hospitals, particularly if a group of a hospital's principal physician admitters determines to curtail its use of a hospital service in favor of competing facilities.

Additionally, scientific and technological advances, new procedures, drugs, and appliances, preventive medicine and outpatient health care delivery may reduce utilization and revenues of the hospitals in the future or otherwise lead the way to new avenues of competition. In some cases, hospital investment 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.

In addition, competition could result from forms of health care delivery that are able to offer lower priced services to the population served by the Obligated Group. These services could be substituted for some of the revenue generating services currently offered by members of the Obligated Group and their affiliates. The services that could serve as substitutes for hospital treatment include skilled and specialized nursing facilities, home care, intermediate nursing home care preventive care, and drug and alcohol abuse programs. See **Appendix A—Adena Health System and the Obligated Group—Service Area, Market Share and Economy**.

Availability of Insurance Products. In recent years, the health care industry has seen significant reductions in the availability of general commercial liability and other insurance products. There can be no assurance that the Obligated Group will be able in the future to fund any self-insurance or obtain commercial insurance on reasonably acceptable terms and conditions. Increases in the cost of such insurance products could have a material adverse effect on the Obligated Group and its results of operations.

Technological Changes. Medical research and resulting discoveries have grown considerably in the last decade. These new discoveries may add greatly to the Obligated Group's cost of providing services with no or little offsetting increase in federal or other third party reimbursement and may also render obsolete certain of the Obligated Group's health services. New drugs and devices may increase hospitals' expenses because, for the most part, the costs of new drugs and devices are not typically accounted for in the DRG payment received by hospitals for inpatient care. The PPS system imposed on outpatient services does permit a direct pass-through of certain new technologies defined by the government.

The ARRA includes funds to assist states and certain high risk hospitals in establishing a nationwide electronic medical records system and the Secretary appointed a National Coordinator for Health Information Technology to lead the effort. The costs to acquire and implement an electronic

medical records system are significant but it is widely believed that such systems will lead to greater efficiencies in the provision of patient care and improved quality of care. The acquisition and operation of certain equipment and services may continue to be a significant factor in hospital utilization, but the ability of the Obligated Member to offer such equipment or services may be subject to the availability of equipment and specialists, governmental approval and the ability to finance such acquisitions and operations.

Staffing Shortages. In past years, the health care industry experienced a scarcity of nursing personnel, respiratory therapists, radiation technicians, pharmacists, and other trained health care technicians. A significant factor underlying this trend included a decrease in the number of persons entering these professions. Competition for employees, coupled with increased recruiting and retention costs, could increase hospital operating costs, possibly significantly. Growth, therefore, could be constrained. Such a trend could have a material adverse impact on the financial condition and performance of hospitals. On occasion, the Obligated Group members utilize nursing agencies to assist with shortages.

Physician Relations. The primary relationship between a hospital and physicians who practice in it is through the hospital's organized medical staff. Medical staff bylaws, rules and policies establish the criteria and procedures by which a physician may be awarded medical staff membership and privileges, or may have his or her membership and/or privileges curtailed, denied, or revoked. Physicians who are denied medical staff membership or certain clinical privileges, or who have such membership or privileges curtailed, denied, or revoked often file legal actions against hospitals. Such actions may include a wide variety of claims, some of which could result in substantial uninsured damages to a hospital. 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. All hospitals, including the hospitals of the Corporation are subject to such risk. An emerging area of potential risk for all hospitals surrounds the appropriate management of physician conflicts of interest with hospitals that grant practice privileges. This is described as "economic credentialing" by physicians who oppose efforts of hospitals to manage the presence of direct competitors within the leadership or boardroom. This issue requires all hospitals to thoughtfully manage these potential conflicts in order to maintain a healthy, collegial, and professional relationship with the independent medical staff, while ensuring that the organization is not suffering irreversible harm from a competitor gaining specific or specialized information not available to the public regarding the hospital's plans. In the worst circumstances, such efforts have led to litigation and potentially material impacts on the practice patterns of physicians at a specific facility. It is not possible to predict the course of such decisions or make any assurances that the Corporation will be successful in managing such conflicts without causing some changes in physician practice patterns that could have a material effect on the Corporation.

Physician Shortages. The health care industry has also recently experienced a shortage of physicians, especially in primary care. This physician shortage may be compounded by the expansion of coverage to the uninsured under the Health Care Reform Act.

Risks Related to Tax-Exempt Status

The Corporation is a nonprofit corporation, exempt from federal income taxation as an organization described in Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"). At the same time, the Corporation conducts complex business transactions and is a major employer in the geographic area in which it operates. There can often be a tension between the rules designed to regulate a wide range of charitable organizations and the day-to-day operations of a complex health care system.

The tax-exempt status of the Series 2017 Bonds depends upon maintenance by the Corporation that receives or benefits from the proceeds of the Series 2017 Bonds (the "Benefiting Member"), of its status as an organization described in Section 501(c)(3) of the Code. The maintenance of such status is contingent on compliance with general rules promulgated in the Code and related regulations regarding the organization and operation of tax-exempt entities, including their operation for charitable and other permissible purposes and their avoidance of transactions that may cause their earnings or assets to inure to the benefit of private individuals. As these general principles were developed primarily for public charities that do not conduct large-scale technical operations and business activities, they often do not adequately address the myriad of operations and transactions entered into by a modern health care organization. Although traditional activities of health care providers, such as medical office building leases, have been the subject of interpretations by the IRS, many activities or categories of activities have not been fully addressed in any official opinion, interpretation or policy of the IRS.

The members of the Obligated Group participate in a variety of joint ventures and transactions with physicians either directly or indirectly. Management of the Corporation believes that the joint ventures and transactions to which the members of the Obligated Group are a party are consistent with the requirements of the Code as to tax-exempt status, but, as noted above, there is uncertainty as to the state of the law.

The IRS has periodically conducted audit and other enforcement activity regarding tax-exempt health care organizations. The IRS conducts special audits of large tax-exempt health care organizations with at least $500 million in assets or $1 billion in gross receipts. Such audits are conducted by teams of revenue agents, often take years to complete and require the expenditure of significant staff time by both the IRS and taxpayers. These audits examine a wide range of possible issues, including tax-exempt bond financing of partnerships and joint ventures, retirement plans and employee benefits, employment taxes, political contributions, and other matters.

If the IRS were to find that a member of the Obligated Group had participated in activities in violation of certain regulations or rulings, the tax-exempt status of such entity could be in jeopardy. Although the IRS has not frequently revoked the 501(c)(3) tax-exempt status of nonprofit health care corporations, it could do so in the future. Loss of tax-exempt status by even one Benefiting Member potentially could result in loss of tax exemption of the Series 2017 Bonds and of other tax-exempt debt benefiting members of the Obligated Group, defaults in covenants regarding the Series 2017 Bonds and other related tax-exempt debt, and the triggering of other obligations, including substantial tax liabilities on income of the member of the Obligated Group. For these reasons, loss of tax-exempt status of any Benefiting Member could have a material adverse effect on the financial condition and performance of the Obligated Group.

In some cases, the IRS has imposed substantial monetary penalties on tax-exempt hospitals in lieu of revoking their tax-exempt status. In those cases, the IRS and exempt hospitals entered into settlement agreements requiring the hospital to make substantial payments to the IRS. Given the size of the Obligated Group, the wide range of complex transactions entered into by the members, and potential exemption risks, members could be at risk for incurring monetary and other liabilities imposed by the IRS.

In addition, the IRS has asserted that tax-exempt hospitals that are in violation of Medicare and Medicaid regulations regarding inducement for referrals may also be subject to revocation of their tax-exempt status. Because a wide variety of hospital-physician transactions potentially violate these broadly stated prohibitions on inducement for referrals, the IRS has broadened the range of activities that may directly affect tax exemption, without defining specifically how those rules will be applied. As a result, tax-exempt hospitals, particularly those that have extensive transactions with physicians, are currently

subject to an increased degree of scrutiny and potential enforcement by the IRS. The IRS's policy position is not necessarily indicative of a judicial adjudication of the applicable issues.

Increasingly, the operations and practices of health care providers have been challenged or questioned to determine if they are consistent with the regulatory requirements for not-for-profit, tax-exempt organizations. These challenges, in some cases, are broader than concerns about compliance with federal and state statutes and regulations, such as Medicare and Medicaid compliance, and instead in many cases are examinations of core business practices of the health care organizations. Areas that have come under examination include pricing practices, billing and collection practices, charitable care, executive compensation, exemption of property from real property taxation and entitlement to sales tax exemption, and others. These challenges and questions have come from a variety of sources, including state attorneys general, the IRS, labor unions, Congress, state legislatures, and patients, class action plaintiffs' attorneys, and in a variety of forums, including hearings, audits, and litigation. These challenges or examinations include the following, among others:

Section 4958 of the Code imposes excise taxes on "excess benefit transactions" between "disqualified persons" and tax-exempt organizations such as the Members of the Obligated Group. According to the legislative history and regulations associated with Section 4958, these excise taxes may be imposed by the IRS either in lieu of or in addition to revocation of exemption. These intermediate sanctions may be imposed in situations in which a "disqualified person" (such as an "insider") engages in "excess benefit transactions" such as (a) a transaction with a tax-exempt organization on other than a fair market value basis, (b) receipt of unreasonable compensation from a tax-exempt organization or (c) receipt of payment in an arrangement that violates the prohibition against private inurement. A disqualified person who benefits from an excess benefit transaction will be subject to an excise tax equal to 25% of the amount of the excess benefit. Organizational managers who participate in the excess benefit transaction knowing it to be improper are subject to an excise tax equal to 10% of the amount of the excess benefit, subject to a maximum penalty of $20,000 per transaction. A second penalty, in the amount of 200% of the excess benefit, may be imposed on the disqualified person (but not upon the organizational manager) if the excess benefit is not corrected within a specified period of time. Fair market value and reasonable compensation for tax purposes typically reflect a range rather than a specific dollar amount, and the IRS does not rule in advance on whether a transaction results in more than fair market value payment or more than reasonable compensation to a disqualified person. Although it is not possible to predict what enforcement action, if any, the IRS might take related to potential excess benefit transactions, consistent with the legislative history of Section 4958, regulations issued by the IRS in March 2008 indicate that not all excess benefit transactions jeopardize exempt status. Rather, the IRS will consider all relevant facts and circumstances including: the size and scope of the organization's activities that further exempt purposes; the size, scope, and frequency of any excess benefit transactions; whether the organization has implemented appropriate safeguards reasonably designed to prevent future excess benefit; and whether the organization has made good faith efforts to correct any excess benefit such as by obtaining repayment of the amount of any excess benefit.

The legislation is potentially favorable to taxpayers because it provides the IRS with a punitive option short of revoking tax-exempt status to deal with incidents of private inurement. However, the standards for tax exemption have not been changed, including the requirement that no part of the net earnings of an exempt entity inure to the benefit of any private individual. Consequently, although the IRS has only infrequently revoked the tax exemption of non-profit health care corporations in the past, risk of revocation remains and there can be no assurance that the IRS will not direct enforcement activities against Obligated Group Members.

In certain cases, the IRS has imposed substantial monetary penalties and future charity care or public benefit obligations on tax-exempt hospitals in lieu of revoking their tax-exempt status, as well as

requiring that certain transactions be altered, terminated, or avoided in the future and/or requiring governance or management changes. These penalties and obligations are typically imposed on the tax-exempt hospital pursuant to a "closing agreement" with respect to the hospital's alleged violation of Section 501(c)(3) exemption requirements. Given the uncertainty regarding how tax-exemption requirements may be applied by the IRS, the Obligated Group members are, and will be, at risk for incurring monetary and other liabilities imposed by the IRS through this "closing agreement" or similar process. Like certain of the other business and legal risks described in this Official Statement that apply to large multi-hospital systems, these types of situations could arise and liability could be substantial and have a material adverse effect on the financial condition and performance of the Obligated Group.

The Health Care Reform Act places additional requirements on tax-exempt hospitals for them to receive and maintain their Section 501(c)(3) federal tax-exempt status. One significant new requirement is that tax-exempt hospitals must perform a community health needs assessment every three years and develop an implementation strategy to meet the identified needs. Requirements relating to community health needs assessments are effective for taxable years beginning after March 23, 2012. Any tax-exempt hospital that fails to satisfy the community health needs assessment requirement for any taxable year will be subject to an excise tax penalty of $50,000. Furthermore, the United States Secretary of the Treasury or that individual's delegate is to review the community benefit activities of each tax-exempt hospital at least every three years. Another major element of the Health Care Reform Act relating to the tax-exempt status of hospitals involves charges. A hospital must limit the amounts charged for emergency room or other medically necessary care provided to patients eligible for assistance under the hospital's financial assistance policy to no more than the amounts generally billed to patients who have insurance covering such care. In other words, hospitals cannot charge persons eligible for financial assistance higher rates than the amounts charged to patients who have insurance covering such care. The Health Care Reform Act also requires that tax-exempt hospitals have a written financial assistance policy in place. Finally, the Health Care Reform Act prohibits a hospital from engaging in extraordinary collection actions (which may include, among other things, a restriction on filing suit) before it has made reasonable efforts to determine whether the subject individual is eligible for financial assistance.

The Tax Exempt and Governmental Entities Division of the IRS is responsible for the Team Examination Program (referred to as "TEP") of the IRS and conducts audits of exempt organizations using teams of revenue agents. The TEP audit teams consider a wide range of possible issues, including the community benefit standard, private inurement and private benefit, partnerships and joint ventures, retirement plans and employee benefits, employment taxes, tax-exempt bond financing, political contributions, and unrelated business income. In addition, the IRS conducts compliance checks and correspondence audits that focus initially on limited issues, such as executive compensation, unrelated business income, or community benefit. Such limited scope reviews can be expanded in certain circumstances to include a variety of other issues in a TEP audit.

One or more of the Obligated Group members could be audited by the IRS. Management of the Corporation believes that Obligated Group members have properly complied with the tax laws. Nevertheless, because of the complexity of the tax laws and the presence of issues about which reasonable persons can differ, a TEP or other audit could result in additional taxes, interest and penalties. A TEP or other audit could also potentially affect the tax-exempt status of any of the Obligated Group members.

In addition, as a result of the increased scrutiny of community benefit activity by the IRS, tax-exempt hospitals may be required to increase resources spent on qualifying activities. On February 12, 2009, the IRS released its Final Report containing the results of a two-year study focusing on community benefit reporting practices and executive compensation practices of tax-exempt hospitals. The results are based on a compliance check survey the IRS sent to 500 hospitals in May 2006 and builds on the analysis

of results first released by the IRS in its Interim Report in July 2007 and the results of a 2004 compliance check on executive compensation arrangements of 501(c)(3) tax-exempt organizations generally. The Final Report, however, does not reach specific conclusions concerning whether the existing community benefit standard is appropriate and whether tax-exempt hospital executives are being compensated appropriately.

As described in this Official Statement under the caption **Tax Matters**, failure to comply with certain legal requirements may cause the interest on the Series 2017 Bonds to become included in gross income of the recipients thereof for federal income tax purposes. The Bond Indenture does not provide for the payment of any additional interest or penalty in the event the interest on the Series 2017 Bonds is determined to be includible in gross income for federal income tax purposes.

Internal Revenue Service Form 990. IRS Form 990 is used by 501(c)(3) not-for-profit organizations to submit information required by the federal government to maintain tax-exemption. Form 990 requires detailed public disclosure of compensation practices, corporate governance, loans to management and others, joint ventures and other types of transactions, political campaign activities, and other areas the IRS deems to be compliance risk areas. Form 990 also requires the reporting of detailed community benefit information on Schedule H to the Form 990 and establishes uniform standards for the reporting of charity care. Form 990 also contains a separate schedule requiring detailed reporting of information relating to tax-exempt bonds, including compliance with the arbitrage rules and rules limiting private use of bond-financed facilities, including compliance with the safe harbor guidance in connection with management contracts and research contracts. Form 990 allows for enhanced transparency as to the operations of exempt organizations. It is likely to result in enhanced enforcement, as Form 990 makes available a wealth of detailed information on compliance risk areas to the IRS and other stakeholders, including state attorneys general, unions, plaintiff's class action attorneys, public watchdog groups, and others. The Health Care Reform Act amended the Code to require tax-exempt hospitals to include in their Form 990 a report describing how they are addressing the needs identified in each community health needs assessment conducted and their audited financial statements (or the consolidated financial statements in which they are included).

Charity Care and Tax-Exempt Status. Hospitals are permitted to obtain tax-exempt status under the Code because the provision of health care historically has been treated as a "charitable" enterprise. This treatment arose before most Americans had health insurance, when charitable donations were required to fund the health care provided to the sick and disabled. Some commentators and others have taken the position that, with the onset of employer health insurance and governmental reimbursement programs, there is no longer any justification for special tax treatment for the health care industry, and the availability of tax-exempt status should be eliminated. Federal and state tax authorities are also beginning to demand that tax-exempt hospitals justify their tax-exempt status by documenting their charitable care and other community benefits.

As described above under the subheading, "Health Care Reform Act," the Health Care Reform Act imposes additional requirements for tax-exemption upon tax-exempt hospitals, including obligations to adopt and publicize a financial assistance policy; limit charges to patients who qualify for financial assistance to the amounts generally billed to insured patients; and control the billing and collection processes. Additionally, tax-exempt hospitals are required to conduct a community needs assessment every three years and adopt an implementation strategy to meet those identified needs. 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.

The Health Care Reform Act also imposes new 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 Health Care Reform Act 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 of the Health Care Reform Act. These statutorily mandated requirements for periodic review and submission of reports relating to community benefit activities 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 and may increase IRS scrutiny of particular 501(c)(3) hospital organizations.

Challenges to Real Property and Sales Tax Exemptions. Recently, the real property and sales tax exemptions afforded to certain nonprofit health care providers by state and local taxing authorities have been challenged on the grounds that a portion of its property was not being used to further the charitable purposes of the institutions or that the institutions did not provide sufficient care to indigent persons so as to warrant exemption from taxation as a charitable institution. These challenges have been based on a variety of grounds, including allegations of aggressive billing and collection practices and excessive financial margins.

Certain Matters Relating to Security for the Series 2017 Bonds

Amendments. Certain amendments to the Bond Indenture may be made with the consent of the holders of not less than a majority of the principal amount of all Bonds Outstanding under the Bond Indenture. Certain amendments to the Master Indenture may be made with the consent of the holders of not less than a majority in aggregate principal amount of Notes Outstanding under the Master Indenture at the time. Such amendments may adversely affect the security of the holders of the Series 2017 Bonds. With respect to amendments to the Master Indenture requiring consent of the holders of not less than a majority in aggregate principal amount of Outstanding Notes, the holders of the requisite percentage of Outstanding Notes may be composed wholly or partially of the holders of outstanding Notes previously issued or Notes issued after the date of this Official Statement. *See* **Appendix C—Summary of Certain Bond Documents—Summary of the Master Indenture—Supplements and Amendments to the Master Indenture** and **—Summary of the Bond Indenture—Supplemental Indentures Note Requiring Consent of Owners of Series 2017 Bonds.**

Replacement of the Series 2017A Note. Under the circumstances described in the Bond Indenture, the Series 2017A Note may be exchanged by the Bond Trustee, without the consent of any of the holders of the Series 2017 Bonds, for an obligation issued under a different master trust indenture securing obligations of a different obligated group that would include among its members the Corporation or any other member of the Obligated Group. 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 from the Obligated Group. Such new obligated group could have substantial debt outstanding that would rank on a parity with the substitute obligation. To exchange the Series 2017A Note, the Obligated Group must meet certain tests and requirements, as described in **Appendix C—Summary of Certain Bond Documents—Summary of the Bond Indenture—Supplemental Indentures Not Requiring Consent of Owners of Series 2017 Bonds** and **—Summary of the Master Indenture—Substitution of Notes**.

Enforceability of the Master Indenture, the Sublease, and the Series 2017A Note. The legal right and practical ability of the Bond Trustee to enforce rights and remedies under the Sublease and of

the Master Trustee to enforce its rights and remedies under the Master Indenture and the Series 2017A Note may be limited by laws relating to bankruptcy, insolvency, reorganization, fraudulent transfer or moratorium, and by other similar laws affecting creditors' rights. The state of fraudulent transfer and bankruptcy laws relating to the enforceability of guaranties or obligations issued by one corporation in favor of another corporation's creditors (such as a member of the Obligated Group's obligation to make debt service payments on behalf of another member of the Obligated Group) is unsettled. In particular, such obligations may be voidable under the Federal Bankruptcy Code or applicable state fraudulent transfer laws if (1) the obligation is incurred without "fair" and/or "fairly equivalent" consideration to the obligor and (2) the obligor is insolvent or rendered insolvent by the incurrence of the obligation. The standards for determining the fairness of consideration and the manner of determining insolvency are somewhat subjective and may vary under cases interpreting the Federal Bankruptcy Code and the various state fraudulent transfer statutes. Consequently, the Bond Trustee's and the Master Trustee's ability to enforce the rights and remedies under the Sublease, the Master Indenture, and the Series 2017A Note against any member of the Obligated Group that would be rendered insolvent thereby could be subject to challenge. In addition, enforcement of such rights and remedies will depend upon the exercise of various remedies specified by such documents, which, in many instances, may require judicial actions that are subject to discretion and delay, that otherwise may not be readily available or that may be limited by certain legal principles, including fraudulent transfer or moratorium and other similar laws.

The joint and several obligation described in this Official Statement of each member of the Obligated Group to pay debt service on the Series 2017A Note may not be enforceable against a member under any of the following circumstances:

(a) to the extent payments on the Series 2017A Note are requested to be made from assets of such member which are donor-restricted or which are subject to a direct, express, or charitable trust that does not permit the use of such assets for such payments;

(b) if the purpose of the debt created and evidenced by the Series 2017A Note is not consistent with the charitable purposes of such member, or if the debt was incurred or issued for the benefit of an entity other than a nonprofit corporation that is exempt from federal income taxes under Sections 501(a) and 501(c)(3) of the Code and is not a "private foundation" as defined in Section 509(a) of the Code;

(c) to the extent payments on the Series 2017A Note would result in the cessation or discontinuation of any material portion of the health care or related services previously provided by such member; or

(d) if and to the extent payments are requested to be made pursuant to any loan violating applicable usury laws.

These limitations on the enforceability of the joint and several obligations of the members of the Obligated Group on the Series 2017A Note also apply to their obligations on all Notes. If the obligation of a particular member of the Obligated Group to make payment on a Note is not enforceable and payment is not made on such Note when due in full, then Events of Default will arise under the Master Indenture.

There exists common law authority and authority under certain statutes for the ability of the courts to terminate the existence of a 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 purposes. Such court action may arise on the court's own motion or pursuant to a petition of the state Attorney General or such 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 to see to the application of their funds to their intended charitable uses.

The various legal opinions delivered concurrently with the issuance of the Series 2017 Bonds are qualified as to the enforceability of the various legal instruments by limitations imposed by state and federal laws, rulings, policy, and decisions affecting remedies and by bankruptcy, reorganization, or other laws of general application affecting the enforcement of creditors' rights or the enforceability of certain remedies or document provisions.

Bankruptcy

In the event of the bankruptcy of a member of the Obligated Group, the rights and remedies of the bondholders are subject to various provisions of the Federal Bankruptcy Code. If a member of the Obligated Group was to become a debtor in a bankruptcy case, payments made by that Obligated Group member during the 90-day (or perhaps one-year) period immediately preceding the filing of the case may be avoidable as preferential transfers to the extent, among other requirements, that such payments allow the recipients thereof to receive more than they would have received in the event of the Obligated Group member's liquidation. Security interests and other liens granted to the Bond Trustee or the Master Trustee and perfected during such preference period also may be avoided as preferential transfers to the extent, among other requirements, that such security interest or other lien secures obligations that arose prior to the date of such perfection.

A bankruptcy filing would operate as an automatic stay of various creditor actions to enforce, maintain, or enhance the rights of the Bond Trustee and the Master Trustee. Such actions would include (a) the commencement or continuation of any judicial or other proceeding against the member of the Obligated Group and its property, including all or some funds held under the Bond Indenture for the payment of Bond Service Charges on the Series 2017 Bonds, and (b) any act or proceeding to enforce a lien upon or to otherwise exercise control over property of the Obligated Group member. If the bankruptcy court so ordered, the property of the Obligated Group member, including all or some funds held under the Bond Indenture for the payment of Bond Service Charges on the Series 2017 Bonds, could be used for the financial rehabilitation of such member despite any security interest of the Bond Trustee or the Master Trustee in the property. The rights of the Bond Trustee and the Master Trustee to enforce their respective security interests and other liens could be delayed during the pendency of the rehabilitation proceeding.

An Obligated Group member could file a plan for the adjustment of its debts in any bankruptcy case, which plan could include provisions modifying or altering the rights of its secured or unsecured creditors. The plan, if confirmed by the court, binds all creditors and, with certain limited exceptions, discharges all claims against the debtor to the extent provided for in the plan. No plan may be confirmed unless certain conditions are met, among which are conditions that the plan be feasible and that it shall have been accepted by each class of claims impaired thereunder. The plan will be accepted by an impaired class if holders of at least two-thirds in dollar amount and more than one-half in number of claims in the class cast votes in its favor. Even if the plan is not so accepted, it may be confirmed if the court finds that the plan meets the other requirements for confirmation and determines that the plan is fair and equitable with respect to each class of non-accepting creditors impaired thereunder and does not discriminate among such creditors unfairly.

In the event of the bankruptcy of an Obligated Group member, there is no assurance that certain covenants, including tax covenants, contained in the Sublease or certain other documents would survive. Accordingly, a bankruptcy trustee could take action that would adversely affect the exclusion of interest on the Series 2017 Bonds from gross income of the bondholders for federal income tax purposes.

Bond Examinations

For several years, IRS officials have indicated that more resources would be invested in audits of tax-exempt bonds in the charitable organization sector with specific review of private use. In addition, the IRS sent several hundred post-issuance compliance questionnaires to nonprofit corporations that had borrowed on a tax-exempt basis regarding their post-issuance compliance with various requirements for maintaining the federal tax exemption of interest on their bonds. The questionnaire included questions relating to the borrower's (a) record retention, which the IRS has particularly emphasized, (b) qualified use of bond-financed property, (c) arbitrage yield restriction and rebate requirements, (d) debt management policies, and (e) voluntary compliance and education. In September 2008, the IRS issued an interim report analyzing the responses from the completed questionnaires. The report indicated that there were significant gaps in the implementation by nonprofit corporations of post-issuance and record retention procedures for tax-exempt bonds.

Although management of the Corporation believes that its expenditure and investment of bond proceeds, use of property financed with tax-exempt debt, and record retention practices have complied in all material respects with applicable laws and regulations, there can be no assurance that the issuance of surveys or a random audit will not lead to an IRS review that could adversely affect the market value of the Series 2017 Bonds or of other outstanding tax-exempt indebtedness of the Obligated Group. Additionally, the Series 2017 Bonds or other tax-exempt obligations issued for the benefit of Obligated Group members may be, from time to time, subject to examinations by the IRS. The Obligated Group believes that the Series 2017 Bonds and other tax-exempt obligations issued for the benefit of any Obligated Group member properly comply with the tax laws. In addition, Bond Counsel will render an opinion with respect to the tax-exempt status of the Series 2017 Bonds, as described under the heading **Tax Matters**. The Obligated Group has not sought to obtain a private letter ruling from the IRS with respect to the Series 2017 Bonds, however, and the opinion of Bond Counsel is not binding on the IRS or the courts. There can be no assurance that any IRS examination of the Series 2017 Bonds will not adversely affect the market value of the Series 2017 Bonds. See **Tax Matters**.

Business Relationships and Other Business Matters

Integrated Physician Groups. Hospitals and hospital systems often own, control, or have affiliations with relatively large physician groups. Generally, the sponsoring hospital or health system will be the primary capital and funding source for such alliances and may have an ongoing financial commitment to provide growth capital and support operating deficits. These types of alliances are generally designed to respond to trends in the delivery of medicine to better integrate hospital and physician care, to increase physician availability to the community, and to enhance the managed care capability of the affiliated hospitals and physicians. However, these goals may not be achieved, and an unsuccessful alliance may be costly and counterproductive to all of the above-stated goals.

Integrated delivery systems carry with them the potential for legal or regulatory risks in varying degrees. 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. In addition, participating physicians may seek their independence for a variety of reasons, thus putting the hospital or health system's investment at risk, and potentially reducing its managed care leverage and/or overall utilization.

International Classification of Disease, 10th Revision Coding System. On October 1, 2015, implementation off CMS' final rule adopting the International Classification of Disease, 10th Revision coding system (ICD-10), became effective. ICD-10 provides a common approach to the classification of diseases and other health problems, allowing the United States to align with other nations to better share

medical information, diagnoses and treatment codes. Implementation of ICD-10 required staff to be retrained, processes redesigned, and computer applications modified as the current available codes and digit size dramatically increased. ICD-10 is not without risks, as there is a potential for temporary coding and payment backlog, as well as possible increases in claim errors. There is a potential for revenue stream disruption for health care organizations, and the magnitude of the transition within the industry may add pressure to the cash flows of health care organizations. At this time, however, it is not possible to predict the full effects of ICD-10 implementation.

Physician Financial Relationships

Hospitals and hospital systems frequently have various additional business and financial relationships with physicians and physician groups. These are in addition to hospital-physician contracts for individual services performed by physicians in hospitals. They potentially include: joint ventures to provide a variety of outpatient services; recruiting arrangements with individual physicians, and physician groups; loans to physicians; medical office leases; equipment leases from or to physicians; and various forms of physician practice support or assistance. These and other financial relationships with physicians (including hospital-physician contracts for individual services) may involve financial and legal compliance risks for the hospitals and systems involved. From a compliance standpoint, these types of financial relationships may raise federal and state anti-kickback statute and Stark law issues (*see* "Regulatory Environment," above), tax-exemption issues, as well as other legal and regulatory risks, and these could have a material adverse impact on hospitals.

Labor Relations and Collective Bargaining

Hospitals are large employers with a wide diversity of employees. Increasingly, employees of hospitals are becoming unionized, and many hospitals have collective bargaining agreements with one or more labor organizations. Employees subject to collective bargaining agreements may include essential nursing and technical personnel, as well as food service, maintenance and other trade personnel. Dealing with a new bargaining unit or renegotiating collective bargaining agreements upon expiration may result in significant cost increases to hospitals. Employee strikes or other adverse labor actions may have an adverse impact on operations, revenue and hospital reputation.

Currently, the members of the Obligated Group have no collective bargaining agreements, and management is not aware of any organizational activity.

Capital Needs vs. Capital Capacity

Hospital operations are capital intensive. Regulation, technology, and physician/patient expectations require constant and often significant capital investment. Total capital needs may outstrip capital capacity. Furthermore, capital capacity of hospitals and health systems may be reduced as a result of credit market dislocations and economic uncertainty.

Facility Damage

Hospitals are highly dependent on the condition and functionality of their physical facilities. Damage from fire, flood or other natural disasters, deliberate acts of destruction, or various facilities system failures may have a material adverse impact on hospital operations, financial condition, and financial performance.

Risks Related to Outstanding Variable Rate Obligations

Certain outstanding Obligations issued under the Master Indenture secure instruments which bear interest at a variable rate, the interest rates on which could rise. Such interest rates vary on a periodic basis and may be converted to a fixed interest rate. This protection against rising interest rates is limited, however, because the Obligated Group would be required to continue to pay interest at the variable rate until it is permitted to convert the obligations to a fixed rate pursuant to the terms of the applicable transaction documents.

Investments

The Obligated Group has significant holdings in a broad range of investments. Market fluctuations may affect the value of those investments and those fluctuations may be and historically have been at times material.

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. Large employers with complex workforces, such as hospitals, are susceptible to actual and alleged violations of these standards. In recent years, there has been a proliferation of lawsuits over these "wage and hour" issues, often in the form of large, sometimes multi-state, class actions. For large employers such as hospitals and health systems, such class actions can involve multi-million dollar claims, judgments, and settlements. A major class action decided or settled adversely to the Corporation or any other member of the Obligated Group could have a material adverse impact on the financial condition and performance of the Obligated Group.

Health Care Worker Classification

Health care providers, like all businesses, 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 Internal Revenue Service (the "IRS") has established criteria for determining whether a worker is an employee or an independent contractor for tax purposes. If the IRS were to reclassify a significant number of hospital independent contractors (e.g., physician medical directors) as employees, back taxes and penalties could be material.

Bond Ratings

There is no assurance that one or more of the ratings assigned to the Series 2017 Bonds at the time of issuance will not be lowered or withdrawn at any time, which could adversely affect the market price for and marketability of the Series 2017 Bonds. See **Ratings**.

Market for Series 2017 Bonds

Subject to prevailing market conditions, the Underwriter intends, but is not obligated, to make a market in the Series 2017 Bonds. There is presently no secondary market for the Series 2017 Bonds and no assurance that a secondary market will develop. Consequently, investors may not be able to resell the Series 2017 Bonds purchased should they need or wish to do so for emergency or other purposes.

Other Risk Factors

In the future, the following factors, among others, may adversely affect the operations of health care providers, including the members of the Obligated Group or the market value of the Series 2017 Bonds, to an extent that cannot be determined at this time.

(a) Hospitals 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 Obligated Group members bear a wide variety of risks in connection with their employees. These risks include 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. The Obligated Group members are subject to all of the risks listed above, and such risks, alone or in combination, could have a material adverse impact on the financial condition and performance of the Obligated Group.

(b) The occurrences of natural or man-made disasters, including floods and earthquakes, may damage some or all of the facilities, interrupt utility service to some or all of the facilities, result in an abnormally high demand for health care services or otherwise impair the operation of some or all of the facilities operated by the Obligated Group members or the generation of revenues from some or all of the facilities.

(c) Decrease in availability of grants, or in receipt of contributions or bequests.

(d) The occurrence of a large-scale terrorist attack or a global pandemic that increases the proportion of patients who are unable to pay fully for the cost of their care and that disrupts the operation of certain health care facilities by resulting in an abnormally high demand for health care services.

(e) Instability in the stock market that may adversely affect both the principal value of, and income from, the Obligated Group's investment portfolio.

(f) Adoption of a so-called "flat tax" federal income tax, a reduction in the marginal rates of federal income taxation, or replacement of the federal income tax with another form of taxation, any of which might adversely affect the market value of the Series 2017 Bonds.

(g) Adoption of legislation that would establish a national or statewide single-payor health program or that would establish national, statewide, or otherwise regulated rates applicable to hospitals and other health care providers.

(h) Reduced demand for the services of Obligated Group members that might result from decreases in population.

(i) Increased unemployment or other adverse economic conditions that would increase the proportion of patients who are unable to pay fully for the cost of their care.

(j) Bankruptcy of an indemnity/commercial insurer, managed care plan, or other payor.

(k) Efforts by insurers and governmental agencies to limit the cost of hospital services, to reduce the number of beds and to reduce the utilization of hospital facilities by such means as preventive medicine, improved occupational health and safety and outpatient care, or comparable regulations or attempts by third-party payors to control or restrict the operations of certain health care facilities.

(l) The shift of medical staff loyalties to health systems and facilities other than the Obligated Group members would have an adverse effect, to the extent that each medical staff member has influence in admitting or directing a particular patient, with the patient's consent, to a particular facility.

(m) Increased levels of costs incurred in connection with uncompensated care services for indigent patients or in connection with catastrophic illnesses, pandemics, and other diseases.

(n) Limitations on the availability of, and increased compensation necessary to secure and retain, nursing, technical, and other professional personnel.

The occurrence of one or more of the foregoing, or the occurrence of other unanticipated events, could adversely affect the financial performance of the Obligated Group.

Tax-Exempt Status of the Series 2017 Bonds; Continuing Legal Requirements

As described under the caption **Tax Matters**, failure to comply with certain legal requirements may cause the interest on the Series 2017 Bonds to become included in gross income for Federal income tax purposes. In such event, the Series 2017 Bonds may be accelerated at the discretion of the Bond Trustee or at the written request of holders of not less than a majority of the aggregate principal amount of the outstanding Series 2017 Bonds. The Bond Indenture does not provide for the payment of any additional interest or penalty in the event the interest on the Series 2017 Bonds becomes included in gross income for Federal income tax purposes.

TAX MATTERS

Federal Tax Matters

In the opinion of Dinsmore & Shohl LLP, Bond Counsel for the Series 2017 Bonds, based upon an analysis of existing laws, regulations, rulings and court decisions, interest on the Series 2017 Bonds will be excludible from gross income for federal income tax purposes. Bond Counsel for the Series 2017 Bonds is also of the opinion that interest on the Series 2017 Bonds will not be a specific item of tax preference under Section 57 of the Internal Revenue Code of 1986, as amended (the "Code") for purposes of the federal individual or corporate alternative minimum taxes. Furthermore, Bond Counsel for the Series 2017 Bonds is of the opinion that the Series 2017 Bonds, the transfer thereof, and the income therefrom, including any profit made on the sale thereof, are exempt from taxation within the State of Ohio, subject to continuing compliance with certain covenants and agreements as set forth in this opinion.

A copy of the opinion of Bond Counsel for the Series 2017 Bonds is set forth in **Appendix D.**

The Code imposes various restrictions, conditions, and requirements relating to the qualification of the Series 2017 Bonds as so called "tax-exempt" bonds. Both the Issuer and the Corporation have covenanted to comply with certain restrictions designed to ensure that interest on the Series 2017 Bonds will not be includible in gross income for federal income tax purposes. Failure to comply with these covenants

could result in the Series 2017 Bonds not qualifying as "tax-exempt bonds," and thus the interest on the Series 2017 Bonds being includible in the gross income of the holders thereof for federal income tax purposes. Such failure to qualify and the resulting inclusion of interest could be required retroactively to the date of issuance of the Series 2017 Bonds. The opinion of Bond Counsel assumes compliance with these covenants. However, Bond Counsel has not undertaken to determine (or to inform any person) whether any actions taken (or not taken) or events occurring (or not occurring) after the date of issuance of the Series 2017 Bonds may adversely affect the tax status of the interest on the Series 2017 Bonds.

Certain requirements and procedures contained or referred to in the Bond Indenture, the Tax Regulatory Agreement and other relevant documents may be changed and certain actions (including, without limitation, defeasance of the Series 2017 Bonds) may be taken or omitted under the circumstances and subject to the terms and conditions set forth in such documents. Bond Counsel expresses no opinion as to any Series 2017 Bonds or the interest thereon if any such change occurs or action is taken or omitted upon the advice or approval of bond counsel other than Dinsmore & Shohl LLP.

Although Bond Counsel for the Series 2017 Bonds is of the opinion that interest on the Series 2017 Bonds will be excludible from gross income for federal income tax purposes and the Series 2017 Bonds will be exempt from taxation within the State of Ohio, as described above, the ownership or disposition of, or the accrual or receipt of interest on, the Series 2017 Bonds may otherwise affect a Bondholder's federal, state or local tax liabilities. The nature and extent of these other tax consequences may depend upon the particular tax status of the holder or the holder's other items of income or deduction. Bond Counsel expresses no opinions regarding any tax consequences other than those set forth in its opinion and each holder or potential holder is urged to consult with tax counsel with respect to the effects of purchasing, holding or disposing of the Series 2017 Bonds on the tax liabilities of the individual or entity.

For example, although Bond Counsel for the Series 2017 Bonds is of the opinion that interest on the Series 2017 Bonds is not a specific item of tax preference for the federal alternative minimum tax, corporations are required to include all tax-exempt interest in determining "adjusted current earnings" under Section 56(c) of the Code, which may increase the amount of any alternative minimum tax owed. Receipt of tax-exempt interest, ownership or disposition of the Series 2017 Bonds may result in other collateral federal, state or local tax consequences for certain taxpayers. Such effects may include, without limitation, increasing the federal tax liability of certain foreign corporations subject to the branch profits tax imposed by Section 884 of the Code, increasing the federal tax liability of certain insurance companies, under Section 832 of the Code, increasing the federal tax liability and affecting the status of certain S Corporations subject to Sections 1362 and 1375 of the Code, increasing the federal tax liability of certain individual recipients of Social Security or Railroad Retirement benefits, under Section 86 of the Code and limiting the use of the Earned Income Credit under Section 32 of the Code that might otherwise be available. Ownership of any Series 2017 Bonds may also result in the limitation of interest and certain other deductions for financial institutions and certain other taxpayers, pursuant to Section 265 of the Code. Finally, residence of the holder of Series 2017 Bonds in a state other than Ohio or being subject to tax in a state other than Ohio, may result in income or other tax liabilities being imposed by such states or their political subdivisions based on the interest or other income from the Series 2017 Bonds.

PROSPECTIVE PURCHASERS OF THE SERIES 2017 BONDS ARE ADVISED TO CONSULT THEIR OWN TAX ADVISERS PRIOR TO ANY PURCHASE OF THE SERIES 2017 BONDS AS TO THE IMPACT OF THE INTERNAL REVENUE CODE OF 1986, AS AMENDED, UPON THEIR ACQUISITION, HOLDING, OR DISPOSITION OF THE SERIES 2017 BONDS.

Premium

"Acquisition Premium" is the excess of the cost of a bond over the stated redemption price of such bond. The Series 2017 Bonds are being initially offered and sold to the public with Acquisition Premium. For federal income tax purposes, the amount of Acquisition Premium on the Series 2017 Bonds must be amortized and will reduce the holder's adjusted basis in that bond. However, no amount of amortized Acquisition Premium on the Series 2017 Bonds may be deducted in determining holder's taxable income for federal income tax purposes. The amount of any Acquisition Premium paid on the Series 2017 Bonds that must be amortized during any period will be based on the "constant yield" method, using the original holder's basis in such Series 2017 Bonds and compounding semiannually. This amount is amortized ratably over that semiannual period on a daily basis.

Please note that because the Series 2017 Bonds that mature on December 1 in the years 2037, 2042, and 2047 (the "Callable Series 2017 Bonds") are callable prior to their stated maturity, the required amortization period for the Acquisition Premium of each Callable Premium Bond will depend on which call dates produces the greatest diminution in the yield to the holder. The Series 2017 Bonds that mature on December 1 in each of the years 2021 through 2027, inclusive (the "Non-Callable Series 2017 Bonds"), are not callable prior to their stated maturity date, the respective final maturity dates will determine the amortization period of the Acquisition Premium of each Non-Callable Premium Bond.

Holders of any Series 2017 Bonds, both original purchasers and any subsequent purchasers, should consult their own tax advisors as to the actual effect of any Acquisition Premium with respect to their own federal income tax situation and as to the treatment of the Acquisition Premium for state tax purposes.

State Tax Matters

Dinsmore & Shohl LLP, Bond Counsel for the Series 2017 Bonds, is also of the opinion that, under existing law, interest on the Series 2017 Bonds, the transfer thereof, and any profits made on their sale, exchange, transfer, or other disposition are exempt from the Ohio personal income tax and income taxes imposed by certain political subdivisions in Ohio. Interest on the Series 2017 Bonds, as is the case with most other forms of interest on debt obligations, is not subject to the Ohio commercial activity tax. No opinion is expressed regarding taxation of interest on the Series 2017 Bonds under any other provision of Ohio law. The tax consequences arising with respect to the Series 2017 Bonds may be different under the applicable state and local tax laws of states other than Ohio. Each purchaser of the Series 2017 Bonds should consult his or her own tax advisor regarding the taxable status of the Series 2017 Bonds in a particular or local jurisdiction other than Ohio.

THE FOREGOING IS NOT INTENDED AS A DETAILED OR COMPREHENSIVE DESCRIPTION OF ALL POSSIBLE TAX CONSEQUENCES OF BUYING OR HOLDING THE SERIES 2017 BONDS. PERSONS CONSIDERING THE PURCHASE OF THE SERIES 2017 BONDS SHOULD CONSULT THEIR TAX ADVISORS AS TO THE CONSEQUENCES OF BUYING OR HOLDING THE SERIES 2017 BONDS IN THEIR PARTICULAR CIRCUMSTANCES.

LEGAL MATTERS

Certain legal matters incident to the authorization, issuance, and sale of the Series 2017 Bonds and the tax-exempt status of the interest on the Series 2017 Bonds (see **Tax Matters**) are subject to the approval of Dinsmore & Shohl LLP, Bond Counsel. A signed copy of that opinion, dated and speaking only as of the date of original delivery of the Series 2017 Bonds, will be delivered to the Underwriter at the time of such original delivery, a copy of the opinion will be printed on the Series 2017 Bonds and a draft of that opinion is attached as **Appendix D**.

Certain legal matters pertaining to each member of the Obligated Group will be passed upon by Dinsmore & Shohl LLP.

Certain legal matters will be passed upon for the Underwriter by Vorys, Sater, Seymour and Pease LLP. In addition as serving as counsel to the Underwriter, Vorys, Sater, Seymour and Pease LLP advises the Corporation from time to time on certain healthcare matters.

LITIGATION

Issuer

To the knowledge of the Issuer, there is no pending or threatened litigation seeking to restrain or enjoin the issuance, sale, execution, or delivery of the Series 2017 Bonds, or in any way contesting or affecting the validity of the Series 2017 Bonds or any proceeding of the Issuer taken with respect to the issuance or sale of the Series 2017 Bonds, the pledge or application of any moneys or security provided for the payment of the Series 2017 Bonds, or existence or powers of the Issuer, or the authority of the Issuer to enter into any document relating to the Bond Indenture or the Series 2017 Bonds.

The Obligated Group

No litigation or proceedings are pending or, to the knowledge of members of the Obligated Group, threatened against any member of the Obligated Group except (a) litigation involving claims for hospital professional liability in which the aggregate of the probable recoveries and the estimated costs and expenses of defense, in the opinion of management of the members of the Obligated Group, will be entirely within the applicable insurance policy limits (subject to applicable deductibles) or within the applicable self-insurance reserves of the members of the Obligated Group, (b) a voluntary disclosure submitted by the Corporation to the Centers for Medicare and Medicaid Services regarding possible noncompliance with the federal physician self-referral statute in which the likely repayment amount resulting from the self-disclosure, in the opinion of counsel to the Corporation based on information known at this time, would not materially or adversely affect the financial condition or results of operation of the Obligated Group, and (c) litigation and proceedings other than those described in (a) and (b) which would not in the opinion of management of the Obligated Group, materially and adversely affect the financial condition or the results of operations of the members of the Obligated Group, the transactions contemplated by this Official Statement, or the validity of the Master Indenture, the Lease, the Sublease, or the Series 2017A Note and the issuance of the Series 2017A Note if the Corporation or other members of the Obligated Group were found liable under such proceedings.

INDEPENDENT AUDITORS

The consolidated financial statements of Adena Health System and Subsidiaries, as of December 31, 2016 and 2015 and December 31, 2015 and 2014, and for the years then ended, included in this Official Statement, have been audited by Plante & Moran, PLLC, independent auditors, as stated in their reports included in **Appendices B-1** and **B-2.**

FINANCIAL STATEMENTS

The consolidated financial statements set forth in **Appendices B-1** and **B-2** include information concerning certain organizations that, by membership, equity interest or contract, are affiliated with, but are not themselves, members of the Obligated Group. In 2017, considering the impact of consolidating and eliminating entries, the Obligated Group accounted for approximately 92% of total assets of Adena Health System and its subsidiaries and 91% of the total consolidated net revenues of Adena Health

System and its subsidiaries. The controlled affiliated entities outside the Obligated Group do not have any liability with respect to the Series 2017 Bonds, and the holders of the Series 2017 Bonds do not have any claim against those entities or their assets for payment of Bond Service Charges on the Series 2017 Bonds.

The unaudited summary financial information of Adena Health System and its subsidiaries as of and for the years ended December 31, 2016 and 2015 and December 31, 2015 and 2014, and as of and for the three-month period ended March 31, 2017 and 2016 included in **Appendix A** and **Appendices B-1** and **B-2** to this Official Statement have been prepared by Corporation management and have not been audited by any firm of independent auditors and, thus, no opinion on such interim information is expressed in this Official Statement.

VERIFICATION OF MATHEMATICAL COMPUTATIONS

Concurrent with the delivery of the Series 2017 Bonds, Dinsmore & Shohl LLP (the "Verification Agent"), will deliver its verification report indicating that it has verified, certain information provided by the Corporation. Included in the scope of its verification will be a verification of the mathematical accuracy of (a) the mathematical computations of the adequacy of the various escrow deposits to pay, when due, the Escrow Account Payments, and (b) the mathematical computation supporting the conclusion of Bond Counsel that the Series 2017 Bonds are not "arbitrage bonds" under the Code and the regulations promulgated under the Code.

The verification performed by the Verification Agent will be solely based upon data, information, and documents provided to the Verification Agent by the Corporation and its representatives. The Verification Agent has restricted its procedures to recalculating the computations provided by the Corporation and its representatives and has not evaluated or examined the assumptions or information used in the computations.

UNDERWRITING

The Series 2017 Bonds are being purchased by the Underwriter. The Underwriter has agreed to purchase the Series 2017 Bonds in accordance with a purchase contract between the Issuer, the Corporation, and the Underwriter, subject to certain conditions (the "Bond Purchase Agreement"). The Series 2017 Bonds will be purchased at a purchase price of $159,967,658.97, (representing the principal amount of the Series 2017 Bonds, less an Underwriter's discount of $1,127,667.28, plus original issue premium of $15,525,326.25.

The Underwriter intends to offer the Series 2017 Bonds to the public initially at the offering prices set forth on the inside front cover page of this Official Statement. As described under **Regarding this Official Statement**, those offering prices may subsequently change without any requirement of prior notice, and the Underwriter may offer and sell Series 2017 Bonds to certain dealers (including dealers depositing Series 2017 Bonds into investment trusts) at prices lower than the public offering prices. The Underwriter also reserves the right to join with dealers and other underwriters in offering the Series 2017 Bonds to the public.

The Bond Purchase Agreement provides that the Underwriter will purchase all the Series 2017 Bonds, if any are purchased, and requires the Corporation to indemnify the Underwriter and the Issuer against losses, claims, and liabilities arising out of any untrue statement of a material fact contained in, or omission from, the information contained in this Official Statement in connection with the transactions contemplated by this Official Statement. The initial public offering price may be changed, from time to time, by the Underwriter.

The Underwriter also served as placement agent for the Taxable Bank Loan and as bidding agent for the purchase of defeasance obligations in connection with the refunding of the Series 2008 Bonds.

RATINGS

Moody's Investors Service, Inc. ("Moody's") and Standard & Poor's Ratings Services, a division of the McGraw-Hill Companies Inc. ("S&P") have given the Series 2017 Bonds ratings of "A3" and "A-," respectively. No application has been made to any other rating agency for the purpose of obtaining an additional rating on the Series 2017 Bonds. The ratings reflect only the views of the respective rating agency, and an explanation of the significance of the ratings may be obtained from each rating agency. There is no assurance that any such rating will continue for any given period of time or that a rating will not be revised downward or withdrawn entirely by the rating agency, if in the judgment of the rating agency, circumstances so warrant. Any such downward revision or withdrawal of a rating may have an adverse effect on the market price of the Series 2017 Bonds. Neither the Issuer nor the Underwriter has agreed to take any action with respect to any proposed rating change or to bring any such rating change that may occur to the attention of owners of the Series 2017 Bonds.

CONTINUING DISCLOSURE

In accordance with the Securities and Exchange Commission Rule 15c2-12 (the "Rule") and so long as the Series 2017 Bonds are outstanding, the Corporation, on behalf of itself and the other members of the Obligated Group (together, the "Obligated Persons"), has agreed in a Continuing Disclosure Agreement to be delivered on the date of delivery of the Series 2017 Bonds (the "Disclosure Agreement"), to provide the following information:

(a) Each year, certain financial information and operating data relating to the Corporation and its subsidiaries, including Adena Medical Group (the "Annual Report") by not later than 150 days after the end of the Corporation's fiscal year, commencing with the Annual Report for the fiscal year ended December 31, 2017; provided, however, that if the audited financial statements of the Corporation and its subsidiaries are not available by such date, they will be provided as soon as they become available.

(b) No later than 60 days after the end of each fiscal quarter ending March 31, June 30, and September 30, and December 31, unaudited financial statements prepared in conformity with generally accepted accounting principles (the "Quarterly Report").

(c) Timely notices of the occurrence of the events described under **Event Notices** below.

(d) Notice of the failure of the Corporation to provide the Annual Report or the Quarterly Report by the dates required.

Currently the fiscal year of the Corporation commences on January 1. For purposes of the Disclosure Agreement, "Beneficial Owner" means any person who has the power, directly or indirectly, to vote or consent with respect to, or to dispose of ownership of, any Series 2017 Bonds, including persons holding Series 2017 Bonds through nominees, depositories, or other intermediaries.

The Annual Report, the Quarterly Report, notices of the enumerated events, and notices of the failure to timely provide the reports will be filed in an electronic format by the Corporation with the Electronic Municipal Market Access system ("EMMA") of the Municipal Securities Rulemaking Board

(the "MSRB"). These covenants have been made in order to assist the Underwriter and registered brokers, dealers, and municipal securities dealers in complying with the requirements of the Rule.

Event Notices

The Corporation covenants to provide notice of the occurrence of any of the following events with respect to the Series 2017 Bonds:

(1) Principal and interest payment delinquencies;

(2) Non-payment-related defaults, if material;

(3) Unscheduled draws on debt service reserves reflecting financial difficulties;

(4) Unscheduled draws on credit enhancements reflecting financial difficulties;

(5) Substitution of credit or liquidity providers, or their failure to perform;

(6) Adverse tax opinions, the issuance by the Internal Revenue Service of proposed or final determinations of taxability, Notices of Proposed Issue (IRS Form 5701-TEB) or other material notices or determinations with respect to the tax status of the Series 2017 Bonds, or other material events affecting the tax-exempt status of the Series 2017 Bonds;

(7) Modifications to rights of security holders, if material;

(8) Bond calls, if material, and tender offers (except for mandatory scheduled redemptions not otherwise contingent upon the occurrence of an event);

(9) Defeasances;

(10) Release, substitution, or sale of property securing repayment of the Series 2017 Bonds, if material;

(11) Rating changes;

(12) Bankruptcy, insolvency, receivership or similar event of the obligated person (Note: For the purposes of this event, the event is considered to occur when any of the following occur: the appointment of a receiver, fiscal agent or similar officer for an obligated person in a proceeding under the U.S. Bankruptcy Code or in any other proceeding under state or federal law in which a court or governmental authority has assumed jurisdiction over substantially all of the assets or business of the obligated person, or if such jurisdiction has been assumed by leaving the existing governing body and officials or officers in possession but subject to the supervision and orders of a court or governmental authority, or the entry of an order confirming a plan of reorganization, arrangement or liquidation by a court or governmental authority having supervision or jurisdiction over substantially all of the assets or business of the obligated person);

(13) The consummation of a merger, consolidation, or acquisition involving an obligated person or the sale of all or substantially all of the assets of the obligated person, other than in the ordinary course of business, the entry into a definitive agreement to undertake

such an action or the termination of a definitive agreement relating to any such actions, other than pursuant to its terms, if material; and

(14) Appointment of a successor or additional trustee or the change of name of a trustee, if material.

Annual Report

The Annual Report will contain or incorporate by reference at least the following items:

(a) The annual audited financial information prepared for the Corporation and its subsidiaries, including Adena Medical Group, which must include, if prepared, a balance sheet, a statement of revenue and expenditure and a statement of changes in fund balances. All such financial information shall be prepared using generally accepted accounting principles, provided, however, that the Corporation may change the accounting principles used for preparation of such financial information so long as the Corporation includes as information provided to the public a statement to the effect that different accounting principles are being used, stating the reason for such change and how to compare the financial information provided by the differing financial accounting principles.

(b) An update of the financial information and operating data of the same general nature as that contained in the information and tables under the captions **Inpatient Discharge Data**, **Outpatient Discharge Data**, **Health System Financial and Operational Information**, **Key Financial Ratios of the Health System**, and **Management Discussion and Analysis of Financial Performance of Health System** in **Appendix A**.

Quarterly Report

The Quarterly Report will include unaudited fiscal year to date financial statements of the Obligated Group, including a balance sheet, a statement of revenue and expenditures, and a statement of changes in fund balances, and (a) operating data of the same general nature as that contained in the information and tables under the captions **Inpatient Discharge Data** and **Outpatient Discharge Data, Health System Financial and Operational Information, Key Financial Ratios of the Health System,** and **Management Discussion and Analysis of Financial Performance of Health System** in **Appendix A,** and (b) operating data of the Obligated Group that includes patient days, average length of stay, Medicare case mix index, inpatient surgeries, clinic visits, full-time equivalent employees, physician full-time equivalent employees, admissions, emergency room visits, and births.

Failure to Comply

If the Corporation fails to comply with any provision of the Disclosure Agreement, any beneficiary of the Disclosure Agreement may, and, at the request of the Underwriter or the holders of at least 25% aggregate principal amount of outstanding Series 2017 Bonds, the non-defaulting party must, enforce the obligations of the Corporation under the Disclosure Agreement. The sole remedy available in any proceeding to enforce the Disclosure Agreement is an action to compel performance. The occurrence of any event of default as provided in the Disclosure Agreement is not an event of default under the Bond Indenture or the Sublease.

Amendment of the Disclosure Undertaking

The Corporation may amend the Disclosure Agreement and any provision of the Disclosure Agreement may be waived, if such amendment or waiver is supported by an opinion of nationally recognized bond counsel or counsel expert in federal securities laws acceptable to the Corporation and the Obligated Group Representative to the effect that such amendment or waiver would not, in and of itself, cause the undertakings in the Disclosure Agreement to violate the Rule if such amendment or waiver had been effective on the date of the Disclosure Agreement but taking into account any subsequent change in or official interpretation of the Rule as well as any change in circumstance.

Without limiting the foregoing, in the event of an Obligated Group Transaction (as defined in the Master Indenture) or a similar occurrence which affects the Corporation and the Obligated Group in the future, the Corporation may adopt that new obligated group's reporting requirements or undertaking which satisfy the Rule, subject to the opinion of nationally recognized bond counsel described in the immediate preceding paragraph.

Past Compliance with the Rule

The Corporation has previously entered into continuing disclosure agreements in connection with certain tax-exempt revenue bonds. A review of the filing history over the past five years shows the following instances of non-compliance with the Corporation's continuing disclosure obligations:

(a) the Corporation did not timely file its audited financial statements and annual operating data and information for the Fiscal Year ended December 31, 2015;

(b) the Corporation did not timely file the quarterly updates of its annual financial information and operating data on 15 occasions between 2012 and 2017, and did not file quarterly updates of its annual financial information and operating data for quarters ended June 30, 2012 and December 31, 2013;

(c) the Corporation inadvertently omitted a certain portion of its required operating data and information in its annual reports for Fiscal Years ended December 31, 2012 and December 31, 2013 and also omitted a certain portion of its required operating data and information in its quarterly reports for the quarters ended March 31, 2012 and June 30, 2012;

(d) the Corporation did not timely report certain rating changes of the bond insurer (Assured Guaranty Corporation) that insured the Series 2008 Bonds in 2013 and 2014; and

(e) the Corporation did not timely provide notice of the failure to timely file certain annual and quarterly reports.

Some of the instances of non-compliance noted above may be material. The failure to provide such information was an unintentional oversight by the Corporation. The Corporation has implemented policies and procedures to improve its ongoing continuing disclosure obligations, including a resolution of the Board of Trustees of the Corporation authorizing senior management to take any and all action necessary to ensure future continuing disclosure compliance. The resolution also requires senior management to provide the Finance Committee of the Board of Trustees confirmation of the timely filing of information and notices with EMMA. These policies and procedures are designed to assure reporting will be made on a timely basis and such reporting will comply in all material respects with the requirements of the Disclosure Agreement. Moreover, in connection with the issuance of the Series 2017

Bonds, the Corporation has engaged Digital Assurance Certification LLC to serve as dissemination agent for the Series 2017 Bonds.

ELIGIBILITY AS INVESTMENTS UNDER OHIO LAW

To the extent the subject matters are governed by Ohio law and subject to the applicable limitations under other provisions of Ohio law, including Section 140.07, Ohio Revised Code, the Series 2017 Bonds are lawful investments for banks, savings and loan associations, credit union share guaranty corporations, trust companies, trustees, fiduciaries, insurance companies, including domestic for life and domestic not for life, trustees or other officers having charge of sinking and bond retirement or other funds of the State, subdivisions and taxing districts of the State, the commissioners of the sinking fund of the State, the administrator of workers' compensation, subject to the approval of the workers' compensation board, the state teachers, public employees, and school employees retirement systems, and the police and firemen's pension fund of the State and are also acceptable as security for the repayment of the deposit of public monies in the State.

MISCELLANEOUS

The references in this Official Statement and in the attached Appendices to the Master Indenture, the Bond Indenture, the Lease, the Sublease, the Series 2017A Note, and the Tax Regulatory Agreement are brief outlines of certain provisions of those documents. Those outlines do not purport to be complete. For full and complete statements of such provisions, reference is made to the Series 2017 Bonds, the Master Indenture, the Bond Indenture, the Lease, the Sublease, the Series 2017A Note, and the Tax Regulatory Agreement.

The agreement of the Issuer with the holders of the Series 2017 Bonds is fully set forth in the Bond Indenture, and neither any advertisements of the Series 2017 Bonds nor this Official Statement is to be construed as constituting an agreement by the Issuer, the Corporation, or any future member of the Obligated Group with the purchasers of the Series 2017 Bonds. Copies of the documents mentioned under this heading are on file with the Underwriter and following delivery of the Series 2017 Bonds will be on file at the designated corporate trust office of the Bond Trustee.

The cover page and the attached Appendices are integral parts of this Official Statement and should be read together with all of the foregoing statements. All estimates and other statements in this Official Statement involving matters of opinion, whether or not expressly so stated, are intended as such and not as representations of fact.

The Issuer has furnished only the information contained in this Official Statement under the headings **Introductory Statement—The Issuer, The Issuer**, and **Litigation—Issuer** and has not reviewed nor verified any other information contained in this Official Statement.

The Corporation has furnished all of the information in this Official Statement relating to the Corporation's operations and facilities.

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This Official Statement, its execution, and its delivery and distribution to prospective purchasers of the Series 2017 Bonds, has been approved and authorized by the Issuer and Adena Health System on its behalf and on behalf of each member of the Obligated Group.

City of Chillicothe, Ohio

By: /s/ Luke Feeney
Mayor

By: /s/ Kristal Spetnagel
City Auditor

Approved:

Adena Health System, acting on behalf of itself and on behalf of Adena Medical Group, LLC

By: /s/ Lisa M. Carlson
Chief Financial Officer

APPENDIX A

INFORMATION CONCERNING

ADENA HEALTH SYSTEM AND THE OBLIGATED GROUP

The information contained herein as Appendix A to this
Official Statement has been provided by
Adena Health System

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APPENDIX A

ADENA HEALTH SYSTEM AND THE OBLIGATED GROUP

OVERVIEW

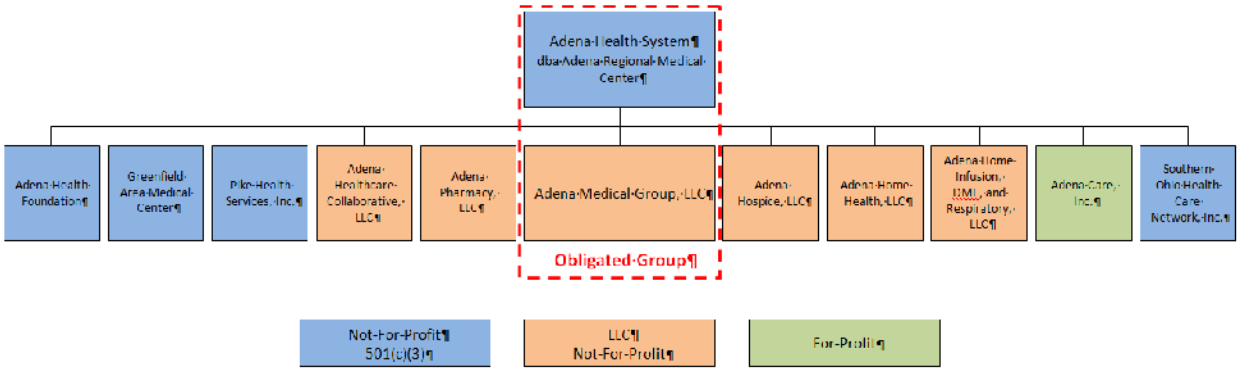
Adena Health System (the corporate entity shall hereafter be referred to as "Adena Health"), a private, non-profit corporation exempt from federal income taxation as a charitable organization described in Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code"), was incorporated under the laws of the State of Ohio on June 29, 1895 and began operations on January 1, 1896.

Today, Adena Health leads an integrated healthcare delivery system comprised of one hospital and eleven wholly-owned subsidiaries, including two critical access hospitals, that serves a broad geographic area in South Central Ohio (Adena Health and all subsidiaries shall hereafter collectively be referred to as the "Health System"). The Obligated Group portion of the Health System is comprised of its flagship hospital, Adena Regional Medical Center ("Hospital"), and Adena Medical Group, LLC ("AMG"), a multi-specialty group practice of physician and advanced practice providers. The Hospital is a modern, full-service acute-care general hospital comprised of a total of 261 beds, including 222 registered short-term adult and pediatric beds and 39 newborn, level II beds in Ross County, Ohio (the "County") near the City of Chillicothe, Ohio (the "City"). The Health System also includes two critical access hospitals: Adena Greenfield Medical Center ("AGMC") in Greenfield, Ohio, and Adena Pike Medical Center ("APMC"), in Waverly, Ohio. In addition, the Health System provides a variety of outpatient, urgent care, ancillary services, home health, hospice and psychiatric services at various other Ohio locations, including Piketon, Jackson, Washington Courthouse, Hillsboro, Oak Hill, Circleville and Wellston. Adena Health's wholly-owned subsidiaries operate a retail pharmacy, durable medical equipment company, home care and hospice centers which round out the medical operations of the Health System.

The Health System has a medical staff of more than 319 members, including 172 employed physicians, in various specialties such as pediatrics, primary care, obstetrics and gynecology, oncology, radiology, emergency medicine, orthopedics, hospitalists, cardiology, urology, gastroenterology and pathology. The Health System serves more than 400,000 residents of 10 Ohio counties.

In addition to offering comprehensive care, the Health System also offers the latest in medical technology, including: magnetic resonance imaging (MRI) with cardiac MRI capabilities, and magnetic resonance angiography (MRA), abdominal and vascular ultrasound, single photon emitted computed tomograhpy (SPECT) nuclear medicine, computed tomography (CT) and positron emitted tomography (PET) scanning, digital mammography, cardiac catheterization and balloon angioplasty, advanced orthopedics, including total joint replacement, spinal surgery, robotic surgery, open heart cardiothoracic and vascular surgery, minimally invasive surgery, GreenLight and Holmium laser lithotripsy, bronchial thermoplasty, endobronchial ultrasound, dialysis, linear accelerator and stereostatic breast biopsy.

ORGANIZATIONAL STRUCTURE



Corporate Organization

Adena Health is governed by a 15 member Board of Trustees. The Board of Trustees brings a variety of expertise and perspective on the needs of the communities served by the Health System. As shown above, Adena Health is the sole member of eleven subsidiaries. In addition, Adena Health owns a 49% joint interest in Court Dialysis, LLC dba Adena DaVita Dialysis Center.

The Obligated Group

The Obligated Group consists of Adena Health and AMG (the "Obligated Group"). Adena Health is the sole member of AMG. For the year ended December 31, 2016, the Obligated Group represented 91% of the Health System's total consolidated net patient revenues and 92% of the Health System's total assets.

The Hospital

The Hospital is an acute-care general hospital comprised of three floors utilizing approximately 367,880 square feet. The following table illustrates the number of beds by type that are licensed and available for use.

Classification	Licensed Beds	Beds In Use
Medical/Surgical	158	139
ICU	12	12
Psychiatric	15	10
OB	27	26
Pediatrics	10	6
Newborn	39	28
Total	261	221

The Hospital and additional medical facilities are spread across an approximately 100-acre campus, which is part of an approximately 220-acre site owned by Adena Health, adjacent to U.S. Route 23, approximately 2.5 miles outside of the City. Adena Health owns and manages a medical office building on the campus adjacent to the Hospital that is approximately 59,878 square-feet. The medical office

building houses both employed and independent Hospital medical staff physicians. A second, mixed-use facility, the approximately 75,893 square-foot Adena Health Pavilion, is attached to the main facility via an all-weather bridge. This facility is leased in its entirety to Adena Health and is owned by Northstar Asset Management and managed by Cornerstone Real Estate Services. The Adena Health Pavilion houses a variety of physician offices, the Hospital's outpatient surgery center, sleep center and outpatient diagnostic services. Additionally, the Hospital has sufficient surface parking available for its patients, employees, physicians and visitors with additional land available for expansion.

Adena Medical Group, LLC

AMG is an Ohio nonprofit limited liability company employing 172 physicians and 79 advanced practice providers. These providers are located at 17 practice sites throughout the Health System's 10-county service region and assist in meeting the needs of the population served in the South Central Ohio area. AMG employs primary and specialty physicians, including fellowship-trained surgeons and sub-specialists, in a number of areas, such as orthopedics, cardiology, urology, gastroenterology and others. In addition, advanced practice providers act as physician extenders in specialty practices and also provide improved primary care access. AMG provided more than 400,000 patient visits in 2016. Additionally, AMG primary care has steadily expanded its unique lives to more than 82,000. Unique lives are the individuals who have chosen AMG as the primary provider to manage their healthcare.

In addition the the services provided at the three hospital facilities, AMG also provides services at 14 other Ohio locations:

- Adena Family Medicine – Piketon, 100 Indian Ridge Drive, Piketon
- Adena Family Medicine – Wellston, 118 S. New York Ave., Suite A, Wellston
- Adena Family Medicine of Chillicothe, 626 Central Center, Chillicothe
- Adena Health and Wellness Center – Main Campus, 4457 State Route 159, Chillicothe
- Adena Health Center – Hillsboro, 160 Roberts Lane, Hillsboro
- Adena Health Center Circleville, 140 Morris Road, Circleville
- Adena Health Center Oak Hill, 315 Washington Street, Oak Hill
- Adena Pickaway Ross Family Physicians, 100 North Walnut Street, Chillicothe
- Adena Health Center – Jackson, 1000 Veterans Drive, Jackson
- Adena Health Center Washington Courthouse, 308 Highland Avenue, Washington Courthouse
- Adena Primary Care, Western Ave, 55 Centennial Boulevard, Chillicothe
- Adena DaVita Dialysis Center, 1180 North Bridge Street, Chillicothe
- Adena Family Medicine at Bristol Village, 621 East 5th Street, Waverly
- The Clinic at Walmart, 85 River Trace Lane, Chillicothe

Excluded Property

Certain properties and interests not essential to the Health System are Excluded Property under the Master Indenture. The Excluded Property is not subject to the restrictions contained in the Master Indenture and can be transferred or encumbered by the Health System without restriction. Currently, the Excluded Property consists of the following: (1) an undeveloped tract of land near the Scioto River for

which the Health System has no current plans and may donate to the County, (2) a medical office building owned by a solo practitioner located on the Hospital's main campus, (3) a garage and building on the Hospital's main campus that is currently used to house ambulances and satellite offices used by MedCare Ambulance, (4) a certain urgent care facility and related property located in Waverly, Ohio, (5) an undeveloped approximately 19.46 acre tract of land adjacent to the Adena Health Center – Western Avenue, and (6) an undeveloped land located on the main campus of the Hospital for which there are no current plans for development.

Health System management believes that the revenues derived from the operation of the Obligated Group's facilities will be sufficient to pay debt service on the obligations of the Obligated Group under the Master Indenture. The Obligated Group further retains the right from time to time to classify additional real or tangible personal property as Excluded Property upon the execution of supplemental indentures to the Master Indenture and upon the satisfaction of certain financial tests as set forth in the Master Indenture.

Additional Medical Facilities on Hospital Campus

The PACCAR Medical Education Center, 466 Hospital Road, Chillicothe. The PACCAR Medical Education Center (the "Center") is the teaching facility for the Hospital's Graduate Medical Education Program. The Center integrates educational opportunities for clinicians in the region and provides opportunities to educate caregivers by establishing nursing programs where students, both inside and outside of the Hospital, may obtain a Bachelor of Science degree in Nursing. With an advanced virtual hospital, the Center is truly a flagship site for clinical education. Four of the Center's programs are accredited by the Accreditation Council for Graduate Medical Education ("ACGME") and the American Osteopathic Association ("AOA"). The Graduate Medical Education Program allows for students and residents beginning a career in medicine to be trained within the Health System.

Adena Cancer Center, 4435 State Route 159, Chillicothe. A freestanding Cancer Center that offers both medical and radiation oncology, the approximately 26,000 square-foot facility brings advancement of protocols in image-guided radiation therapy, intensity-modulated radiation therapy, high-dose brachytherapy, mammosite, the latest in general radiation therapy and more. The center is the only free-standing cancer center in the region offering such services.

Adena Health and Wellness Center, 4457 State Route 159, Chillicothe. Adena Health and Wellness Center provides full-service occupational health services to area employers.

Medical Facilities off Hospital Campus

Adena Health Center – Western Avenue, 55 Centennial Boulevard, Chillicothe. Adena Health Center – Western Avenue is an approximately 21,500 square-foot, two-story facility owned and operated by Adena Health. Services at this facility include an integrated primary care practice; diagnostic services including radiology, mammography, laboratory, nuclear medicine, and cardiac diagnostic; and Adena Urgent Care. This facility, located approximately 10 miles from the Hospital, occupies a 25-acre campus and provides convenient access to primary care for residents of the service area.

The Adena Counseling Center, 455 Shawnee Lane, Chillicothe. This approximately 7,580 square-foot leased facility designed specifically for the provision of outpatient mental health services.

The Adena Rehabilitation and Wellness Center, 445 Shawnee Lane, Chillicothe. This leased facility, located in the City, provides approximately 14,000 square feet for rehabilitation and wellness services. It is one of only two locations for rehabilitation services located in the City.

The Adena Wellness Center - West, 2077 Western Avenue, Chillicothe. This leased facility is home to an outpatient rehabilitation center, the Health System's Accountable Care Organization ("ACO"), and home care, which includes home health, hospice, durable medical equipment ("DME"), and respiratory/infusion services. The facility includes approximately 17,500 square feet and provides a secondary location near the City for patients to obtain rehabilitation services close to home.

Carlisle Building, 9 South Paint Street, Chillicothe. A recently renovated historic building located in the heart of the City's downtown, the Carlisle Building consists of executive suites and apartments for graduate medical students who have enrolled into the Health System's Graduate Medical Program. The location allows the Health System to attain the goal of investing in and developing the community.

Other Subsidiaries and Affiliates of the Hospital

Adena Health controls, directly or indirectly, organizations that own or operate health care facilities. The following subsidiaries and affiliates are not members of the Obligated Group, but are included in the consolidated audited financial statements of the Health System:

Adena Health Foundation, 9 South Paint Street, Chillicothe. Adena Health Foundation (the "Foundation") is a wholly-owned subsidiary of Adena Health. This nonprofit corporation functions primarily as a fundraising organization to support the Health System and the communities it serves. The Foundation is separately incorporated as tax-exempt under Code Section 501(c)(3) and as a supporting organization under Code Section 509(a)(3). The five functions of the Foundation are: (1) to serve as a focal point for charitable giving for health and health-related initiatives in a 10-county region of Southern Ohio; (2) to translate gifts and resources from the Health System to community benefit programs to improve health and wellness in the 10-county region; (3) to maintain the funds of donors who designate gifts to special programs or unique needs for healthcare in the area; (4) to conduct capital campaigns as directed to support construction and expansion of programs; and (5) to provide accountability and stewardship for donors. The vision of the Foundation is to be a significant source of support for community benefit and for the excellence and growth of the Health System.

Adena Greenfield Medical Center, 550 Mirabeau Street, Greenfield. In 1999, Adena Health entered into an Affiliation Agreement with Greenfield Area Medical Center ("Greenfield Medical Center") under which Adena Health became the owner and operator of a 25-bed critical access hospital in Greenfield, Ohio, approximately 30 miles southwest of the City. Adena Health is the sole member of Greenfield Medical Center, which includes the right to elect the members of Greenfield Medical Center's Board of Trustees after the candidates are nominated by the current sitting members of the Greenfield Medical Center Board of Trustees. While Greenfield Medical Center is maintained as a separate non-profit corporation, clinical and administrative functions have been integrated with the Health System. Greenfield Area Medical Center now operates under the name of Adena Greenfield Medical Center.

Adena Pike Medical Center, 100 Dawn Lane, Waverly. In 2011, Adena Health entered into an Affiliation Agreement with Pike Health Services, Inc. ("PHS"), a separate non-profit tax-exempt

corporation doing business as Pike Community Hospital, under which Adena Health became the owner and operator of a 25-bed critical access hospital in Pike County, Ohio, approximately 20 miles south of the City. Adena Health is the sole member of PHS, which includes the right to elect the members of the Board of Trustees of PHS after the candidates are nominated by the current sitting members of the PHS Board of Trustees. While PHS is maintained as a separate non-profit corporation, clinical and administrative functions have been integrated with the Health System. PHS now operates under the trade name of Adena Pike Medical Center.

Adena Pharmacy, LLC, 111 West Water Street, Chillicothe. This subsidiary was formed to operate the retail pharmacy and became operational on November 1, 2012.

Adena Home Care, 111 West Water Street and 2077 Western Avenue, Chillicothe. Adena Hospice, LLC, Adena Home Health, LLC, and Adena Home Infusion, DME, and Respiratory, LLC are collectively referred to as Adena Home Care.

Adena Care, Inc., 2077 Western Avenue, Chillicothe. This subsidiary is used solely to administer the Adena Employee Health Plan.

Adena Healthcare Collaborative, LLC, 2077 Western Avenue, Chillicothe. This subsidiary was formed in 2014 for participation as an ACO in the Medicare Shared Savings Program. The Health System is in its third year of ACO participation.

HEALTH SYSTEM MEDICAL SERVICES

The Health System offers the following primary services lines:

Primary Care. The Health System's primary care service line has a focused strategy of population health management within its service area. The service line consists of 67 primary care providers, practicing in 14 outpatient sites throughout South Central Ohio. Patient convenience is essential to meeting the needs of current and prospective patients. Three urgent care sites, combined with three primary care walk-in clinics and one retail clinic, are targeted at meeting patient expectations for access to care.

The backbone of the value-based care that is provided includes a Level 3 National Committee for Quality Assurance Patient-Centered Medical Home designation, the highest possible, for 11 of the 14 outpatient sites with applications pending for the remaining three sites. Additionally, at the end of 2016, Medicare CPC+ status (Comprehensive Primary Care) was awarded to 12 sites, which allows for additional payment to facilitate patient health management.

Cancer. The Health System's Cancer Care is centered on the patient and utilizes a team approach to care, multidisciplinary clinics, patient navigators and survivorship programs. It received full accreditation from the American College of Surgeons' Commission on Cancer (CoC) in 2014. The Health System's Cancer Center is located on the Hospital campus in a dedicated cancer facility, built to cater to both patients and families. Services include radiation delivered with pinpoint precision through use of the advanced Trilogy® Linear Accelerator. In addition, ongoing clinical trials offer patients access to innovative cancer therapies using the latest biological agents to help the patient's natural immune system fight cancer.

Cardiology and Vascular. The Health System's cardiovascular service line includes a comprehensive continuum of care from medication management, to various therapies and minimally invasive procedures, to open thoracic and vascular procedures. All procedural interventions are provided by a team of 16 providers working collaboratively across this continuum following the standards of the American Colleges. The service is accredited by the Intersocietal Accreditation Commission in echo, vascular and nuclear cardiology.

Women's Health. The Health System's OB/GYN, with six physicians and four certified nurse midwives, provides the latest in women's care and treatments, including minimally invasive robotic gynecological surgery. The Hospital's labor and delivery unit contains large postpartum rooms that allow the baby to stay with its mother and also accommodate family to celebrate the birth. Specialized services include American Institute of Ultrasound in Medicine certified ultrasounds, nuchal translucency testing and in-office certified lactation services. Maternal fetal medicine specialists are available twice a month. Based on the needs of the service area, the Health System has a focused and specialized prenatal program to assist expectant mothers with opioid addiction.

Orthopedics, Sports Medicine and Spine. The bone and joint service line is the Health System's largest multi-specialty service line with 19 physicians and five advanced practice providers. The service line is comprised of orthopedic surgeons, providers specializing in neurology, podiatry and sports medicine, and a spine center, which includes spine surgery, physiatry and interventional pain management. Our fellowship-trained orthopedic surgeons specialize in hand and elbow, spine and sports medicine. Patient navigation is offered for all spine and total joint replacement surgical patients throughout the continuum of care. The sports medicine program provides athletic trainers to eight local school systems in addition to physician coverage at sporting events. Regional outreach serves six counties at eight locations.

Pediatrics. Pediatrics provides a broad range of specialized services to newborns, infants, and adolescents in both the inpatient and ambulatory settings. In partnership with Nationwide Children's Hospital, the Hospital is able to provide services for cardiology and cancer conditions. The breadth of pediatric services includes care for diabetes, asthma, allergies and depression, in addition to general pediatric care.

Emergency Medicine. The Hospital's Emergency Center is the front door for many patients of the Hospital. The Emergency Center served approximately 49,000 patient visits in 2016. With exam rooms and clinical space built in the 1980's and renovated in the early 1990's, the Emergency Center is Adena Health's highest priority in its overall master facility plan. See **PROJECT DESCRIPTION**.

Surgery. The Hospital's general surgery is focused on providing high quality service with evolving high-tech instrumentation and advanced technology. Procedures such as major abdominal surgery are now replaced with minimally invasive laparoscopic and robotic techniques that often reduce pain, accelerate recuperation and reduce cost without sacrificing good outcomes. General surgery recently received an Epicenter designation for robotic surgery.

INPATIENT DISCHARGE DATA

The following table sets forth the distribution of adult and pediatric discharges at the Health System's hospitals among the major diagnostic categories for years 2014, 2015 and 2016 and the first quarter of 2016 and 2017. Total discharges for the quarter ended March 31, 2017 saw a 4.7% increase from the same period in 2016, a substantial improvement from fiscal year 2016 levels.

Inpatient Discharges	**Year ended December 31**			**Three Months Period ended March 31**	
	2014	**2015**	**2016**	**2016**	**2017**
Cardiac Services	1,412	1,541	1,418	377	358
ENT	100	80	34	15	8
General Medicine	4,591	4,775	4,503	1,198	1,243
General Surgery	533	596	564	130	124
Gynecology	71	46	33	6	20
Neonatology	984	1,075	962	240	246
Neurology	303	264	328	77	80
Neurosurgery	5	2	1	0	3
Obstetrics	1,071	1,075	949	232	248
Onc/Hematology	195	206	203	58	57
Ophthalmology	5	4	7	3	1
Orthopedics	1,025	1,061	995	234	298
Other Trauma	19	16	20	4	6
Rehabilitation	392	298	59	16	21
Spine	152	150	113	30	37
Thoracic Surgery	59	50	50	12	16
Urology	129	153	101	33	31
Vascular	277	310	295	78	74
Not grouped	17	3	0	0	0
Total	11,340	11,705	10,635	2,743	2,871
Information is grouped using the Advisory Board Classification Categories					

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OUTPATIENT DISCHARGE DATA

The Health System recognizes the need for continuing investment and development of ambulatory hospital services to meet growing volume and complexity of patient care needs. Total outpatient visits for fiscal year 2016 increased 5.5% over fiscal year 2015. In a similar trend, total outpatient visits for the quarter ended March 31, 2017 increased 5.8% over the same period in 2016.

The following table provides a comparison of the Health System's ambulatory service volumes from years 2014, 2015 and 2016 and the first quarter of 2016 and 2017. The Obligated Group represents 90% of the Health System's ambulatory service volumes.

Outpatient Hospital Visit Types	Year ended December 31			Three Month Period ended March 31	
	2014	2015	2016	2016	2017
Routine, Clinical	423,845	410,762	399,468	100,002	103,155
ER and Urgent Care	104,567	102,103	102,607	25,989	28,466
Recurring Patients	110,957	118,897	152,366	31,745	36,062
Reference Tests	25,838	45,149	62,290	16,347	16,702
Same Day Care	18,916	19,757	20,747	5,126	5,315
Total	684,123	696,668	737,478	179,209	189,700

ACCREDITATIONS, CERTIFICATIONS, MEMBERSHIPS, AND LICENSES

Accreditations. The Health System's health care facilities and programs are each properly accredited by the following accreditation organizations:

- All three hospitals are accredited by The Joint Commission;
- All facilities are Medicare and Medicaid approved as relevant;
- College of American Pathologists – Clinical laboratory accreditation;
- Commission for the Accreditation of Rehabilitation Facilities – AGMC inpatient rehabilitation unit is CARF accredited;
- American College of Surgeons Commission on Cancer – Cancer Center is accredited as a Community Cancer Center;
- Intersocietal Accreditation Commission – Nuclear Cardiology, Vascular and Echocardiology;
- The American Academy of Sleep Medicine – Sleep Center accredited;
- Continuing Medical Education program is accredited by Ohio State Medical Association, American Osteopathic Association and Board of Certification – Certified Athletic Trainers;
- American College of Radiology – Mammography and Ultrasound accredited all sites;
- Medical Residency Program Accreditation;
    - Family Medicine Residency – ACGME and AOA accredited;
    - Transitional Year Residency – ACGME and AOA accredited;

- Internal Medicine Residency – ACGME and AOA accredited;
- Emergency Medicine Residency – AOA accredited, actively pursuing ACGME accreditation; and
- Adena Health System as an Institutional Sponsor – ACGME accredited.

Certifications. Certain Health System programs have met the requirements for the following certifications:

- Advanced Certification for Primary Stroke Centers (the Hospital, AGMC and APMC) through the Joint Commission and the American Hospital Association/American Stroke Association;
- National Certified Gold Safe Sleep Champion;
- Crib for Kids Designation;
- 1 Star Level for Ohio Healthy Baby 1st Steps; and
- MQSA Certification – Mammography all sites.

Memberships. The Health System participates as a member in the following organizations:

- American Hospital Association;
- Ohio Hospital Association;
- Southern Ohio Hospital Council;
- Consortium for Health Education in Appalachia;
- Surgery Regional Collaboration;
- Consortium for Health Education in Appalachia; and
- Midwest Purchasing Coalition.

Licenses. Programs of the Health System are licensed as follows:

- Ohio Department of Health;
- Cardiac Catheterization;
- Open Heart Surgery;
- Maternity;
- Home Health;
- Psychiatric Unit;
- Pharmacy;
- Radiology; and
- Nuclear Regulatory Commission.

AWARDS AND RECOGNITIONS

The Health System has earned many awards and recognitions, including:

- Epicenter of Excellence Designation for Robotic Surgery;
- "Surgery Safety Rating Leapfrog "A" rating in 2015 and 2016;
- Awarded "Most Promising Program of 2017" by National Hospital Charities Foundation for Centering and Baby Centered Recovery Group;
- Awarded "Most Supportive Breastfeeding Professional" by Ohio Lactation Association;
- Becker's Hospital Review "Top 150 Places to Work in Healthcare", 2014, 2015 and 2016;
- Corporate Citizenship Award by Chillicothe-Ross Chamber of Commerce – 2016;
- State Historic Preservation Office Award of Merit – 2016;
- Heritage Ohio Best Commercial Rehabilitation – 2016;
- Ohio State Medical Association CME Program "Accreditation with Commendation" 2015-2021; and
- American Osteopathic Association CME Program "Accreditation with Commendation" 2016-2022.

GOVERNANCE

The Board of Trustees

Pursuant to Adena Health's Code of Regulations, all authority to operate Adena Health is vested in and exercised by the Board of Trustees. The Adena Health Board of Trustees is comprised of 15 persons, including nine persons representing the nine churches which are the sole corporate members of Adena Health, four members-at-large and two members of the Hospital medical staff. All Trustees have three-year terms of office and are limited to nine years of continuous service and a maximum of 12 years of total service.

An Executive Committee of the Board of Trustees, consisting of the Chair, Vice Chair, Secretary, Treasurer, the Chief Executive Officer ("CEO") and the Chief of Staff of the Hospital medical staff, has the authority to act when the Board of Trustees is not in session. The present members of the Board of Trustees are listed on the table below.

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Name	Board Title	Profession	Company/Affiliation
Steven P. Burkhardt	Chair	Treasurer	Horizon Telephone, Retired
Virginia Wettersten	Vice-Chair	English Teacher	Unioto High School, Retired
Thomas G. White	Secretary	President	Accurate Heating & Cooling
Joseph P. Sulzer	Treasurer	Attorney at Law	Former Mayor of Chillicothe, Attorney at Law, Retired
Ralph J. D'Antoni, Jr.	Board Trustee	Principal Nuclear Safety Engineer	Fluor-BWXT Portsmouth LLC
Bartow Kelley Henshaw	Board Trustee	Counselor	Chillicothe City Schools, Retired
Carvel E. Simmons	Board Trustee	Owner	Trio Trucking, Nationwide Insurance, Retired
Evan J. Phillips, Jr.	Board Trustee	Insurance Broker	Network Financial Services
Reggina Yandila, D.O.	Board Trustee	Physician	Adena Internal Medicine
W. Bradley Strauch, M.D.	Board Trustee	Physician	Adena Bone and Joint
Ralph "David" Strickland	Board Trustee	Insurance Broker	State Farm
Gail Richardson Taylor, J.D.	Board Trustee	Retired	Case Western Reserve University
Joseph Watson	Board Trustee	President/CEO	Petland Inc.
Jennifer Thompson McKell	Board Trustee	Librarian	Chillicothe & Ross County Public Library, Retired

Executive Management

In the fall of 2016, Adena Health and its President and CEO began the process of planning for the expiration of the CEO's contract term. After reaching a contractual impasse, the CEO opted for early termination of his contract in October 2016. Prior to and unrelated to the CEO's departure, Adena Health's Chief Financial Officer ("CFO") accepted another health care financial leadership position in the Chicago market. John Fortney, M.D., former Adena Health's Chief Physician Executive, was appointed as Adena Health's Interim President & CEO. Placing Dr. Fortney in the CEO position brings leadership continuity and stability during the transition to a permanent CEO. In October 2016, Lisa Carlson was hired to serve as Adena Health's interim CFO during the search for a permanent replacement. In May 2017, Lisa Carlson accepted an employment offer to serve as Adena Health' new permanent CFO.

Adena Health's Board of Trustees established a Search Committee to steer the selection of the organization's next President and CEO. The Board engaged Witt/Kieffer, a well-regarded national healthcare executive search firm, to manage the CEO search. At this time, final candidates, including Dr. Fortney for the CEO position are being interviewed, with a targeted date of June 2017 for the selection of the permanent CEO.

Adena Health is managed on a day-to-day basis by a Senior Executive Team organized to carry out the required duties and responsibilities set by the Board of Trustees. The Senior Executive Team is experienced in health system management and is comprised of the following individuals:

John Fortney, M.D., 65, Interim President and CEO. Prior to taking the interim role, Dr. Fortney was the Chief Physician Executive at Adena Health from 2015 to 2016, Adena Health's Chief Medical Officer and AMG's President and CEO since 2009. Dr. Fortney served Adena Health in 2003 as Senior Medical Director and previously was the Physician Administator for Adena Health and the Smith & Fleischer Pediatric Groups for 20 years. He has a Master's Degree in Hospital Administration from Ohio University, a Medical Degree from The Ohio State University School of Medicine and a Bachelor of Science Degree also from The Ohio State University. He holds a lifetime certification from the American Academy of Physicians.

Lisa M. Carlson, CPA, 60, CFO. Ms. Carlson joined Adena Health in October 2016 through Tatum, an interim placement organization and has since been employed by Adena Health. Ms. Carlson has since accpeted an offer to remain with Adena Health as the permanent CFO. Ms. Carlson had been with Tatum since 2012, and previously served as an Executive Consultant for VHA. She was the Corporate CFO for Sanford Health System from 2009 to 2012 after MeritCare merged into Sanford. Prior to that position, Ms. Carlson served in multiple financial leadership roles at MeritCare Health System from 1987 through 2009, with her final position as CFO of MeritCare from 2003 to 2009 prior to the Sanford merger. Ms. Carlson has a Bachelor of Science Degree from Minnesota State University and a Certificate of Completion from the St. Thomas Leadership Academy.

Jack Berno, M.D., 66, Chief of Staff and Interim Chief Physician Executive. Dr. Berno has been with Adena Health for 35 years. Prior to his current appointment, he served as the Chief of Medicine and Chief Medical Strategy Officer, in addition to other positions, including previous appointments as the Chief of Staff. Before joining Adena Health, Dr. Berno was in private practice, developed the initial Hospitalist program and was President of First Capital Internal Medicine. He has a Medical Degree from the Medical College of Toledo, a Master's of Science Degree from The Ohio State University and a Bachelor of Arts Degree from Williams College.

Eric Cecava, 37, Chief Operating Officer. Mr. Cecava has been with Adena Health for seven years and previously served as Adena Health's Vice President of Regional Operations before being appointed Chief Operating Officer in February 2015. Prior to joining Adena Health, he spent more than five years with the Honeywell Corporation in operations in the United States and Latin America. Mr. Cecava has a Master's Degree in Business Administration from The Ohio State University and a Bachelor of Science Degree from Purdue University.

Jay Justice, J.D., 64, Chief Human Resources Officer. Mr. Justice was named Adena Health's Interim Chief Human Resources Officer in March 2016, prior to assuming the permanent role in November 2016. Before joining Adena Health, Mr. Justice was the Chief People Officer for Hospital Sisters Health System from 2008 to 2015. He held senior healthcare consulting leadership roles with Integrated Healthcare Consulting, Cejka and Towers Watson from 1995 to 2004. Mr. Justice was the Senior Vice-President of Human Resources during the formation of BJC Health System, and, prior to that position, held senior human resources roles for banking institutions in the Midwest. He has a Bachelor of Arts Degree from Rockhurst University and a Juris Doctor from Washburn University School of Law.

Martha D. Livingston, RN, 63, Chief Strategy Officer. Ms. Livingston joined Adena Health in 2009 and served as the System Director of Cardiovascular, Surgical and Oncology Services and later the Executive Director of Strategic Growth prior to her appointment as the Chief Strategy Officer in 2012. Before transitioning to Adena Health, Martha was employed at Riverside Methodist Hospital and progressed from Vice President of Heart Services, to Senior Vice President of Clinical Services and finally Interim Chief Operating Officer. She also served in service line management roles at Baptist Memorial Health Care Corporation, where she started her career in nursing, acted as the nurse coordinator for clinical trials, directed a large cardiac and pulmonary rehabilitation and wellness program, and took on various other roles involving critical care and patient education. Ms. Livingston has a Bachelor of Nursing Degree from St. Olaf College, a Master of Sciences Degree from the University of Wisconsin-LaCrosse, and a Master of Business Adminstration Degree from the University of Chicago.

Timothy J. Cahill, J.D., 45, General Counsel. Mr. Cahill has served as Adena Health's General Counsel since December 2014. Prior to joining Adena Health, Mr. Cahill was an Associate General Counsel at Nationwide Children's Hospital from 2008 to 2014. Mr. Cahill also practiced in the Health Care Law Group at Porter Wright Morris & Arthur and clerked for The Honorable Sylvia H. Rambo in the Middle District of Pennsylvania. Prior to practicing law, Mr. Cahill practiced as a physical therapist for four years. He has a Bachelor of Science Degree from The Ohio State University and a Juris Doctor degree from the University of Cincinnati College of Law.

Corporate Compliance and Conflicts of Interest

The Health System has an active Corporate Compliance and Ethics program in place to ensure the Health System achieves consistently high levels of compliance with all laws and regulations. The Compliance and Ethics Officer acts as a consultant for regulatory issues, identifies compliance vulnerabilities, develops corrective action plans and educates the Board of Trustees, management, employees and physicians on regulatory compliance issues. The Corporate Compliance and Ethics Officer has the responsibility for administration and management of the Program and reports to the Audit Committee of the Board of Trustees. The Compliance and Ethics Officer is accessible to all employees of the organization and maintains frequent and direct communication with the Health System's senior management and governing board. In accordance with this program, the Board of Trustees, Senior Management and Department Directors are required to complete a conflict of interest statement and mandatory compliance education on an annual basis. No conflicts of interest have been identified.

HOSPITAL MEDICAL STAFF

General

The accompanying table presents the Hospital's Medical Staff profile (including advanced practice providers with admitting clinical privileges) as of December 31, 2016 and identifies by specialty the top admitting providers on the Hospital's Medical Staff. The total Medical Staff of the Health System consists of 319 members holding active, affiliate and honorary privileges with an additional 79 advanced practice providers. The average age of the group is 45 years. The breakdown of the specific AMG-employed providers is 172 employed physicians with active, affiliate and honorary privileges and 59 advanced practice providers.

The 38 providers below, listed by specialty, represent 70.8% of Hospital admissions. Providers whose admissions represent less than 1% of total admissions are excluded. Anesthesiologists, radiologists, emergency physicians, and pathologists were also excluded, as they do not admit patients. The average age of these top 38 admitters is 42.7 years.

Hospital's Top Admitting Providers

Rank (2016 admits)	Specialty	Age of Provider (as of 04/06/2017)	Employment Status[1]	% of Total Admits, 2016
1	Orthopedics	48	Employed	5.0
2	Hospitalist- ARMC	47	Contracted	3.8
3	Hospitalist- ARMC	43	Contracted	3.4
4	Pediatrics	56	Employed	3.1
5	Pediatrics	48	Employed	3.1
6	Hospitalist- ARMC	63	Contracted	2.7
7	Hospitalist- ARMC	34	Contracted	2.5
8	Hospitalist- ARMC	38	Contracted	2.4
9	Hospitalist- ARMC	47	Contracted	2.2
10	Hospitalist- ARMC	37	Contracted	2.0
11	Psychiatry	34	Employed	2.0
12	Hospitalist- ARMC	50	Contracted	2.0
13	Hospitalist- ARMC	40	Contracted	1.9
14	Hospitalist- ARMC	52	Contracted	1.9
15	OB/GYN	48	Employed	1.9
16	Pediatrics	35	Employed	1.8
17	Psychiatry	32	Employed	1.8
18	Hospitalist- ARMC	30	Contracted	1.7
19	Hospitalist- ARMC	41	Contracted	1.6
20	OB/GYN	41	Employed	1.6
21	Hospitalist- ARMC	48	Contracted	1.6
22	Hospitalist- ARMC	41	Contracted	1.5
23	OB/GYN	54	Employed	1.4
24	Hospitalist- ARMC	54	Contracted	1.4
25	Hospitalist- ARMC	50	Contracted	1.4
26	OB/GYN	50	Employed	1.4
27	Hospitalist- ARMC	38	Contracted	1.4
28	OB/GYN	61	Employed	1.3
29	Hospitalist- ARMC	48	Contracted	1.2
30	Hospitalist- ARMC	33	Contracted	1.2
31	OB/GYN	61	Employed	1.2
32	Hospitalist- ARMC	36	Contracted	1.2
33	Hospitalist- ARMC	35	Contracted	1.2
34	Hospitalist CNP- ARMC	35	Contracted	1.2
35	Vascular Surgery	44	Employed	1.0
36	Hospitalist- ARMC	39	Contracted	1.0
37	Hospitalist- ARMC	35	Contracted	1.0
38	Hospitalist- ARMC	34	Contracted	1.0
	Total			70.8%

Notes:
(1) Please see "Collaborating Physician Groups: Partners in Patient Care" Section for additional detail on ARMC's contracted hospitalists.

Employed Physician Strategy

The Health System is a highly integrated system of hospital, ambulatory and physician and advanced practice providers. Physicians, working in collaboration with Health System management, have produced high levels of productivity, growth and sustained financial performance. This collaborative philosophy has enhanced the Health System's ability to support its mission activities and has provided an opportunity to increase the scope of services provided locally.

The recent Health System focus on development of specialty and sub-specialty physician services has been made possible by the successful maintenance of a loyal primary care physician base. This tier of specialty service allows the Health System to offer unique services across the South Central region of Ohio while continuing to provide high quality foundational services such as general surgery, emergency medicine and family medicine for the community.

Provider Recruitment

The Health System has an active clinical planning process driven by service line physician leadership and management and based on the need for services. The clinical leadership, in partnership with the provider recruitment staff, has primary responsibility for carrying out the physician recruitment plan and executing the plan using the Health System's established recruitment and compensation packages for each specialty.

Residency Program

The Health System plans to utilize the Graduate Medical Education program as a critical component of its physician recruitment and retention strategy. Physicians trained in the residency program will be mentored and potentially transitioned into primary care or emergency medicine at the Health System.

The Hospital boasts four accredited Graduate Medical Education Programs: Family Medicine, Internal Medicine, Emergency Medicine, and Transitional Year. In 2017, the programs will consist of 57 residents at various stages of their residency. With strong ties to Ohio University, Lincoln Memorial University-DeBusk College of Osteopathic Medicine, Lake Erie College of Osteopathic Medicine and others, the programs continue to grow each year. The programs' American Osteopathic Association accreditation and the current transition to accreditation by the Accreditation Council for Graduate Medical Education allow the programs to offer a unique experience. The programs receive direct and indirect medical education support from Medicare which assists in the Health System's ability to continue to invest in this Medical Education strategy.

Collaborating Physician Groups: Partners in Patient Care

Hospitalists. As of July 1, 2015, Adena Health contracts with Apogee Physicians, Inc., formerly employed physicians, to provide inpatient acute and critical care within the Hospital. With 16 physicians and six nurse practitioners, the arrangement helps to ensure that patients receive the highest level of care inside of the Hospital. Apogee Physicians, Inc. is a network of approximately 750 physicians and nurse practitioners that spans across the nation.

Pathology. In collaboration with CORPath, the Hospital provides pathology services to all sites within the Health System. With three physicians practicing medicine in the facility and access to 15

specialized pathologists within 60 miles, the Health System is able to provide specialty services in a rural community.

Emergency Center. The Hospital contracts with Schumacher Group for Emergency Services physician coverage at the Hospital. TeamHealth physician group provides similar services for AGMC and APMC. The strong relationship with the Schumacher Group is critical in meeting the needs of emergency care in the Health System's service area. The Schumacher Group has been intimately involved in leading the planning for the renovation of the Emergency Center.

Radiology. RadPartners, formerly Columbus Radiology, performs professional radiology services for all imaging service lines, including diagnostic imaging, mammography, MRI, and CT/PET services. Utilization of their nationwide network allows for off-hour emergent services, provided by the appropriate radiology specialist. RadPartners is the Health System's longest tenured affiliated group.

Employed Providers

To meet the needs of the population served in the South Central Ohio area, the Health System has employed primary and specialty physicians through AMG including fellowship-trained surgeons and sub-specialists in a number of areas, such as orthopedics, cardiology, urology, gastroenterology and others.

The following table provides a breakdown of full-time equivalent ("FTE") primary care and specialist physicians and advanced practice providers.

Health System Providers by FTE

	Year Ended December 31			Three Month Period ended March 31	
	2014	**2015**	**2016**	**2016**	**2017**
Advanced Practice Providers					
Primary	23.6	25.7	30.2	27.0	34.8
Specialty	34.4	39.2	41.6	41.7	46.5
Total	58	64.9	71.8	68.7	81.2
Physicians					
Primary	52.5	52.0	47.7	50.1	50.1
Specialty	97.7	88.6	77.5	79.9	71.7
Total	150.2	140.6	125.2	130	121.8
Residents	23.1	31.6	40.6	34.2	42.6

Availability of Qualified Workforce

The Health System has been able to recruit and retain sufficient numbers of qualified nursing staff to meet substantially all of its needs. The Health System's success in meeting its nursing personnel requirements is, in part, a result of the Health System's affiliations and proximity to four nursing schools. In addition, the Health System offers competitive salary and benefit packages and other market-driven recruitment inducements, such as flexible scheduling and tuition reimbursement. In addition, Adena Health Foundation provides scholarship support for hard-to-fill positions and other support based on donor intent.

Like most other health systems in its service area, the Health System has experienced periodic shortages in certain other professional categories. These shortages cycle among specialties such as physical therapists, pharmacists, medical coders and registered nurses. Such temporary shortages have not materially impacted Health System operations.

The Health System monitors its turnover and uses national healthcare data as a benchmark. Currently, the Health System has an annual employee (excluding physicians) turnover rate of 10.3% which is favorable when compared with the national rate of 17%.

The PACCAR Medical Education Center is focused on expanding the learning capacity of the Health System workforce while addressing the needs for qualified health professionals. In partnerships with multiple universities, the PACCAR Center is home to: Graduate Medical Education physician residency programs in emergency medicine, internal medicine and family practice; and a four-year, pre-licensure Bachelors of Science in Nursing program; and serves as a hub for medical student rotations and shadowing programs. In addition to providing avenues for higher education, the PACCAR Center supports the learning needs of the Health System's providers, clinicians, and leaders, as well as health education for the general public. Through the PACCAR Medical Education Center, the Health System has taken steps to transform into a learning organization that is agile, innovative, and capable of adapting to the ever-changing healthcare industry.

Management believes that workforce availability will be a continuing strategic focus of the Health System, driven by the clinical and service development plans of the organization and the aging of the current workforce. With the strategic focus on medical and clinical professional organization, the Health System does not believe workforce shortages will be a major barrier to achieving its strategic goals.

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Employee Composition

The following table shows the Health System's employee composition by FTE for the first quarter of 2017.

	Number of FTEs	% of Total
Executives	7	0.3%
Physicians	122	4.7%
Advanced Practice Providers	81	3.1%
Residents	43	1.7%
Management	150	5.8%
Nursing	596	23.2%
Technical and Professional	815	31.7%
Administrative Support	561	21.8%
Service	199	7.7%
Total	2,574	100.0%

STRATEGIC PLAN

Overview

In 2013, the Health System independently performed the Community Health Needs Assessment for the three hospital facilities. Then in 2015, the Health System adopted a new vision: "To be instrumental in creating healthy and thriving communities." This vision sets an expectation for the Health System to both lead and partner with others to drive community initiatives, while also supporting existing local initiatives which promote the health and well-being of the communities we serve. This past year, the Health System facilitated a 19-agency group, Partners for a Healthier Ross County, to create a collective Community Health Needs Assessment and integrated Action Plan.

To create healthy and thriving communities, the Health System needs to be balanced from a work-life perspective and successful from a business perspective. In 2016, management developed a simplified System Strategic Map, describing the Health System's vision and its four key elements: Employee Engagement, Safety and Quality, Service Excellence and Stewardship.

Employee Engagement

At its core, the Health System must have engaged caregivers and providers working efficiently and effectively at the top of their respective capabilities and supported by cohesive processes. Emphasis is placed on retention, which is approximately 90%, and driving down voluntary turnover. Initiatives to recruit and retain the right people have been strengthened through the establishment of an Advisory Council and monthly leader engagement roundtables sharing innovative practices. Employee engagement must be supported by a healthy culture through open and honest communication, setting of clear expectations and accountability. In order to achieve this end, the Health System is adopting a philosophy called "Just Culture" which provides a consistent structure for promoting learning from errors while properly assigning accountability for behaviors.

Safety and Quality

In order to meet the more than 3,000 required safety and quality measures for a health system provider, the measures have been organized in three domains: inpatient, outpatient and population health. For emphasis and attention, five system-wide elements with a number of associated key measures important to achieving the Health System's annual success have been highlighted. The elements are then cascaded down to the appropriate providers of that care. Results are populated in safety and quality dashboards which are reviewed at a variety of levels. Caregivers from every area of the Health System gather daily for a 20-minute Patient Safety Huddle where real-time safety and quality issues are shared and addressed before they become problems. In addition, Quality Collaborative Teams have been formed around each of the major clinical service lines. In 2015, the Health System successfully participated as a Medicare Shared Savings Program ACO; reporting all 33 quality metrics and achieving $5.2 million total savings and a $2.6 million performance payment. The Health System was also awarded Comprehensive Primary Care Plus (CPC+) status for Medicare and Medicaid.

In 2016, an initiative called "Patient 1st" began. The first system-wide project attempts to eliminate non-value added waiting by addressing how a patient arriving in the Emergency Center progresses through the Health System. The process redesign starts in the Emergency Center and includes in-patient units, all ancillary departments such as lab, radiology, cardiac testing, pharmacy, hospitalists, social workers and transportation. In addition to improving the way care is organized in the Emergency Center, Patient Centered Rounds were successfully piloted where the hospitalist, nurse, discharge coordinator and pharmacist all gather in the patient's room to discuss with the patient and family the plan of care. Patient satisfaction rose and discharge time moved to earlier in the day. Finally, "Surge Alert" was created to address patient flow when census in the Emergency Center and inpatient units reach a certain level.

Service Excellence

Patient and family satisfaction is an important third element of the System Strategic Map. There are four domains that are regularly measured using a surveying tool from Press Ganey: inpatient, outpatient, provider clinic and Emergency Center. Each unit has an improvement target based upon the prior year's performance levels. In addition, action plans have been created to impact the most important elements to move that area's score. Key areas of focus are nurse and physician communication, access to care and cleanliness.

In addition there are two foundational projects in this quadrant: the Emergency Center renovation and expansion and the creation of an integrated electronic health record to coordinate the care, clinical information and billing for the Hospital and AMG services. The need for the renovation and expansion of the Hospital's Emergency Center has been one of the top two concerns from community stakeholder feedback since 2014 and is widely addressed throughout this Appendix A. In 2014, the Health System began the journey to create an integrated electronic health record. First, foundational infrastructure was updated and in August 2015, the acute phase went live with the implementation of Meditech 6.15. Efforts continue to optimize functionality of the acute product with particular focus on the revenue cycle and upgrade elements of the current ambulatory product, eClinical Works, while waiting for Meditech to further develop key components of their new ambulatory module.

Stewardship

Providing financial stewardship to assure that needed resources are available to serve the Health System's communities is the essence of the fourth quadrant of the System Strategic Map. Central to this is continuously sustaining and improving the Health System's operating margin and maintaining a solid investment grade rating.

Growth is an important component under this quadrant. Because market share data lags six to nine months behind, growth is tracked as patient lives attributed to a primary care provider. A target of 115,000 unique lives has been set for 2021. This number will create sufficient volume to maintain the necessary compliment of specialists, provide a critical mass for population health and provide the volume needed to achieve operating margin growth. Growth in unique patients will be accomplished through practice acquisition, expansion of the regional footprint and creating additional access to allow for shorter appointment wait time. With the acquisition of a new clinic in Waverly, Ohio, 2017 is on track to achieve this year's growth target.

Additionally, the breadth and depth of clinical service offerings based on community need, the provider recruitment plan, acquisition of new technology and evaluation of existing or new contractual relationships with clinical partners are important components of the financial stewardship quadrant.

Connecting Strategy to Performance: The Health System's Management Accountability System

Management has developed an accountability system which connects the strategic goals, high leverage tactics and operational performance. It is a continuous process, but has a strategic cycle that culminates in a July annual refreshing of the environmental assessment, an internal SWOT, and development of strategic priorities for the next year. This launches a budget/financial planning cycle which culminates with a December strategic update and annual budget approval. This is followed immediately by an operational cycle which assures the integration of the strategic goals into the clinical and operational plans of the organization.

Each month, the executive team reviews the key metrics of performance in each of the quadrants of the balanced scorecard. Opportunities and issues are identified, and action plans are developed with the appropriate members of the management team. In the stewardship quadrant, performance against budget for volumes, staffing and total expenses on a volume-adjusted basis are reviewed and the executive team takes corrective action as needed. On a quarterly basis, the executive team reviews the status and plans of the high leverage strategic tactics for the year. This combination of strategic and operational discipline has contributed to the operating performance improvement seen in 2017 when compared to the same time period in 2016.

PROJECT DESCRIPTION

The proceeds from the sale of the Series 2017 Bonds, together with other available funds, will be used to provide funds for the purposes of the "Series 2017 Project" including (1) advance refunding of the Series 2008 Bonds issued to refinance certain hospital facilities owned and operated by Adena Health; (2) paying costs of financing the acquisition, construction, reconstruction, equipping, and installation of the Series 2017 Project described below, or to reimburse the Corporation for costs of its Series 2017 Project already incurred, and (3) paying certain issuance costs in connection with the Series 2017 Bonds.

The Series 2017 Project consists of the expansion of the Hospital's Emergency Center from 16,500 square feet to 59,000 square feet, including the addition of six treatment rooms and 32 additional patient-care areas. The Series 2017 Project will also create the capacity to manage patients that are either in transition to inpatient care, transition to home, or under active medical observation. The Series 2017 Project will also include Hospital parking lot improvements and other capital improvements of Adena Health facilities in the County.

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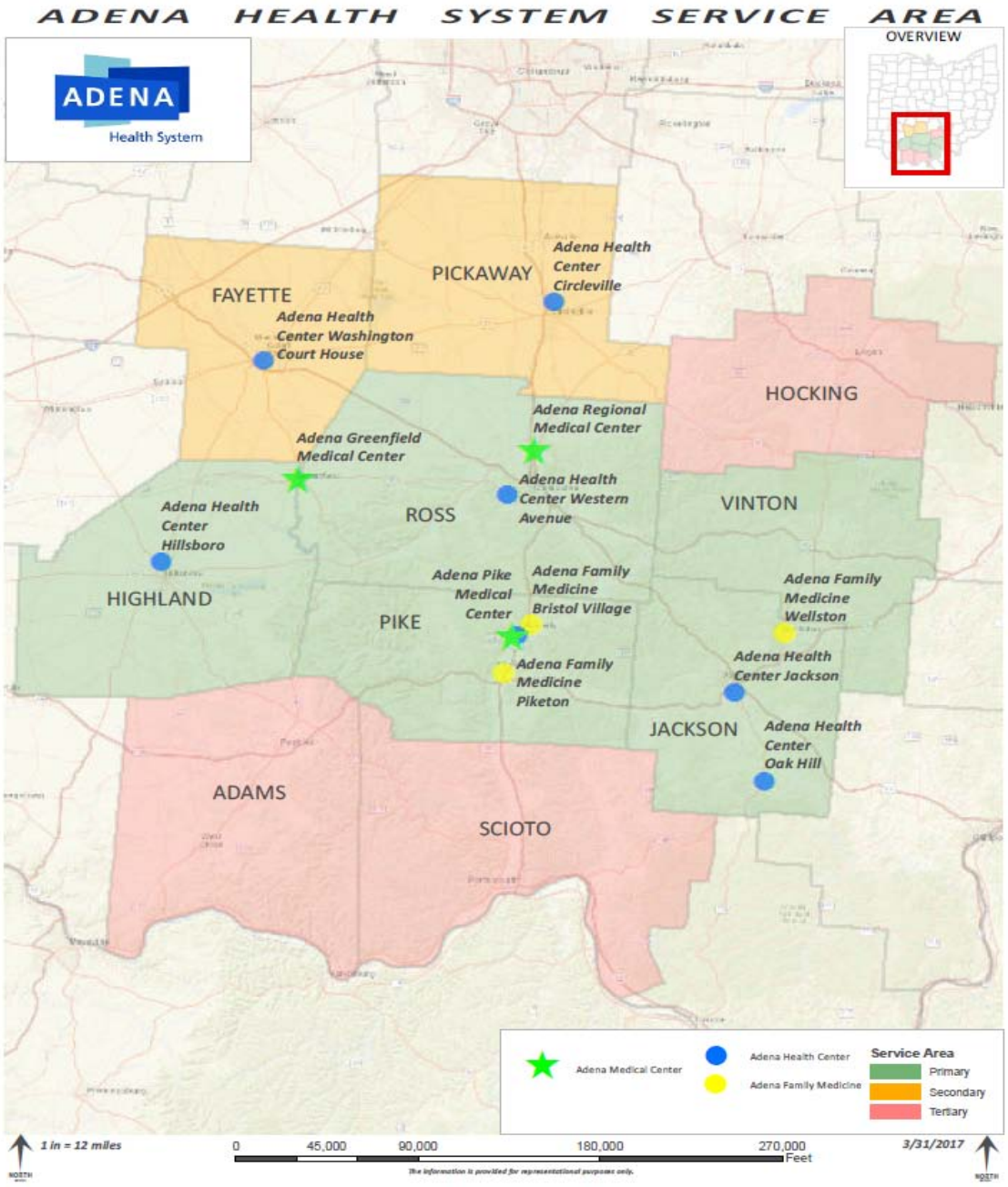
SERVICE AREA, MARKET SHARE AND ECONOMY

Service Area Map

The Health System's Primary Service Area ("PSA") is defined as including the five counties of Ross, Pike, Jackson, Highland and Vinton counties. The Secondary Service Area ("SSA") includes two counties: Pickaway and Fayette. The Tertiary Service Area ("TSA") is comprised of the three counties of Scioto, Adams and Hocking counties. In total, the Health System's overall service area covers 10 counties.



Service Area

The City is located in South Central Ohio near the intersections of U.S. Routes 23, 35 and 50. Route 23 is one of four major north-south highways that cross the State of Ohio. The City is 46 miles from Columbus, Ohio, 73 miles from Dayton, Ohio, and 94 miles from Cincinnati, Ohio, providing the Health System with significant rural geography as a catchment area.

The City is the county seat of the County. The County is midway between Columbus and Portsmouth, Ohio, and covers 687 square miles. The County has a population of approximately 77,170 as determined by the U.S. Census Bureau. The City is the retail hub for the County, as well as for the seven contiguous counties (Fayette, Highland, Pike, Jackson, Vinton, Hocking and Pickaway).

Population Data

The Health System's PSA represents over 90% of the Health System's discharges in 2016. The Health System maintains a physical presence in four of these five counties, with Vinton being the sole exception.

The SSA consists of counties that are contiguous with the County and in which the Health System maintains an ambulatory services center, but has 10% or less of the counties' market share.

The Health System does not have a physical presence in the TSA, but can reasonably expect to draw patients for subspecialty care, such as open-heart surgery, robotic surgery, spine surgery and other advanced procedures. The following table identifies the population by county.

Service Area Population Data

County	Population
Ross	77,170
Pike	28,217
Jackson	32,596
Highland	43,026
Vinton	13,048
Primary Service Area Total	**194,057**
Fayette	28,679
Pickaway	56,998
Secondary Service Area Total	**85,677**
Scioto	76,825
Adams	28,024
Hocking	28,491
Tertiary Service Area Total	***133,340***
Total Adena Service Area	**413,074**
State of Ohio	11,613,423
Source: 2014 American Community Service 5-year estimate.	

For the purposes of this Appendix A, data will be included from the PSA and SSA. The following table summarizes the Hospital's market share by PSA and SSA as well as by county as a percentage of total discharges from all hospitals from 2013 through 2016.

Market Share - Primary and Secondary Counties

County	2013	2014	2015	2016*
Ross	62%	61%	60%	57%
Pike	54%	50%	49%	47%
Jackson	24%	22%	23%	21%
Highland	18%	16%	15%	14%
Vinton	33%	30%	29%	30%
Fayette	12%	11%	13%	11%
Pickaway	5%	5%	6%	5%
Total	**33%**	**31%**	**31%**	**29%**

Source: OHA Insight, CY 2013-Q2 2016, Inpatient Only
*Annualized.

The majority of patients in the PSA who are not utilizing the Health System are patients of larger tertiary hospitals in Columbus, Ohio. Fewer patients choose other regional or rural hospital competitors over the Health System.

Service Area Economy

The City is the principal trading area and industrial center for the County and for South Central Ohio. The City is served by approximately 2,000 retail and service establishments. While farming represents a major factor in the regional economy, manufacturing also plays a significant role as industries located in the City manufacture paper, railroad car springs, trucks, fiberglass components, highway signs and hi-tech metal marking systems. In addition, the Federal and State governments employ approximately 2,500 persons at the Veterans Administration Medical Center and two correctional institutions.

Major Employers- Ross County		
Employers	**Employees**	**Industry**
Adena Health System	2,953	Health/Medical Services
Kenworth Truck Company	2,215	Assembly of Heavy Trucks
Veterans Affairs Medical Center	1,520	Veterans Hospital
P.H. Glatfelter Company	1,180	Specialty Papers
Chillicothe Correctional Institution	532	Ohio Penal Institution
Ross County Correctional Institution	493	Ohio Penal Institution
Ross County	417	County Government
Pickaway/Ross Career and Tech Center	344	Vocational Education
Chillicothe City School District	314	Education
City of Chillicothe	251	City Government

Source: Economic Development Alliance of Southern Ohio website search, March 28, 2017.

Economic Development

The Economic Development Alliance of Southern Ohio reports that manufacturing and distribution space leased/purchased or constructed has grown by 1,316,340 square feet since 2010. The County's sales tax has grown by 35% in the past six years, increasing from $11.9 million in 2010 to over $16 million in 2016. In addition, property values have increased by 12.3% from a total of $1.16 billion to $1.3 billion from 2010 to 2016. The following table highlights comparative labor force as of 2015 and unemployment statistics as of February 2017 for the Health System's service areas.

County	Population	Civilian Labor Force	Unemployment Rates
Ross	77,170	33,600	6.2%
Pike	28,217	10,700	8.8%
Jackson	32,596	12,700	9.2%
Highland	43,026	16,700	7.1%
Vinton	13,048	5,500	8.8%
Primary Service Area	**194,057**	**79,200**	
Fayette	28,679	14,500	4.9%
Pickaway	56,998	26,400	5.6%
Secondary Service Area	**85,677**	**40,900**	
Scioto	76,825	30,100	8.6%
Adams	28,024	11,000	9.5%
Hocking	28,491	13,400	7.0%
Tertiary Service Area	**133,340**	**54,500**	
Total Adena Service Area	**413,074**	**174,600**	
State of Ohio	11,613,423	5,700,000	5.1%

Source: Labor Force - Department of Development, 2015; Unemployment Rates - Ohio Department of Jobs and Family Services, Office of Workforce Development, Bureau of Labor Market information, February 2017.

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Competition

The Health System operates the only acute care general community hospital in the County. There are several hospitals of substantially smaller bed count located in the Health System's PSA and TSA. Southern Ohio Medical Center in Scioto County is located in the Health System's TSA and is the only facility within the Health System's Service Area of equivalent size.

The following table provides the number of registered beds and miles from the Hospital for each of the hospitals located within the Health System's service area.

Hospital Name	County	County Population 2015 Estimated	Beds	Miles from Hospital
Adena Regional Medical Center*	Ross	77,170	261	0
Adena Pike Medical Center*	Pike	28,217	25	22
Holzer Medical Center	Jackson	32,596	25	35
Highland District Hospital	Highland	43,026	45	49
Adena Greenfield Medical Center*	Highland	43,026	25	31
Fayette County Memorial	Fayette	28,679	25	34
Berger Health System	Pickaway	56,998	83	16
King's Daughters Medical	Scioto	76,825	10	51
Southern Ohio Medical	Scioto	76,825	436	48
Adams County Regional Medical Center	Adams	28,024	25	63
Hocking Valley Community Hospital	Hocking	28,491	30	36

Note: (*) Indicates Adena Health entity.
Source: Bed Count - Ohio Department of Health - Directory of Registered Hospitals, 2017; Population - Ohio Dept. of Development, Miles from ARMC - Mapquest 2017, Affiliations - Adena Business Development

Larger tertiary centers in Columbus or Cincinnati represent the most significant competition to the Health System. Certain procedures may only be performed at urban tertiary centers and patients requiring such procedures are referred to these in Columbus and Cincinnati.

HEALTH SYSTEM FINANCIAL AND OPERATIONAL INFORMATION

The following Consolidated Statement of Operations and Consolidated Balance Sheet are a summary of certain financial and operational information for the Health System, including non-Obligated Group members. This summary should be read in conjunction with the audited financial statements, related notes, management's discussion and other financial information included in Appendix B of this Official Statement.

Health System Operating Results

The following consolidated Statement of Operations for years ended December 31, 2014, 2015 and 2016 is derived from audited consolidated financial statements of the Health System. The information for the first quarter ended March 31, 2016 and 2017 are derived from the unaudited financial statements of the Health System.

Adena Health System and Subsidiaries | Consolidated Statement of Operations

	Year Ended December 31			Three Month Period ended March 31	
	2014	**2015**	**2016**	**2016**	**2017**
Net Patient Service Revenue	$436,698,926	$457,508,306	$443,913,305	$112,970,611	$113,341,828
Provision for Bad Debt	(19,087,179)	(25,421,220)	(16,063,296)	(5,638,157)	(3,209,422)
Net Patient Revenue less provision for bad debts	$417,611,747	$432,087,086	$427,850,009	$107,332,454	$110,132,406
Other Operating revenue	10,029,310	9,171,674	8,920,507	2,201,495	1,821,366
Net Assets released from restrictions	474,879	339,419	391,312	1,153	3,018
Total Unrestricted Revenue	$428,115,936	$441,598,179	$437,161,828	$109,535,102	$111,956,790
Salaries and Wages	$197,720,619	$200,451,617	$197,941,796	$49,517,917	$50,444,789
Employee benefits and payroll taxes	47,531,476	46,484,716	48,776,331	11,805,561	12,123,265
Operating supplies and expenses	65,991,546	75,492,620	73,024,579	18,363,358	17,979,758
Professional Services	1,944,826	3,268,136	2,554,859	489,416	879,780
Purchased Services	43,030,985	43,425,935	44,403,368	10,414,344	10,864,950
Insurance	2,182,379	2,422,364	2,361,891	871,435	834,069
Utilities	4,930,043	4,551,399	4,777,400	1,184,593	1,090,204
Travel/Education	2,909,359	2,515,718	2,564,579	564,866	584,634
Repairs, maintenance , and rental	19,422,455	19,470,326	19,370,110	5,286,999	4,905,145
Assessments	3,913,833	4,159,427	4,404,790	989,021	1,240,626
Depreciation and amortization	22,335,845	22,210,452	22,680,825	5,744,266	5,629,651
Interest Expense	8,462,222	8,498,435	8,397,747	2,011,415	2,020,103
Total Expenses	$420,375,588	$432,951,145	$431,258,275	$107,243,191	$108,596,974
Operating Income	$7,740,348	$8,647,034	$5,903,553	$2,291,911	$3,359,816
Non Operating Income					
Interest Income and net realized gains	$11,981,241	$3,735,127	$2,152,762	$5,445	$237,915
Unrealized gains on trading securities	(5,027,080)	(4,078,031)	8,510,081	3,581,706	7,352,842
Other income (loss)	(3,126,364)	(1,479,534)	102,150	(79,591)	(137,708)
Total Non Operating	$3,827,797	($1,822,438)	$10,764,993	$3,507,560	$7,453,049
Excess of Revenues over Expenses	$11,568,145	$6,824,596	$16,668,546	$5,799,471	$10,812,865

The above financial statements have been restated from the audited financial statements in Appendix B. The Health System has elected the early adoption of the change in accounting for defined benefit retirement plans. The purpose of the making this election is to provide stability and comparability in the operating margin as the Health System considers termination of its frozen defined benefit retirement plan. The restatement reflects certain defined benefit costs as non-operating expenses, previously categorized as operating expenses. The impact of the restatement is to increase the operating margin as follows: a) 2014: $1,921,507; b) 2015: $1,802,322; c) 2016: $92,550; First quarter 2016: $62,065; First quarter 2017: N/A.

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Health System Statements of Financial Position

The following Statement of Financial Position for the Health System as of December 31, 2014, 2015, and 2016 is derived from audited consolidated financial statements of the Health System. The information for the first quarter ended March 31, 2016 and 2017 are derived from the unaudited Health System financial statements.

Adena Health System and Subsidiaries Consolidated Balance Sheet

	Year Ended December 31			Three Month Period Ended March 31	
	2014	**2015**	**2016**	**2016**	**2017**
Current Assets					
Cash and Cash Equivalents	$35,836,255	$40,204,259	$76,879,564	$49,133,030	$76,789,176
Short-term Investments	5,319,335				
Patient Accounts Receivable, net	54,453,222	75,661,174	57,268,333	70,785,046	61,455,675
Other Current Assets	11,952,490	8,924,195	3,367,153	8,897,134	5,520,463
Estimated third-party receivables	2,572,019	2,616,338		3,539,363	
Inventory	7,226,585	5,735,699	6,148,715	5,792,538	6,062,427
Prepaid Expenses	9,309,830	7,491,336	13,674,905	9,864,957	7,022,621
Total Current Assets	$126,669,736	$140,633,001	$157,338,670	$148,012,068	$156,850,362
Assets Limited as to use	184,742,660	183,113,487	193,488,269	189,219,127	203,879,072
Property and Equipment, net of depreciation	151,249,060	149,466,647	144,099,358	145,677,438	141,582,721
Indefeasible Right -of-use asset	16,207,830	15,429,426	14,657,555	15,236,458	14,464,587
Other Assets					
Notes and Grants Receivable	2,338,981	1,698,427	1,916,912	1,698,427	1,916,912
Defined Benefit Plan Receivables			1,171,676		1,045,676
Other non current assets	4,818,891	12,067,379	12,737,424	11,990,524	12,748,043
Total Assets	$486,027,158	$502,408,367	$525,409,864	$511,834,042	$532,487,373
Liabilities and Net Assets					
Current portion of long-term debt	$4,061,349	$4,049,871	$4,366,413	$3,944,633	$4,366,413
Accounts payable and other liabilities	14,269,568	15,395,933	17,769,628	15,804,067	15,526,989
Estimated third-party payables			2,063,528		2,279,766
Accrued Compensation	24,294,159	25,338,335	26,633,783	30,248,878	26,218,538
Deferred Compensation	4,948,236	5,225,000	5,292,102	1,370,028	1,377,000
Accrued Interest	697,502	686,250	672,457	2,490,518	2,485,280
Other current accrued liabilities	2,058,435	1,806,233	1,812,338	1,806,233	1,812,338
Total Current Liabilities	$50,329,249	$52,501,622	$58,610,249	$55,664,357	$54,066,324
Long Term Debt and capital leases	$160,676,583	$156,761,484	$154,397,592	$156,568,138	$154,132,257
Defined Benefit liability	1,783,505	600,290		674,625	
Other Liabilities	8,198,539	17,423,712	18,126,893	17,910,718	18,555,553
Total Liabilities	$220,987,876	$227,287,108	$231,134,734	$230,817,838	$226,754,134
Unrestricted Net Assets	$261,279,340	$271,212,030	$289,904,506	$277,019,885	$300,810,287
Temporarily Restricted Net Assets	3,580,742	3,730,029	4,191,424	3,817,119	4,743,752
Permanently Restricted Net Assets	179,200	179,200	179,200	179,200	179,200
Total Net Assets	$265,039,282	$275,121,259	$294,275,130	$281,016,204	$305,733,239
Total Net Assets and Liabilities	$486,027,158	$502,408,367	$525,409,864	$511,834,042	$532,487,373

The above 2014 financial statements have been restated from the audited financials in Appendix B to reflect the change in accounting for unamortized debt issuance costs. Unamortized debt issuance costs are now categorized as a reduction of long-term debt. The purpose of this restatement of 2014 is to provide consistency with the 2015 and 2016 financial reporting.

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KEY FINANCIAL RATIOS OF THE HEALTH SYSTEM

Key Financial Ratios

Health System Key Financial Ratios					
	Year ended December 31			Three Month Period ended March 31	
	2014	2015	2016	2016	2017
Unrestricted Days Cash on Hand	189.9	181.8	225.1	194.6	225.9
Debt to Total Capitalization	39.1%	37.7%	35.8%	37.1%	34.9%
Cash & Investments to Long-Term Debt	123.4%	124.9%	155.5%	132.8%	160.2%
Debt Service Coverage Ratio	3.8	3.3	3.1	3.3	3.6

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Additional Financial Information

	Year Ended December 31			Three Month Period Ended March 31	
Additional Financial Information	**2014**	**2015**	**2016**	**2016**	**2017**
Net Patient Service Revenue	$417,611,747	$432,087,086	$427,850,009	$107,332,454	$110,132,406
Unrestricted Days Cash on Hand	189.9	181.8	225.1	194.6	225.9
Operating Expenses	$420,375,588	$432,951,145	$431,258,275	$107,243,191	$108,596,974
Depreciation & Amortization	22,335,845	22,210,452	22,680,825	5,744,266	5,629,651
OP Expenses to Depreciation and Amortization	$398,039,743	$410,740,693	$408,577,450	$101,498,925	$102,967,323
Operating Expenses per day	$1,090,520	$1,125,317	$1,116,332	$1,115,373	$1,144,081
Unrestricted Cash					
Cash	$35,836,255	$40,204,259	$76,829,136	$49,133,030	$76,737,502
Short-Term Investments	5,319,335	0	0	0	0
Board Designated Investments	165,986,217	164,368,017	174,470,992	167,899,584	181,697,212
Total Unrestricted Cash	$207,141,807	$204,572,276	$251,300,128	$217,032,614	$258,434,714
Debt to Total Capitalization	39.1%	37.7%	35.8%	37.1%	34.9%
Long-Term Debt	$160,676,583	$156,761,484	$154,397,592	$156,568,138	$154,132,257
Current Portion of Long-Term Debt	4,061,349	4,049,871	4,366,413	3,944,633	4,366,413
Add back unamortized issuance and discount	3,128,847	2,994,074	2,859,302	2,960,381	2,825,609
Total Long-Term Debt	167,866,779	163,805,429	161,623,307	163,473,152	161,324,279
Total Unrestricted Assets	$261,279,340	$271,212,030	$289,904,506	$277,019,885	$300,810,287
Cash & Investments to Long-Term Debt	123.4%	124.9%	155.5%	132.8%	160.2%
Unrestricted Cash	$207,141,807	$204,572,276	$251,300,128	$217,032,614	$258,434,714
Total Long-Term Debt	$167,866,779	$163,805,429	$161,623,307	$163,473,152	$161,324,279
Debt Service Coverage Ratio	3.8X	3.3X	3.1X	3.3X	3.6X
Excess of Revenues over Expenses	$11,568,145	$6,824,596	$16,668,546	$5,799,471	$10,812,865
Unrealized Gains (Losses)	(5,027,080)	(4,078,031)	8,510,081	3,581,706	7,352,842
Excess of Revenue over Expenses without Unrealized Gain/Loss	$16,595,225	$10,902,627	$8,158,465	$2,217,765	$3,460,023
Depreciation & Amortization	22,335,845	22,210,452	22,680,825	5,744,266	5,629,651
Interest	8,462,222	8,498,435	8,397,747	2,011,415	2,020,103
Total Available for Debt Service	$47,393,292	$41,611,514	$39,237,037	$9,973,446	$11,109,777
Principal Payment	$3,898,387	$4,061,349	$4,243,556	$1,053,466	$1,054,267
Interest Payment	8,462,222	8,498,435	8,397,747	2,011,415	2,020,103
Debt Service	$12,360,609	$12,559,784	$12,641,303	$3,064,881	$3,074,370

Payor Mix

The following table sets forth the patient services gross revenues by major payer source for the years ended December 31, 2014, 2015, and 2016.

Gross Revenue by Payer										
	Year Ended December 31						Three Month Period Ended March 31			
	2014		2015		2016		2016		2017	
Medicare	$476,780,385	42.9%	$494,956,335	43.4%	$542,869,969	43.5%	$142,775,267	43.5%	$ 146,143,023	43.2%
Commercial	319,697,788	28.8%	318,460,370	27.9%	342,523,318	27.4%	89,448,624	27.2%	88,560,347	26.2%
Medicaid	285,090,708	25.7%	304,619,497	26.7%	338,130,786	27.0%	89,528,790	27.3%	95,315,833	28.2%
Self Pay	28,642,367	2.6%	22,762,204	2.0%	25,715,929	2.1%	6,664,502	2.0%	8,104,314	2.4%
	$1,110,211,248	100.0%	$1,140,798,406	100.0%	$1,249,240,002	100.0%	$328,417,183	100.0%	$338,123,517	100%

MANAGEMENT DISCUSSION AND ANALYSIS OF FINANCIAL PERFORMANCE OF HEALTH SYSTEM

Three-Month Period Ended March 31, 2017 as Compared to the Three-Month Period Ended March 31, 2016

The Health System reported operating income of $3.4 million in the first quarter of 2017, which is a $1.1 million increase (46.6%) when compared to the operating income of $2.3 million in the first quarter of 2016. The increase in operating income is primarily attributable to a 2.2% increase in operating revenues accompanied by a 1.3% increase in total expenses.

Total operating revenues for the Health System were $112.0 million for the first quarter of 2017 compared with $109.5 million for the same period in 2016. This is an increase of $2.4 million (2.2%) compared to the first quarter of 2016. A focus on provider recruitment, including a 20% increase in the number of advanced practice providers, resulted in a 4.5% increase in clinic visits. This increase in clinic visits translated into a proportional increase in hospital activity, where inpatient admissions increased by 4.6%, which includes a 7.6% increase in inpatient surgeries. Based on this late 2016 growth in inpatient admissions, management estimates inpatient PSA and SSA market share has grown from 29.6% through third quarter 2016 to 31.9% through fourth quarter 2016 and to 33.7% through first quarter 2017.

The Health System's operating expenses were $108.6 million in the first quarter of 2017, an increase of $1.4 million or 1.3% when compared to the same period of 2016. While increased staffing was needed to support the volume of clinic providers and visits, as well as increased hospital volume, other staffing efficiency improvements allowed for year over year staff cost increases (3.5%) to be primarily related to annual wage rate increases. Provider salaries decreased 1.3% despite the increase in the number of advanced practice providers due to the mix of specialty physicians. The change in specialty physicians included the loss of a high producing Otorhinolaryngology ("ENT") and orthopedic physicians. In 2017, the ENT specialist services have been partially replaced. A new general and hand orthopedic surgeon will join Adena on July 1, and an interventional spine physician is committed to start later in the calendar year. Benefit costs increases were contained at an increase of 2.2%, due primarily to a

population health management approach to Adena Health's employee health plan. Patient care supplies decreased slightly in 2017 despite the higher volume of services, specifically surgical services, due to improved contractual pricing for the purchase of supplies in 2017 as a result of the implementation of a new group purchasing organization.

Non-operating income during the first quarter of 2017 was $7.5 million, a $4.0 million increase when compared to the first quarter of 2016, reflecting the strong performance of the Health System's investment portfolio.

Year Ended December 31, 2016 as Compared to the Year Ended December 31, 2015

The Health System reported operating income of $5.9 million in 2016 compared to the operating income of $8.6 million in 2015. The erosion of operating margin for the year was the result of a 1.0% decrease in operating revenues with expenses managed to a 0.4% decrease.

Total operating revenues for the Health System were $437.2 million for 2016 compared with $441.6 million for 2015. This is a decrease of $4.4 million (1.0%) compared to 2015. Nearly half of the decrease ($1.8 million) is related to the outsourcing of hospitalist services. 2016 operating revenues were also challenged by the loss of some key surgical specialists in ENT and Orthopedics. As a result, inpatient admissions decreased by 8.9% in 2016 (1,035 admissions) along with a decrease in related outpatient surgeries and ancillary services.

The Health System's operating expenses were $431.3 million in 2016 compared with $433.0 million in 2015. Total provider salaries decreased $3.9 million from 2015 to 2016. Approximately half of this decrease ($2.0 million) is related to the outsourcing of hospitalist services. The cost of the hospitalist service is reflected in the cost of purchased services in 2016. The remainder of the change in provider salaries is tied to the loss of the specialists noted in the operating revenue discussion. Total staff salaries increased 1.4% ($1.7 million) in 2016 reflecting annual salary inflationary increases of approximately 2.5% which were partially offset by staffing controls put in place to adjust staffing to lower hospital volume. Despite the lower overall salary costs, employee benefit costs rose $2.3 million in 2016, an increase of 4.9% over 2015. The increase is driven by a $1.9 million increase in employee health insurance expense. In the area of professional services and consultant fees, the Health System experienced a 21.8% reduction in costs ($0.7 million) in 2016, as the majority of the one-time costs related to the Hospital's electronic medical record and billing system implementation were absorbed in 2015.

A non-operating loss of $1.8 million was incurred in 2015 due to unrealized losses on investments. However, non-operating income rebounded to $10.8 million in 2016 due to unrealized gains on investments.

Financial Position

For the period of calendar year 2015 through the first quarter of 2017, the Health System has experienced an overall improvement in financial position as evidenced by the following:

(i) Debt to capitalization improved from 37.7% at December 31, 2015 to 35.8% at December 31, 2016, and decreasing to 34.9% at March 31, 2017.

(ii) A new capitalized lease (approximately $2.1 million) was added during this period, with ratio improvement driven by scheduled debt payments, operating margin and investment performance.

(iii) The debt service coverage was 3.3X for 2015, dipping slightly to 3.1X for 2016, but improving to 3.6X for the first quarter of 2017.

Days cash on hand rose from 181.8 days at December 31, 2015 to 225.1 days at December 31, 2016, with a continued increase to 225.9 days at March 31, 2017. Days cash on hand as of December 31, 2015 were depressed by a significant computer system implementation to the electronic patient record and patient billing system for Hospital services. The computer system implementation occurred in the second half of 2015 and delayed cash through the early months of 2016. Days revenue in accounts receivable rose from 47.6 days at the end of 2014 to 63.9 days at the end of 2015. In 2016, investment returns and a recovery of accounts receivable days from 63.9 days at the end of 2015 to 49.0 days at the end of 2016 drove days cash on hand up from 181.8 days at the end of 2015 to 225.1 days. During the first quarter of 2017, days cash on hand continued to increase slightly to 225.9 days at March 31, 2017. The 2017 investment returns were largely offset by payment of the annual defined contribution pension payment and a temporary increase in accounts receivable.

OTHER INFORMATION

Insurance

The Health System provides claims-made Healthcare Professional Liability coverage to staff and physicians through a self-insurance program in the amount of $1,000,000 per incident and $3,000,000 annual aggregate. Two $10,000,000 umbrella policies are in place offering an additional $20,000,000 of professional liability coverage. The Health System undergoes an annual actuarial review.

Other lines of insurance protection for the Health System include property (which includes business interruption coverage), general liability, employment practices liability, directors and officers (executive risk), cyber liability, automobile, and excess worker's compensation.

The Health System's insurance program is evaluated annually by its insurance broker and senior leaders to determine appropriate coverage levels and to benchmark against its peer group to assure adequate coverage is in place.

Litigation

At this time, there is no pending litigation contesting the plan of financing or the ability of the Health System to enter into the Master Indenture, the Lease or the Sublease, or issue the Series 2017 Note. No litigation or proceedings are pending or, to the knowledge of the Health System, threatened against it except (a) litigation and proceedings involving claims for hospital professional liability in which the probable recoveries and estimated costs and expenses of defense, in the opinion of counsel to the Health System, will be either entirely within the Health System's applicable insurance policy limits (subject to applicable deductibles) or in an amount which would not materially or adversely affect the financial condition or results of operation of the Health System; (b) a voluntary disclosure submitted by the Health System to Centers for Medicare and Medicaid Services regarding possible noncompliance with the federal physician self-referral statute in which the likely repayment amount resulting from the self-

disclosure, in the opinion of counsel to the Health System based on information known at this time, would not materially or adversely affect the financial condition or results of operation of the Health System; and (c) litigation and proceedings other than those described in (a) and (b) which would not in the opinion of management of the Health System, materially or adversely affect the financial condition or results of operation of the Health System, the transaction contemplated by this Official Statement or the validity of the Master Indenture, the Lease, the Sublease, or the Series 2017A Note and the issuance of the Series 2017A Note if the Health System were found liable under such proceedings.

Employees and Labor Relations

The Health System employs 2,953 people, including 172 physicians and 79 advanced practice providers, which equates to approximately 2,574 FTEs.

The Health System has no collective bargaining agreements and management of the Health System is not aware of any current organizational activity.

Management believes that relations with its employees are positive. Management believes that effective human resources management involves active communication with employees and continually focuses on a participative management style. Management conducts an annual Employee Engagement Survey conducted by Gallup and the most recent survey showed significant improvement in overall staff engagement. The Health System is implementing the "Just Culture" algorithm to further enhance its ability to interact with staff and focus on improving outcomes and employee relations. The Health System has a complete set of human resource policies covering all aspects of employee relations including wage and salary administration, disciplinary procedures and other general human resource policies.

Employee Benefits

Employee benefit programs include those common within the industry and are competitive with the marketplace as a whole. Among these benefits are group health insurance, group life insurance, long-term disability and a tax-sheltered annuity match program. The Health System maintained a non-contributory defined benefit pension plan ("Plan") for the benefit of eligible employees until July 2004 when the plan was frozen and a defined contribution plan was installed to replace the prior plan. As of April 1, 2017, the Plan is more than fully funded and is reflected as an asset in the consolidated balance sheet. All accounts are currently held in low risk investments. The Health System has engaged a third party to outline the process to terminate the plan.

Investment Policies

Adena has an investment policy which governs the allocation of the investments. The policy has a target allocation of a 50/50 split of equities and fixed income with a permitted range of a minimum of 40% and a maximum of 60% fixed investments. The strategic target for the investments is:

	Target	Permitted Range
Domestic Equities	19%	14-24%
Non-US Equities	21%	16-26%
Global Equities	10%	5-15%
Growth Fixed Income	5%	0-10%
Core Fixed Income	45%	40-50%
Total	100%	

The investment portfolio is administered by Mercer with oversight provided by the Finance Committee of the Board of Trustees. As of December 31, 2016, Adena Health investments which are directed by this policy total approximately $182 million. Please refer to Note 5 of the Notes to Consolidated Financial Statements in Appendix B which provides a breakdown of Assets Limited as to Use.

Adena has an investment policy which governs the allocation of the investments in the frozen defined benefit retirement plan. The policy has a target allocation of a 30/70 split of equities and fixed income with a permitted range of a minimum of 65% and a maximum of 75% fixed investments. The strategic target for the investments is:

	Target	Permitted Range
Domestic Equities	21.5%	16.5-26.5%
Non-US Equities	8.5%	3.5-13.5%
Fixed Income	70%	65-75%
Total	100%	

The defined benefit retirement plan investment portfolio is also administered by Mercer with oversight provided by the Finance Committee of the Board of Trustees. As Adena's defined benefit retirement plan funding levels increased, particularly with the 2016 investment returns, a more conservative investment position was adopted with a target of 80% fixed income. The investment allocation to equities may be further reduced as the plan is positioned for potential liquidation in early 2019 contingent on the timing of the regulatory processes for approval. As of December 31, 2016, Adena Health System's defined benefit plan assets are approximately $50 million. Please refer to Note 12 of the Notes to Consolidated Financial Statements in Appendix B for more information on the defined benefit plan.

APPENDIX B:-1:

2016 CONSOLIDATED FINANCIAL REPORT OF ADENA HEALTH SYSTEM AND SUBSIDIARIES

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Adena Health System and Subsidiaries

Consolidated Financial Report
with Additional Information
December 31, 2016

Adena Health System and Subsidiaries

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Independent Auditor's Report

To the Board of Directors
Adena Health System and Subsidiaries

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Adena Health System and Subsidiaries (the "System"), which comprise the consolidated balance sheet as of December 31, 2016 and 2015, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Adena Health System and Subsidiaries as of December 31, 2016 and 2015, and the results of their operations, changes in their net assets, and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Plante & Moran, PLLC

March 15, 2017

Praxity
MEMBER
GLOBAL ALLIANCE OF INDEPENDENT FIRMS

Adena Health System and Subsidiaries

Consolidated Balance Sheet

December 31, 2016 and 2015

	2016	2015
Assets		
Current Assets		
Cash and cash equivalents	$ 76,879,564	$ 40,204,259
Patient accounts receivable - Net (Note 4)	57,268,333	75,661,174
Inventory	6,148,715	5,735,699
Other current assets	3,367,153	8,924,195
Estimated third-party payor settlements (Note 8)	-	2,616,338
Prepaid expenses and other	13,674,905	7,491,336
Total current assets	157,338,670	140,633,001
Assets Limited as to Use (Note 5)	193,488,269	183,113,487
Property and Equipment - Net (Note 6)	144,099,358	149,466,647
Indefeasible Right-of-use Asset (Note 7)	14,657,555	15,429,426
Other Assets		
Notes and grants receivable	1,916,912	1,698,427
Defined benefit plan receivable (Note 12)	1,171,676	-
Other noncurrent assets	12,737,424	12,067,379
Total other assets	15,826,012	13,765,806
Total assets	**$ 525,409,864**	**$ 502,408,367**

See notes to consolidated financial statements.

Adena Health System and Subsidiaries

Consolidated Balance Sheet (Continued)

December 31, 2016 and 2015

	2016	2015
Liabilities and Net Assets		
Current Liabilities		
Accounts payable	$ 17,769,628	$ 15,395,933
Current portion of long-term debt (Note 11)	4,366,413	4,049,871
Estimated third-party payor settlements (Note 8)	2,063,528	-
Accrued liabilities and other:		
Accrued compensation	26,633,783	25,338,335
Deferred compensation	5,292,102	5,225,000
Accrued interest	672,457	686,250
Other accrued liabilities	1,812,338	1,806,233
Total current liabilities	58,610,249	52,501,622
Long-term Debt and Capital Lease Obligations - Net of current portion (Note 11)	154,397,592	156,761,484
Defined Benefit Plan Liability (Note 12)	-	600,290
Other Liabilities	18,126,893	17,423,712
Total liabilities	231,134,734	227,287,108
Net Assets		
Unrestricted	289,904,506	271,212,030
Temporarily restricted (Note 14)	4,191,424	3,730,029
Permanently restricted (Note 14)	179,200	179,200
Total net assets	294,275,130	275,121,259
Total liabilities and net assets	**$ 525,409,864**	**$ 502,408,367**

See notes to consolidated financial statements.

Adena Health System and Subsidiaries

Consolidated Statement of Operations

Years Ended December 31, 2016 and 2015

	2016	2015
Unrestricted Revenue, Gains, and Other Support		
Net patient service revenue	$ 443,913,305	$ 457,508,306
Provision for bad debts	(16,063,296)	(25,421,220)
Net patient service revenue less provision for bad debts	427,850,009	432,087,086
Other operating revenue	8,920,507	9,171,674
Net assets released from restrictions (Note 14)	391,312	339,419
Total unrestricted revenue, gains, and other support	437,161,828	441,598,179
Expenses		
Salaries and wages	197,941,796	200,451,617
Employee benefits and payroll taxes	48,868,881	48,287,038
Operating supplies and expenses	73,024,579	75,492,620
Professional services and consultant fees	2,554,859	3,268,136
Purchased services	44,403,368	43,425,935
Insurance	2,361,891	2,422,364
Utilities	4,777,400	4,551,399
Travel/Education	2,564,579	2,515,718
Repair, maintenance, and rental	19,370,110	19,470,326
Assessments	4,404,790	4,159,427
Depreciation and amortization	22,680,825	22,210,452
Interest expense	8,397,747	8,498,435
Total expenses (Note 16)	431,350,825	434,753,467
Operating Income	5,811,003	6,844,712
Nonoperating Income (Loss)		
Interest income and net realized gains (Note 5)	2,152,762	3,735,127
Unrealized gains (losses) on investments	8,510,081	(4,078,031)
Other income	194,700	322,788
Total nonoperating income (loss)	10,857,543	(20,116)
Excess of Revenue Over Expenses	16,668,546	6,824,596
Net Assets Released from Restriction for Purchase of Capital Assets	92,586	78,790
Pension-related Changes Other than Net Periodic Cost	1,913,600	3,019,905
Grant Income	17,744	9,399
Increase in Unrestricted Net Assets	**$ 18,692,476**	**$ 9,932,690**

See notes to consolidated financial statements.

Adena Health System and Subsidiaries

Consolidated Statement of Changes in Net Assets

Years Ended December 31, 2016 and 2015

	2016	2015
Unrestricted Net Assets		
Excess of revenue over expenses	$ 16,668,546	$ 6,824,596
Pension-related changes other than net periodic cost	1,913,600	3,019,905
Grant income	17,744	9,399
Net assets released from restriction for purchase of capital assets (Note 14)	92,586	78,790
Increase in unrestricted net assets	18,692,476	9,932,690
Temporarily Restricted Net Assets		
Restricted contributions	830,975	516,009
Restricted investment income	80,542	69,943
Net realized and unrealized gains (losses) on investments	24,903	(4,802)
Net assets released from restriction (Note 14)	(475,025)	(431,863)
Increase in temporarily restricted net assets	461,395	149,287
Permanently Restricted Net Assets		
Net realized and unrealized gains on investments	17,075	18,860
Net assets released from restriction	(17,075)	(18,860)
Change in permanently restricted net assets	-	-
Increase in Net Assets	19,153,871	10,081,977
Net Assets - Beginning of year	275,121,259	265,039,282
Net Assets - End of year	**$ 294,275,130**	**$ 275,121,259**

See notes to consolidated financial statements.

Adena Health System and Subsidiaries

Consolidated Statement of Cash Flows

Years Ended December 31, 2016 and 2015

	2016	2015
Cash Flows from Operating Activities		
Increase in net assets	$ 19,153,871	$ 10,081,977
Adjustments to reconcile increase in net assets to net cash and cash equivalents from operating activities:		
Depreciation and amortization	22,820,348	22,349,975
Net realized gains on investments	(2,058,684)	(510,355)
Unrealized net (gains) losses on investments	(8,510,081)	4,078,031
Grant income	(17,744)	(9,399)
Pension-related changes other than net periodic cost	(1,913,600)	(3,019,905)
Provision for bad debts	16,063,296	25,421,220
Changes in operating assets and liabilities which provided (used) cash and cash equivalents:		
Patient accounts receivable	2,329,545	(46,629,172)
Other current assets	(1,039,543)	6,337,675
Other noncurrent assets	(912,786)	2,064,111
Accounts payable	2,372,928	1,126,365
Accrued liabilities and other	2,058,810	2,533,189
Estimated third-party payor settlements	4,679,866	(44,319)
Change in defined benefit plan liability	141,634	1,836,690
Net cash and cash equivalents provided by operating activities	55,167,860	25,616,083
Cash Flows from Investing Activities		
Purchase of property and equipment	(14,442,982)	(20,573,652)
Proceeds from sale of property and equipment	-	6,090
Proceeds from sales and maturities of investments	193,983	3,380,832
Net cash and cash equivalents used in investing activities	(14,248,999)	(17,186,730)
Cash Flows from Financing Activities - Principal payments on long-term debt	(4,243,556)	(4,061,349)
Net Increase in Cash and Cash Equivalents	36,675,305	4,368,004
Cash and Cash Equivalents - Beginning of year	40,204,259	35,836,255
Cash and Cash Equivalents - End of year	**$ 76,879,564**	**$ 40,204,259**
Supplemental Cash Flow Information		
Cash paid for interest - Net of capitalized amounts	$ 8,411,000	$ 8,370,000
Grant income	17,744	9,399

See notes to consolidated financial statements.

Note 1 - Nature of Business

Adena Health System and Subsidiaries (the "System"), located in Ross County, Ohio, is a not-for-profit acute-care hospital operating 214 general acute-care beds. Adena Health System provides inpatient, outpatient, and emergency care services for residents of Ross County, Ohio and the surrounding communities.

In September 1999, Adena Health System became the sole member of Greenfield Area Medical Center (Greenfield), a 25-bed acute-care hospital located in Greenfield, Ohio. Greenfield has Section 501(c)(3) status with the IRS. Adena Health System, in its discretion as the sole member of Greenfield, may at any time amend the articles of incorporation and code of regulations of Greenfield in any manner and take any other action with respect to Greenfield that members of not-for-profit corporations may take under the Ohio not-for-profit corporation law. Effective June 1, 2001, Greenfield received federal critical access hospital (CAH) designation, which is awarded to select small, rural hospitals, which allows it to recoup Medicare-defined allowable costs for services provided to Medicare patients. The CAH designation gives Greenfield increased reimbursement so that it can better serve its community. To receive this designation, hospitals must meet specific criteria such as available beds, patient length of stay, and transfer agreements with other facilities.

On January 7, 2002, Adena Health System created the Adena Health Foundation (the "Foundation"). The purpose of the Foundation is to support Adena Health System and community programs to improve the health and well-being of the people served by Adena Health System. The Foundation received its 501(c)(3) status from the IRS on April 10, 2002.

On December 14, 2007, Adena Health System created Southern Ohio Health Care Network, Inc. (SOHCN). The purpose for which SOHCN was formed was to create an inclusive and sustainable broadband healthcare network open to all providers in the southern Ohio service area. The System was granted tax exemption for SOHCN during 2014.

On October 19, 2009, Adena Health System created Adena Medical Group, LLC (AMG). AMG is a disregarded entity with Adena Health System as its sole member. AMG was formed to employ physicians to provide patient care within the Adena Health System, and it became operational on April 1, 2010.

On January 1, 2010, Adena Health System created Adena Pharmacy, LLC (AP). AP is a disregarded entity with Adena Health System as its sole member. AP was formed to establish and operate a retail pharmacy within the Adena Health System, and it became operational on November 1, 2012.

On August 11, 2010, Adena Health System created Adena Hospice, LLC, Adena Home Health LLC, Adena Home Infusion, and DME & Respiratory, LLC (collectively referred to as "Adena Home Care"). Adena Health System is the sole member of these entities. The entities were formed to provide hospice care, home health services, and DME equipment/services, respectively, to patients within the Adena Health System service area.

On November 10, 2011, Adena Health System created Adena Care, Inc., which is doing business as (d/b/a) Adena Health Plan. Adena Health System is the sole shareholder of Adena Care, Inc. Adena Health Plan functions as a taxable entity and was formed to market employee health insurance to organizations in Ohio.

On March 1, 2012, the System became the sole corporate member of Pike Health Services, Inc. (Adena Pike Community Hospital). The System took operational control effective March 1, 2012. Pike Health Services, Inc. is a not-for-profit hospital operating 25 beds in Waverly, Ohio that has received critical access hospital designation.

Note 2 - Significant Accounting Policies

Basis of Consolidation

The accompanying consolidated financial statements include the accounts of Adena Health System and its subsidiaries, Greenfield Area Medical Center, Adena Health Foundation, Southern Ohio Health Care Network, Inc., Adena Medical Group, LLC, Adena Hospice, LLC, Adena Home Health LLC, Adena Home Infusion, DME & Respiratory, LLC, Adena Care, Inc. d/b/a Adena Health Plan, Adena Pharmacy, LLC, and Adena Pike Community Hospital (collectively, the "System"). All significant intercompany transactions and balances have been eliminated in consolidation.

Cash and Cash Equivalents

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

Accounts Receivable

Accounts receivable for patients, insurance companies, and governmental agencies are based on gross charges. An allowance for uncollectible accounts is established on an aggregate basis by using historical write-off rate factors applied to unpaid accounts based on aging. Loss-rate factors are based on historical loss experience and adjusted for economic conditions and other trends affecting the System's ability to collect outstanding amounts. Uncollectible amounts are written off against the allowance for doubtful accounts in the period they are determined to be uncollectible. An allowance for contractual adjustments and interim payment advances is established based on expected payment rates from payors utilizing current reimbursement methodologies and payment rates. This amount also includes amounts received as interim payments against unpaid claims by certain payors.

For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the System records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates, if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts in the period they are determined to be uncollectible.

Physician Receivables and Advances

The System has entered into agreements to advance money to physicians. Based upon the terms of the agreements, these loans are to be repaid by the physicians or fulfilled through providing services at the System for an agreed-upon time period. Most of these loans are expected to be satisfied by the physicians providing services at the System. These amounts are shown within other current assets on the consolidated balance sheet.

Investments

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the consolidated balance sheet. Investment income or loss (including realized and unrealized gains and losses on investments, interest, and dividends) is included in excess of revenue over expenses unless the income or loss is restricted by donor or law.

Note 2 - Significant Accounting Policies (Continued)

Assets Limited as to Use

Assets limited as to use include assets designated by the board of directors for future capital improvement, over which the board retains control, and may, at its discretion, subsequently use for other purposes. Assets limited as to use also include assets held by trustees in connection with repayment of principal and interest on bond indebtedness, and funds designated for the professional liability self-insurance trust. Assets limited as to use include assets temporarily restricted or permanently restricted by the donor.

Inventory

Inventories, which consist of medical, surgical, and office supplies and pharmaceutical products, are stated at the lower of cost, determined on a first-in, first-out basis, or market.

Property and Equipment

Property and equipment are recorded at cost. Donated property and equipment are recorded at the estimated fair market value at the time of donation. Depreciation is computed principally on the straight-line basis over the estimated useful lives of the assets. Costs of maintenance and repairs are charged to expense when incurred.

Indefeasible Right-of-use Asset

The indefeasible right-of-use asset is recorded at cost and is being amortized over the estimated useful life of the asset of 24 years.

Classification of Net Assets

Net assets of the System are classified as permanently restricted, temporarily restricted, or unrestricted depending on the presence and characteristics of donor-imposed restrictions limiting the System's ability to use or dispose of contributed assets or the economic benefits embodied in those assets. Donor-imposed restrictions that expire with the passage of time or that can be removed by meeting certain requirements result in temporarily restricted net assets. Permanently restricted net assets result from donor-imposed restrictions that limit the use of net assets in perpetuity. Earnings, gains, and losses on restricted net assets are classified as unrestricted unless specifically restricted by the donor or by applicable state law.

Excess of Revenue Over Expenses

The consolidated statement of operations includes excess of revenue over expenses. Changes in unrestricted net assets, which are excluded from excess of revenue over expenses, consistent with industry practice, include unrealized gains and losses on investments other than trading securities, pension-related changes other than net periodic benefit cost, permanent transfers of assets to and from affiliates for other than goods and services, indefeasible right-of-use (grant) income (loss), and pension-related changes other than net periodic cost.

Net Patient Service Revenue

The System has agreements with third-party payors that provide for payments to the System for services rendered at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge or service, reimbursed costs, discounted charges, and per-diem payments. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactively calculated adjustments arising under reimbursement agreements with third-party payors are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods, as final settlements are determined.

Note 2 - Significant Accounting Policies (Continued)

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Management believes that it is in compliance with all applicable laws and regulations. Final determination of compliance with such laws and regulations is subject to future government review and interpretation. Violations may result in significant regulatory action including fines, penalties, and exclusions from the Medicare and Medicaid programs.

The System recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients that do not qualify for charity care, the System recognizes revenue on the basis of its standard rates for services provided (or on the basis of discounted rates, if negotiated or provided by policy). On the basis of historical experience, a significant portion of the System's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the System records a significant provision for bad debts related to uninsured patients in the period the services are provided. Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period from these major payor sources in total was $443,913,305 and $457,508,306 for the years ended December 31, 2016 and 2015, respectively. These amounts are made up of amounts from third-party payors of $430,389,896 and $443,622,083 as of December 31, 2016 and 2015, respectively, and amounts from self-pay payors of $13,523,409 and $13,886,223 for the years ended December 31, 2016 and 2015, respectively.

Charity Care

The System provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the System does not pursue collection of amounts determined to qualify as charity care, they are not reported in net patient service revenue.

Charity care is determined based on established polices, using patient income and assets to determine payment ability. The amount reflects the cost of free or discounted health services, net of contributions and other revenue received, as direct assistance for the provision of charity care. The estimated cost of providing charity services is based on a calculation which applies a ratio of cost to charges to the gross uncompensated charges associated with providing care to charity patients. The ratio of cost to charges is calculated based on the System's total operating expenses divided by gross patient service revenue. The System estimates that it provided approximately $8,342,000 and $7,903,000 of services to indigent patients during 2016 and 2015, respectively. The System received $8,902,000 and $3,340,000 in net distributions from the Ohio Medicaid HCAP Program during 2016 and 2015, respectively, as assistance to offset the cost of charity care.

Litigation

The System is exposed to litigation arising in the course of business. The System has purchased excess coverage for these claims in excess of its self-insured retention. Settled claims related to the coverage have not exceeded the amount of insurance coverage in 2016 or 2015. The System accrues an estimate of the ultimate expense, including litigation and settlement expense, for incidents of potential improper professional service and other liability claims occurring during the year, as well as for those claims that have not been reported at year end.

Contributions and Grants

The System reports gifts of cash and other assets as restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the consolidated statement of changes in net assets as net assets released from restrictions.

Note 2 - Significant Accounting Policies (Continued)

The System reports gifts of property and equipment as unrestricted support unless explicit donor stipulations specify how the donated assets must be used. Gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, the System reports the expiration of donor restrictions when the assets are placed in service.

Contributions and grants received for capital purposes are excluded from the performance indicator (excess of revenue over expenses) while grants received for operational purposes are included in other operating income.

Use of Estimates

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

Electronic Health Records Incentive Payments (EHR)

The American Recovery and Reinvestment Act of 2009 (ARRA) established funding in order to provide incentive payments to hospitals and physicians that implement the use of electronic health record (EHR) technology by 2015. The System may receive an incentive payment for up to four years, provided that the System demonstrates meaningful use of certified EHR technology for the EHR reporting period. The revenue from the incentive payments is recognized over the EHR reporting period when there is reasonable assurance that the System will comply with eligibility requirements during the EHR reporting period and an incentive payment will be received. The amounts are recorded within other operating revenue as the incentive payments are related to the System's ongoing and central activities, yet are not critical to the delivery of patient service.

The System attested to the Centers for Medicare and Medicaid Services (CMS) that it had met the second stage of the first year of meaningful use criteria. The incentive payments were recognized as income within other operating revenue in the amount of $1,852,000 and $2,040,000 during 2016 and 2015, respectively.

Tax Status

Adena Health System and its subsidiaries (except for Adena Pharmacy, LLC, Adena Home Care, and Adena Care, Inc. d/b/a Adena Health Plan) are nonprofit, tax-exempt entities. Adena Pharmacy, LLC and Adena Home Care are limited liability companies and, as such, federal and other income taxes are not provided for by these entities. The sole member, Adena Health System, may be taxed on the earnings, but taxes, if any, are not expected to be significant. Adena Care, Inc. is a taxable entity; however, Adena Care, Inc. has recorded operating losses and has an operating loss carryforward at December 31, 2016.

Note 2 - Significant Accounting Policies (Continued)

Upcoming Accounting Pronouncements

In May 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update No. 2014-09, *Revenue from Contracts with Customers (Topic 606)*, which will supersede the current revenue recognition requirements in Topic 605, *Revenue Recognition*. The ASU is based on the principle that revenue is recognized to depict the transfer of goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The ASU also requires additional disclosure about the nature, amount, timing, and uncertainty of revenue and cash flows arising from customer contracts, including significant judgments and changes in judgments and assets recognized from costs incurred to obtain or fulfill a contract. The new guidance will be effective for the System's year ending December 31, 2018. The ASU permits application of the new revenue recognition guidance to be applied using one of two retrospective application methods. The System has not yet determined which application method it will use or the potential effects of the new standard on the consolidated financial statements, if any. The System is in the process of evaluating the impact of the new standard on the consolidated financial statements; however, it does not anticipate the adoption of this accounting change to have a significant impact on its financial statements.

In February 2016, the Financial Accounting Standards Board (FASB) issued ASU No. 2016-02, *Leases*, which will supersede the current lease requirements in ASC 840. The ASU requires lessees to recognize a right-of-use asset and related lease liability for all leases, with a limited exception for short-term leases. Leases will be classified as either finance or operating, with the classification affecting the pattern of expense recognition in the statement of operations. Currently, leases are classified as either capital or operating, with only capital leases recognized on the balance sheet. The reporting of lease-related expenses in the statements of operations and cash flows will be generally consistent with the current guidance. The new lease guidance will be effective for the System's year ending December 31, 2019 and will be applied using a modified retrospective transition method to the beginning of the earliest period presented. The expected impact on the consolidated balance sheet is a significant increase in long-term assets and lease liabilities. The effects on the results of operations are not expected to be significant as recognition and measurement of expenses and cash flows for leases will be substantially the same under the new standard.

In August 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2016-14, *Not-for-Profit Entities (Topic 958): Presentation of Financial Statements of Not-for-Profit Entities*. ASU No. 2016-14 requires significant changes to the financial reporting model of organizations that follow FASB not-for-profit rules, including changing from three classes of net assets to two classes: net assets with donor restrictions and net assets without donor restrictions. The ASU will also require changes in the way certain information is aggregated and reported by the System, including required disclosures about the liquidity and availability of resources. The new standard is effective for the System's year ending December 31, 2018 and thereafter and must be applied on a retrospective basis. The System is currently evaluating the impact this standard will have on the consolidated financial statements and does not anticipate a significant impact on the consolidated balance sheet.

Change in Accounting Policy

As of January 1, 2016, the System adopted ASU No. 2015-07, *Fair Value Measurement (Topic 820): Disclosures for Investments in Certain Entities That Calculated Net Asset Value per Share (or its Equivalent)*, which changes the required disclosures for investments measured at net asset value (NAV) per share (or its equivalent) as a practical expedient. Previously, investments measured at fair value using the NAV practical expedient were classified in the fair value hierarchy based on the redemption features associated with the investment. Under the new guidance, investments measured at fair value using net asset value per share (or its equivalent) as a practical expedient are no longer classified in the fair value hierarchy. The information for 2015 has been adjusted to conform to the new disclosure requirements. See Note 12 and Note 17 for the related fair value disclosures.

Note 2 - Significant Accounting Policies (Continued)

Unamortized Bond Issue Costs and Other Assets

As of January 1, 2016, the System adopted new guidance related to the presentation of debt issuance costs in its consolidated balance sheet. Under the new guidance, debt issuance costs are reported as a direct deduction from the carrying amount of the related debt. Previously, debt issuance costs were presented as an asset. The new presentation requirements have been applied retrospectively and amounts reported in the 2015 consolidated balance sheet have been restated, as follows:

	As Previously Reported	As Restated	Effect of Change
Assets - Debt issuance costs	$ 2,994,075	$ -	$ (2,994,075)
Liabilities - Long-term debt	$ 159,755,559	$ 156,761,484	$ (2,994,075)

Subsequent Events

The consolidated financial statements and related disclosures include evaluation of events up through and including March 15, 2017, which is the date the consolidated financial statements were issued.

Note 3 - Cash in Excess of insured Limits

The System and its subsidiaries maintain cash and investment balances at several financial institutions located in the vicinity of Chillicothe, Ohio. Accounts at each institution are insured by the Federal Deposit Insurance Corporation (FDIC) up to $250,000 per institution. As of December 31, 2016 and 2015, the consolidated uninsured cash balances totaled approximately $76,099,000 and $38,668,000, respectively.

Note 4 - Patient Accounts Receivable

The details of patient accounts receivable are set forth below:

	2016	2015
Patient accounts receivable	$ 220,037,333	$ 238,937,174
Less:		
Allowance of uncollectible accounts	48,264,000	48,819,000
Allowance for contractual adjustments	114,505,000	114,457,000
Net patient accounts receivable	$ 57,268,333	$ 75,661,174

	2016	2015
Medicare	27.00 %	27.00 %
Medicaid	12.00	19.00
Commercial insurance and other	59.00	52.00
Self pay	2.00	2.00
Total	100.00 %	100.00 %

The System's allowance for doubtful accounts for self-pay patients is 97 percent and 95 percent of self-pay accounts receivable at December 31, 2016 and 2015, respectively. The System's charity policies were approved in December 2013 and became effective in January 2014. The System does not maintain a significant allowance for doubtful accounts from third-party payors, nor did it have significant write-offs from third-party payors.

Note 4 - Patient Accounts Receivable (Continued)

On August 1, 2015, the System implemented a significant upgrade to its hospital facilities Electronic Health Record information systems platform. This upgrade positioned the System to meet and exceed federal and state "meaningful use" parameters. The upgrade also fundamentally changed the System's process for capturing patient charges in its hospital setting. These changes caused a delay in submittal of claims on surgical, laboratory, pharmacy, and radiology charges of up to 90 days. This delay in claims submission has resulted in the almost 50 percent increase in net accounts receivable at December 31, 2015. Net accounts receivable has returned to historical levels in 2016 as this process has been improved.

Note 5 - Assets Limited as to Use

The composition of assets limited as to use at December 31, 2016 and 2015 is set forth in the following table:

	2016	2015
Internally designated for capital acquisition and professional liability self-insurance trust:		
Money market accounts	$ 535,378	$ 509,234
Common stock	291,353	276,208
Mutual funds	179,220,176	168,893,466
Corporate bonds	1,649,611	1,655,707
Total	181,696,518	171,334,615
Held by trustee under indenture agreement for certain bond indebtedness principal and interest payments -		
Money market accounts	11,791,751	11,778,872
Total assets limited as to use	$ 193,488,269	$ 183,113,487

Unrestricted investment income and gains for assets limited as to use, cash equivalents, and other investments are comprised of the following for the years ended December 31, 2016 and 2015:

	2016	2015
Interest income	$ 136,056	$ 3,238,830
Net realized gains on sales of securities	2,016,706	496,297
Net unrealized gains (losses) on securities	8,510,081	(4,078,031)
Total income (loss)	$ 10,662,843	$ (342,904)

Note 6 - Property and Equipment

The costs of property, plant, and equipment and depreciable lives are summarized as follows:

	2016	2015	Depreciable Life - Years
Land	$ 3,485,204	$ 3,485,204	-
Land improvements	7,432,502	6,886,538	5-25
Buildings and improvements	186,409,639	183,243,172	5-40
Equipment	204,309,807	193,713,626	5-20
Construction in progress	2,838,094	2,292,304	
Total cost	404,475,246	389,620,844	
Accumulated depreciation	260,375,888	240,154,197	
Net property and equipment	$ 144,099,358	$ 149,466,647	

Depreciation on property and equipment totaled approximately $21,867,000 and $21,397,000 in 2016 and 2015, respectively.

Note 7 - Indefeasible Right-of-use Asset

During 2009, SOHCN received an award from the Federal Communications Commission (FCC) to develop a sustainable broadband healthcare network open to all providers in the southern Ohio service area. The award from the FCC was for a total of $15,765,417, which represented approximately 85 percent of the total contract value of the broadband fiber to be installed, with the remaining 15 percent being a required contribution from the System. At the same time, SOHCN entered into a contract with a broadband partner for that partner to install and maintain the broadband fiber network. The agreement stipulated that the broadband partner would own the fiber, but SOHCN would have an indefeasible right of use of the asset for the next 40 years. All funds from the FCC are to be paid directly to the broadband partner upon approval of fiber construction by the System. During 2011, the broadband partner began installing the fiber with a total cost of $15,562,000 as of December 31, 2011. The asset will be amortized over its estimated useful life of 24 years; amortization commenced in November 2011, with amortization expense totaling $771,871 for both years ended December 31, 2016 and 2015.

Note 8 - Estimated Third-party Settlements

Approximately 47 percent of the System's revenue from patient services is received from the Medicare and Medicaid programs. The Hospital has agreements with these payors that provide for reimbursement to the System at amounts different from its established rates. Contractual adjustments under third-party reimbursement programs represent the difference between the System's established rates for services and amounts reimbursed by third-party payors. A summary of the basis of reimbursement with these third-party payors is as follows:

Medicare

For Adena Health System, inpatient acute-care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Inpatient capital costs are paid at prospectively determined rates per discharge. Most outpatient services and outpatient-defined capital costs related to Medicare beneficiaries are paid based on an ambulatory payment classification system (prospectively determined). Outpatient services for therapies and laboratory services are reimbursed on an established fee screen methodology. For Greenfield Area Medical Center and Adena Pike Community Hospital, the facilities will receive reasonable cost-based reimbursement for both inpatient and outpatient services provided to Medicare beneficiaries.

Note 8 - Estimated Third-party Settlements (Continued)

The professional services supplied by the employed physicians are reimbursed on an applicable fee schedule. These fee schedules are updated as regulations require or as contracts are negotiated in the case of some of Adena's Medicare Advantage plans.

Medicaid

For hospitals, inpatient acute-care services rendered to Medicaid program beneficiaries and capital costs are paid at prospectively determined rates per discharge. The hospitals are reimbursed for outpatient services on an established fee-for-service methodology.

The professional services supplied by the employed physicians are reimbursed on an applicable fee schedule. These fee schedules are updated as regulations require or as contracts are negotiated in the case of some of Adena's Medicaid Managed Care Plans.

Final reimbursement under these programs is subject to audit by fiscal intermediaries. Although these audits may result in some changes in these amounts, they are not expected to have a significant effect on the accompanying consolidated financial statements.

The Medicaid payment system in Ohio is a prospective one, whereby rates for the following state fiscal year beginning on July 1 are based upon filed cost reports for the preceding calendar year. The continuity of this system is subject to the uncertainty of the fiscal health of the State of Ohio, which can directly impact future rates and the methodology currently in place. Any significant change in rates, or the payment system itself, could have a material impact on the future Medicaid funding to providers.

Effective January 1, 2014, the State of Ohio extended Medicaid to more low-income patients, which resulted in patients previously classified as self pay being eligible for Medicaid. The provision for bad debts recorded in 2016 and 2015 was significantly affected by this program.

Commercial

The System has also entered into agreements with certain commercial carriers, health maintenance organizations, and preferred provider organizations. The basis for reimbursement to the System under these agreements is discounts from established charges, prospectively determined rates per discharge, and prospectively determined daily rates.

The professional services supplied by the employed physicians are reimbursed on an applicable fee schedule. These fee schedules are updated from time to time as negotiated.

Note 9 - Medical Malpractice Claims

Based on the nature of its operations, the System is, at times, subject to pending or threatened legal actions which arise in the normal course of its activities.

The System has been insured with various providers. The System added coverage for integrated (employed) physicians to its policy in 1998, sharing primary limits of $1,000,000 per incident and $3,000,000 annual aggregate. Beginning with the 2000-2001 policy year, the physicians were covered under a separate occurrence policy with individual limits for each physician of $1,000,000 per occurrence and $3,000,000 annual aggregate. The coverages for the system and physicians were occurrence-based until 2005, at which time the System became insured on a claims-made basis.

The System's medical malpractice coverage was renewed with a $250,000 deductible per claim on February 22, 2005, and the deductible increased to $500,000 per claim as of February 22, 2006. In addition, as of October 1, 2008, the System modified the physician coverages to include a deductible of $500,000 per claim.

Note 9 - Medical Malpractice Claims (Continued)

On January 1, 2011, the System implemented a self-insured medical malpractice trust with shared retention limits for all medical providers of $1,000,000 per incident and $3,000,000 in the aggregate, annually. Excess policies in the amount of up to $20,000,000 in insurance coverage annually are layered on top of the System's self-insured retention.

At December 31, 2016, the System's management accrued its best estimate of the costs for claims arising prior to December 31, 2016. Based on changes to generally accepted accounting principles, system management has estimated the ultimate costs, if any, to settle these claims through an actuarial valuation and has accordingly allowed for them in the accrual for professional liability claims of approximately $10,900,000 and $11,000,000 for the years ended December 31, 2016 and 2015, respectively. These amounts are recorded in other liabilities on the consolidated balance sheet.

In addition, the System has estimated a receivable from its insurance carrier for payment of claims in excess of self-insured retention. The receivable is estimated at $1,900,000 for both years ended December 31, 2016 and 2015, included in other current assets and other noncurrent assets on the consolidated balance sheet. The System is not aware of any medical malpractice claims, either asserted or unasserted, that would exceed the policy limits.

Note 10 - Self Insurance

The System is partially self insured under a plan covering substantially all employees for health benefits. The plan is covered by a stop-loss policy that covers claims over $250,000 and $225,000 per employee annually in 2016 and 2015, respectively, or total claims in excess of approximately $33,223,000 and $34,658,000 in 2016 and 2015, respectively. Claims and expenses charged to operations when incurred were approximately $26,973,000 and $25,063,000 for the years ended December 31, 2016 and 2015, respectively. The System has recorded a receivable of $0 and $1,578,000 for claims paid exceeding the self-insured retention due from its insurance carrier at December 31, 2016 and 2015, respectively, in other current assets on the consolidated balance sheet.

Note 11 - Long-term Debt

A summary of long-term debt obligations at December 31, 2016 and 2015 is as follows:

	2016	2015
County of Ross, Ohio, Hospital Facilities Revenue Bonds 2010 (maturing in December 2037)	$ 25,870,559	$ 26,788,911
County of Ross, Ohio, Hospital Facilities Revenue Bonds 2008 (maturing in December 2038)	130,575,000	133,070,000
County of Ross, Ohio, Hospital Facilities Revenue Bonds 1998 (maturing in December 2023)	3,310,000	3,700,000
Capital lease obligations for equipment purchases	1,867,748	246,519
Total	161,623,307	163,805,430
Less current portion	4,366,413	4,049,871
Less deferred bond issue costs	2,859,302	2,994,075
Long-term portion	$ 154,397,592	$ 156,761,484

Note 11 - Long-term Debt (Continued)

In September 2010, the County of Ross, Ohio issued $30,000,000 Adjustable Rate Demand Hospital Facilities Revenue Bonds, Series 2010 (Adena Health System Project) (the "Series 2010 Bonds"). The Series 2010 Bonds are a private placement in which PNC Bank (PNC) purchased the Series 2010 Bonds and agreed to hold the Series 2010 Bonds until at least September 1, 2020. The Series 2010 Bonds were issued for the purpose of financing the construction of a cancer center and the renovation and equipping of certain other facilities. The debt has a final maturity date of September 1, 2037 and provides for the repayment of principal in increasing monthly principal payments beginning in 2012 through September 1, 2020, at which time the Series 2010 Bonds are subject to mandatory tender. As long as the interest rate remains at the initial fixed rate (bank rate) and no event of default occurs under the indenture, then the bonds cannot be redeemed by the bondholder until September 1, 2020; however, the System has an option to redeem bonds prior to September 1, 2020, subject to a prepayment premium.

If the System chooses to change the interest rate in accordance with the provisions of the indenture, then the bonds may be redeemable upon such conversion of rate as well. As long as there are no changes in the initial bank rate or early redemptions, then on and after September 1, 2020, the principal of the Series 2010 Bonds will be amortized pursuant to an agreement between the System and the new holder of the Series 2010 Bonds. While the interest rate of the bonds is adjustable based on various indices over the term of the bonds, PNC has agreed to fix the rate at 2.97 percent until September 1, 2020, after which time the rate will become a variable rate to be negotiated between the System and the debt holder, unless the System chooses to change the interest rate in accordance with the indenture before September 1, 2020.

In July 2008, the System entered into an advance refunding plan with the County of Ross, Ohio (Ross County), in which Ross County issued $142,970,000 of Hospital Facilities Revenue Refunding and Improvement Bonds (the "Series 2008 Bonds"). The Series 2008 Bonds were issued for the purpose of refinancing previously issued debt and financing the acquisition, construction, renovation, and equipping of certain facilities. The debt matures in increasing semiannual principal payments beginning in 2009 through 2038. The interest rate per year ranges from 4.70 percent to 5.75 percent over the life of the bonds. The System has obtained bond insurance over the life of the bonds for a portion of the Series 2008 Bonds.

In September 1998, the System entered into an agreement with Ross County in which Ross County issued $8,175,000 of Hospital Facilities Revenue Bonds (Series 1998 Bonds) to (1) pay the costs of acquisition and construction of various improvements to the System, including the 60,000-square foot expansion of a medical office building to provide additional physicians' offices and hospital services and renovation of the women's and maternity unit, (2) pay the cost of acquisition and installation of certain movable equipment and a management information system, and (3) pay certain eligible expenses associated with the issuance of the Series 1998 Bonds. The bonds are secured by an irrevocable letter of credit issued by PNC Bank. The bonds are remarketed weekly and bear interest at variable market rates (0.73 percent and 0.02 percent at December 31, 2016 and 2015, respectively). Should the remarketing agent fail to remarket the bonds, funds would be drawn on the letter of credit to pay the bonds. The System is under no obligation to repay draws on the letter of credit until the 368th day after the occurrence of such draw. The letter of credit expires on October 15, 2018, at which time the System would become liable for draws on the letter of credit, if any.

Interest expense on all indebtedness totaled approximately $8,398,000 in 2016 and $8,498,000 in 2015. Cash paid for interest amounted to approximately $8,411,000 and $8,370,000 for 2016 and 2015, respectively.

Note 11 - Long-term Debt (Continued)

In connection with the Series 1998, 2008, and 2010 Bonds, Ross County, as lessee, and the System, as lessor, entered into a master lease agreement for the System's premises. Ross County, as lessor, then entered into a sublease agreement with the System, as lessee, for the System's premises. The lease agreements expire on December 1, 2038, the mandatory retirement date of the Series 2008 Bonds. Under the terms of the lease and the indenture of trust related to the bonds, the System has pledged to Ross County a security interest in all present and future gross receipts, as defined. After final payment of the bonds, the System's facilities will be surrendered back to the System. Accordingly, such premises, together with the bond proceeds and bond indebtedness, are included in the accompanying consolidated financial statements as assets and liabilities of the System.

The terms of the lease and the indenture of trust between Ross County, the System, and the trustee provide for the establishment and maintenance of certain funds under the control of the trustee into which the System is to make regular payments sufficient to cover principal and interest on the Series 1998, 2008, and 2010 Bonds. The balances of these funds as of December 31, 2016 and 2015 are reflected in the accompanying consolidated financial statements as assets limited as to use. In addition, the System is required to comply with certain financial and other restrictive covenants related to these bonds. For the year ended December 31, 2016, the maximum annual debt service is $12,719,883.

Scheduled future minimum repayments on long-term debt and principal payments on capital lease obligations are as follows:

Years Ending December 31	Bonds	Capital Lease Obligations
2017	$ 3,971,002	$ 395,411
2018	4,064,483	406,380
2019	4,328,823	417,653
2020	4,506,954	429,239
2021	4,687,516	219,065
Thereafter	138,196,781	-
Total	$ 159,755,559	$ 1,867,748

Total interest payments on capital leases for the years 2017 - 2021 are $119,615.

The cost of equipment under capital lease is $9,044,000 and $7,797,000 as of December 31, 2016 and 2015, respectively. Accumulated amortization on the equipment totaled approximately $7,132,000 and $7,473,000 as of December 31, 2016 and 2015, respectively.

Note 12 - Defined Benefit Plan

The System sponsors a defined benefit pension plan.

In January 2004, the board of directors of the System voted to freeze almost all employees' participation in the future accrual of benefits under the existing defined benefit plan, effective July 1, 2004. Approximately 100 employees who had obtained five years of service and were at least 55 years of age were allowed to continue with the existing plan. At the time the plan was frozen, employees vested in the plan earned a rate of return based on the 30-year United States Treasury rates. While the System has not expressed any intent to discontinue its contributions, it reserves and has the right at any time to terminate the plan. Upon termination, participants become 100 percent vested in their accrued benefits.

Note 12 - Defined Benefit Plan (Continued)

	Pension Benefits	
	2016	2015
Obligations and funded status:		
Benefit obligation at beginning of year	$ 48,800,360	$ 54,860,639
Service cost	49,084	34,370
Interest cost	1,710,182	2,186,922
Plan settlements	(2,269,397)	(3,154,969)
Benefits paid	(903,459)	(893,307)
Actuarial losses (gains)	1,756,326	(4,213,691)
Expenses	(20,020)	(19,604)
Benefit obligation at end of year	49,123,076	48,800,360
Change in plan assets:		
Fair value of plan assets at beginning of year	48,200,070	53,077,134
Actual return on plan assets	5,287,558	(809,184)
Plan settlements	(2,269,397)	(3,154,969)
Benefits paid	(903,459)	(893,307)
Expenses	(20,020)	(19,604)
Fair value of plan assets at end of year	50,294,752	48,200,070
Funded status at end of year	$ 1,171,676	$ (600,290)

Amounts reducing unrestricted net assets which have not been included in net periodic benefit costs, reported outside the performance indicator, are as follows:

	Pension Benefits	
	2016	2015
Net loss	$ (9,722,651)	$ (11,627,792)
Prior service cost	(36,464)	(44,923)
Total	$ (9,759,115)	$ (11,672,715)

Information for pension plans with an accumulated benefit obligation in excess of plan assets is as follows:

	Pension Benefits	
	2016	2015
Projected benefit obligation	$ 49,123,076	$ 48,800,360
Accumulated benefit obligation	49,123,076	48,795,704
Fair value of plan assets	50,294,752	48,200,070

Note 12 - Defined Benefit Plan (Continued)

	Pension Benefits	
	2016	2015
Net Periodic Benefit Cost, Employer Contributions, Participant Contributions, and Benefits Paid		
Net periodic benefit cost	$ 141,634	$ 1,836,690
Benefits paid	903,459	893,307
Net Periodic Benefit Cost		
Service cost	49,084	34,368
Interest cost	1,710,182	2,186,922
Expected return on plan assets	(2,809,877)	(2,599,043)
Amortization of prior service cost	8,459	8,459
Settlement loss recognized	449,614	751,418
Amortization of net loss	734,172	1,454,566
Total recognized in net periodic benefit cost	$ 141,634	$ 1,836,690

The estimated net loss and prior service cost for the defined benefit pension plans that will be amortized into net periodic benefit cost over the next fiscal year are $698,775.

Weighted-average assumptions used to determine benefit obligations at December 31 are as follows:

	Pension Benefits	
	2016	2015
Discount rate	4.14 %	4.54 %
Rate of compensation increase	3.00	3.00

Weighted-average assumptions used to determine net periodic benefit cost for the years ended December 31 are as follows:

	Pension Benefits	
	2016	2015
Discount rate	4.54 %	4.13 %
Expected long-term return on plan assets	6.00	5.50
Rate of compensation increase	3.00	3.00

The overall expected rate of return on plan assets represents a weighted-average composite rate based on the historical rates of returns of the respective asset classes.

The following assumption changes have been made:

- The discount rate decreased from 4.54 percent as of December 31, 2015 to 4.14 percent as of December 31, 2016.
- The assumed interest rate to be applied to PEP account balances for the December 31, 2015 disclosure was 3.03 percent for the year 2016, 3.25 percent for the year 2017, 3.50 percent for the year 2018, 3.75 percent for the year 2019, 4.00 percent for the year 2020, and 4.30 percent per year in 2021 and thereafter. For the December 31, 2016 financial disclosure, this assumption has been changed to 2.86 percent for the year 2017, 3.25 percent for the year 2018, 3.75 percent for the year 2019, and 4.25 percent per year in 2020 and thereafter.
- The mortality assumption for healthy participants was changed from the RP-2014 generational mortality table backed off to 2006 using projection scale MP2014 and projected forward using projection scale MP2015 to the RP-2014 generational mortality table backed off to 2006 using projection scale MP2014 and projected forward using projection scale MP2016.

Note 12 - Defined Benefit Plan (Continued)

- The mortality improvement scale for annuity conversion was updated from MP2015 to MP2016.
- The expected return on asset assumption was decreased from 6.00 percent to 5.00 percent for the fiscal year ending December 31, 2017.
- The discount rate setting process is now based on the Mercer Select 100 proprietary yield curve. Last year, the Mercer Bond Model was used to set the discount rate.
- The effective rate for interest on the benefit obligation is now determined using the corresponding spot rate along the Mercer Select 100 proprietary yield curve.

Pension Plan Assets

The goals of the pension plan investment program are to fully fund the obligation to pay retirement benefits in accordance with the plan documents and to provide returns that, along with appropriate funding from the System, maintain an asset/liability ratio that is in compliance with all applicable laws and regulations and assures timely payment of retirement benefits.

The System's overall investment strategy is to achieve a mix of approximately 50 percent of investments in fixed-income securities and 50 percent in equity securities in both 2016 and 2015, respectively.

The fair values of the System's pension plan assets at December 31, 2016 and 2015 by major asset classes are as follows:

	Fair Value Measurements at December 31, 2016			
	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Short-term investments (a)	$ 228,298	$ -	$ -	$ 228,298

	Fair Value Measurements at December 31, 2015			
	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Short-term investments (a)	$ 226,445	$ -	$ -	$ 226,445

(a) This class invests primarily in fixed-income securities including, but not limited to, bonds, notes, or other investments, such as government securities, commercial paper, certificates of deposit, master notes, or variable amount notes with the objective of providing high-current income consistent with the preservation of capital and the maintenance of liquidity. Short-term investments are valued at $1.00/unit, which approximates fair value.

The tables above present information about the pension plan assets measured at fair value at December 31, 2016 and 2015 and the valuation techniques used by the System to determine those fair values.

Fair values determined by Level 1 inputs use quoted prices in active markets for identical assets that the plan has the ability to access.

Note 12 - Defined Benefit Plan (Continued)

Fair values determined by Level 2 inputs use other inputs that are observable, either directly or indirectly. These Level 2 inputs include quoted prices for similar assets in active markets and other inputs such as interest rates and yield curves that are observable at commonly quoted intervals.

Level 3 inputs are unobservable inputs, including inputs that are available in situations where there is little, if any, market activity for the related asset.

In instances whereby inputs used to measure fair value fall into different levels in the above fair value hierarchy, fair value measurements in their entirety are categorized based on the lowest level input that is significant to the valuation. The System's assessment of the significance of particular inputs to these fair value measurements requires judgment and considers factors specific to each plan asset.

Investments in Entities that Calculate Net Asset Value per Share

The System has investments in mutual funds of $50,066,454 and $47,973,625 at December 31, 2016 and 2015, respectively. The System holds shares or interests in mutual funds at year end whereby the fair value of the investment held is estimated based on the net asset value per share (or its equivalent) of the mutual funds.

The equity securities represent investments in actively managed common collective trust funds that invest primarily in equity securities, which may include common stocks, options, and futures. Investments are valued at the net asset value per share multiplied by the number of shares held as of the measurement date.

The fixed-income funds represent investments in actively managed common collective trust funds that invest in a variety of fixed-income investments, which may include corporate bonds, both U.S. and non-U.S. municipal securities, interest rate swaps, options, and futures. Investments are valued at the net asset value per share multiplied by the number of shares held as of the measurement date.

The investments measured at net asset value per share (or its equivalent) of the mutual funds do not have unfunded commitments or redemption periods.

Cash Flow

Contributions

As the System has already met its funding requirements as of December 31, 2016, it does not expect to contribute anything additional to the plan in 2017. Additional discretionary contributions may be made upon further analysis of the retirement plan during the course of the year.

Estimated Future Benefit Payments

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid:

Years Ending	Pension Benefits
2017	$ 3,718,950
2018	3,586,287
2019	3,519,051
2020	4,455,634
2021	3,722,874
2022-2026	16,648,754

Note 13 - Retirement Plan

The System maintains a contributory defined contribution plan 403(b) and a retirement savings plan 401(a) for qualified employees who meet certain service requirements.

The System's contributions to the retirement savings plan 401(a) are board determined and can range from 3 percent to 6 percent of participants' base compensation. The related matching program currently funds 50 percent of employees' contributions, from the related 403(b) plan, up to a maximum of 6 percent of the employee's gross compensation. For the years ended December 31, 2016 and 2015, the retirement savings expense and the related match aggregated approximately $7,377,000 and $7,650,000, respectively.

Note 14 - Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes or periods at December 31, 2016 and 2015:

	2016	2015
Purchase of equipment	$ 1,551,695	$ 1,433,126
Indigent care	1,136,314	972,715
Supplies	407,342	394,643
Healthcare education	716,122	576,864
Research	36,996	36,996
Community benefit	342,955	315,685
Total temporarily restricted	$ 4,191,424	$ 3,730,029

Permanently restricted net assets at December 31, 2016 and 2015 are restricted to the following:

	2016	2015
Investments to be held in perpetuity, the income from which is expendable to support the purchase of equipment or supplies	$ 179,200	$ 179,200

During 2016 and 2015, net assets were released from donor restrictions by incurring expenses satisfying the restricted purposes of health education and purchase of equipment in the amount of $483,898 and $418,209, respectively.

Note 15 - Operating Leases

The System is obligated under operating leases primarily for medical office space and various medical equipment. Total rent expense under these leases was $5,819,000 and $6,128,000 for the years ended December 31, 2016 and 2015, respectively.

The following is a schedule of future minimum lease payments under operating leases that have initial or remaining lease terms in excess of one year.

Future minimum annual commitments under these operating leases are as follows:

Years Ending	Amount
2017	$ 5,015,318
2018	3,236,984
2019	2,311,653
2020	1,812,267
2021	1,279,701
Thereafter	5,757,936
Total	$ 19,413,859

Note 16 - Functional Expenses

The System is a general acute-care facility that provides inpatient and outpatient healthcare services to patients in Ross County and the surrounding vicinity. Expenses related to providing these services for the years ended December 31, 2016 and 2015 are as follows:

	2016	2015
Healthcare services	$ 402,884,959	$ 411,546,969
General and administrative	28,465,866	23,206,498
Total	$ 431,350,825	$ 434,753,467

Note 17 - Fair Value Measurements

Accounting standards require certain assets be reported at fair value in the consolidated financial statements and provide a framework for establishing that fair value. The framework for determining fair value is based on a hierarchy that prioritizes the inputs and valuation techniques used to measure fair value.

The following tables present information about the System's assets measured at fair value on a recurring basis at December 31, 2016 and 2015 and the valuation techniques used by the System to determine those fair values.

Fair values determined by Level 1 inputs use quoted prices in active markets for identical assets or liabilities that the System has the ability to access.

Fair values determined by Level 2 inputs use other inputs that are observable either directly or indirectly. These Level 2 inputs include quoted prices for similar assets in active markets and other inputs such as interest rates and yield curves that are observable at commonly quoted intervals.

Level 3 inputs are unobservable inputs, including inputs that are available in situations where there is little, if any, market activity for the related asset.

In instances whereby inputs used to measure fair value fall into different levels in the above fair value hierarchy, fair value measurements in their entirety are categorized based on the lowest level input that is significant to the valuation. The System's assessment of the significance of particular inputs to these fair value measurements requires judgment and considers factors specific to each asset.

	Assets Measured at Fair Value on a Recurring Basis at December 31, 2016			
	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Balance at December 31, 2016
Assets limited as to use:				
Money market accounts	$ 12,327,129	$ -	$ -	$ 12,327,129
Common stock	291,353	-	-	291,353
Corporate bonds (a)	-	1,649,611	-	1,649,611
Investments valued at fair value	$ 12,618,482	$ 1,649,611	$ -	$ 14,268,093

Note 17 - Fair Value Measurements (Continued)

	Assets Measured at Fair Value on a Recurring Basis at December 31, 2015			
	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Balance at December 31, 2015
Assets limited as to use:				
Money market accounts	$ 12,288,106	$ -	$ -	$ 12,288,106
Common stock	276,208	-	-	276,208
Corporate bonds (a)	-	1,655,707	-	1,655,707
Investments valued at fair value	$ 12,564,314	$ 1,655,707	$ -	$ 14,220,021

(a) This class invests primarily in fixed-income, corporate bond securities with a maturity of less than one year. The fair value of this investment has been estimated using quoted prices from the System's custodian bank.

The System has the ability to conduct transactions related to these funds at any time. The System's policy is to recognize transfers in and transfers out of Level 1, 2, and 3 fair value classifications as of the end of the reporting period. There were no transfers between levels for the years ended December 31, 2016 and 2015.

Investments in Entities that Calculate Net Asset Value per Share

The System has investments in mutual funds of $179,220,176 and $168,893,466 at December 31, 2016 and 2015, respectively. The System holds shares or interests in mutual funds at year end whereby the fair value of the investment held is estimated based on the net asset value per share (or its equivalent) of the mutual funds.

The fixed-income funds invest primarily in U.S. dollar-denominated investment-grade and government securities, U.S. high yield, non-U.S. bonds, and TIPS. The fair value of this investment has been estimated using the net asset value per share of the investment.

The large-cap funds invest primarily in common stock of large-cap and small- to mid-sized companies in the U.S. The fair value of this investment has been estimated using the net asset value per share of the investment.

The emerging market funds invest in companies operating in developed and emerging markets outside the U.S. The fair value of this investment has been estimated using the net asset value per share of the investment.

The investments measured at net asset value per share (or its equivalent) of the mutual funds do not have unfunded commitments or redemption periods.

Additional Information

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Independent Auditor's Report on Additional Information

To the Board of Directors
Adena Health System and Subsidiaries

We have audited the consolidated financial statements of Adena Health System and Subsidiaries as of and for the years ended December 31, 2016 and 2015 and have issued our report thereon dated March 15, 2017, which contained an unmodified opinion on those consolidated financial statements. Our audits were performed for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating balance sheet and consolidating statement of operations are presented for the purpose of additional analysis rather than to present the financial position, changes in net assets, and cash flows of the individual companies and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from, and relates directly to, the underlying accounting and other records used to prepare the 2016 consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the 2016 consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the 2016 consolidated financial statements as a whole.

Plante & Moran, PLLC

March 15, 2017

Praxity MEMBER GLOBAL ALLIANCE OF INDEPENDENT FIRMS

Adena Health System and Subsidiaries

Consolidating Balance Sheet

December 31, 2016

	Adena Health System and Adena Medical Group	Greenfield Area Medical Center	Adena Health Foundation	Southern Ohio Health Care Network	Adena Home Care	Adena Health Plan	Adena Pharmacy	Adena Pike Community Hospital	Eliminating Entries	Total
Assets										
Current Assets										
Cash and cash equivalents	$ 74,926,436	$ 182,818	$ 50,428	$ -	$ -	$ -	$ -	$ 1,719,882	$ -	$ 76,879,564
Patient accounts receivable - Net	51,799,232	2,196,633	-	-	857,608	-	221,653	2,193,207	-	57,268,333
Inventory	4,576,852	231,188	-	-	632,763	-	430,931	276,981	-	6,148,715
Other current assets	3,298,322	21,323	-	-	-	-	-	47,508	-	3,367,153
Prepaid expenses and other	11,210,480	1,066,974	-	-	-	-	-	1,397,451	-	13,674,905
Other current assets - Intercompany	-	-	293,826	-	-	-	-	-	(293,826)	-
Total current assets	145,811,322	3,698,936	344,254	-	1,490,371	-	652,584	5,635,029	(293,826)	157,338,670
Assets Limited as to Use	188,239,938	1,190,810	4,057,521	-	-	-	-	-	-	193,488,269
Property and Equipment - Net	134,988,809	3,049,214	-	-	-	-	51,983	6,009,352	-	144,099,358
Indefeasible Right-of-use Asset	-	-	-	14,657,555	-	-	-	-	-	14,657,555
Other Assets										
Notes and grants receivable	1,916,912	-	-	-	-	-	-	-	-	1,916,912
Defined benefit plan receivable	1,171,676	-	-	-	-	-	-	-	-	1,171,676
Other noncurrent assets	10,832,879	-	7,545	-	-	-	-	1,897,000	-	12,737,424
Total other assets	13,921,467	-	7,545	-	-	-	-	1,897,000	-	15,826,012
Total assets	**$ 482,961,536**	**$ 7,938,960**	**$ 4,409,320**	**$ 14,657,555**	**$ 1,490,371**	**$ -**	**$ 704,567**	**$ 13,541,381**	**$ (293,826)**	**$ 525,409,864**

Adena Health System and Subsidiaries

Consolidating Balance Sheet (Continued)

December 31, 2016

	Adena Health System and Adena Medical Group	Greenfield Area Medical Center	Adena Health Foundation	Southern Ohio Health Care Network	Adena Home Care	Adena Health Plan	Adena Pharmacy	Adena Pike Community Hospital	Eliminating Entries	Total
Liabilities and Net Assets (Deficit)										
Current Liabilities										
Accounts payable	$ 17,487,341	$ 92,047	$ 5,304	$ 9,998	$ 47,525	$ -	$ 24,154	$ 103,259	$ -	$ 17,769,628
Current portion of long-term debt	4,366,413	-	-	-	-	-	-	-	-	4,366,413
Intercompany liabilities	293,826	-	-	-	-	-	-	-	(293,826)	-
Estimated third-party payor settlements	667,248	119,205	-	-	-	-	-	1,277,075	-	2,063,528
Accrued liabilities and other:										
Accrued compensation	25,079,687	540,263	10,376	-	324,397	7,655	45,496	625,909	-	26,633,783
Deferred compensation	5,292,102	-	-	-	-	-	-	-	-	5,292,102
Accrued interest	672,457	-	-	-	-	-	-	-	-	672,457
Other accrued liabilities	1,812,338	-	-	-	-	-	-	-	-	1,812,338
Total current liabilities	55,671,412	751,515	15,680	9,998	371,922	7,655	69,650	2,006,243	(293,826)	58,610,249
Long-term Debt and Capital Lease Obligations - Net of current portion	154,397,592	-	-	-	-	-	-	-	-	154,397,592
Other Liabilities	18,126,893	-	-	-	-	-	-	-	-	18,126,893
Total liabilities	228,195,897	751,515	15,680	9,998	371,922	7,655	69,650	2,006,243	(293,826)	231,134,734
Net Assets (Deficit)										
Unrestricted	252,955,870	5,977,834	3,052,057	14,647,557	1,118,449	(7,655)	634,917	11,525,477	-	289,904,506
Temporarily restricted	1,809,769	1,030,411	1,341,583	-	-	-	-	9,661	-	4,191,424
Permanently restricted	-	179,200	-	-	-	-	-	-	-	179,200
Total net assets (deficit)	254,765,639	7,187,445	4,393,640	14,647,557	1,118,449	(7,655)	634,917	11,535,138	-	294,275,130
Total liabilities and net assets (deficit)	**$ 482,961,536**	**$ 7,938,960**	**$ 4,409,320**	**$ 14,657,555**	**$ 1,490,371**	**$ -**	**$ 704,567**	**$ 13,541,381**	**$ (293,826)**	**$ 525,409,864**

Adena Health System and Subsidiaries

Consolidating Statement of Operations

Year Ended December 31, 2016

	Adena Health System and Adena Medical Group	Greenfield Area Medical Center	Adena Health Foundation	Southern Ohio Health Care Network	Adena Home Care	Adena Health Plan	Adena Pharmacy	Adena Pike Community Hospital	Eliminating Entries	Total
Unrestricted Revenue, Gains, and Other Support										
Net patient service revenue	$ 401,252,653	$ 18,077,721	$ -	$ -	$ 7,162,757	$ -	$ -	$ 17,681,971	$ (261,797)	$ 443,651,508
Provision for bad debts	(13,481,842)	(1,354,641)	-	-	(6,334)	-	-	(1,220,479)	-	(16,063,296)
Net patient service revenue less provision for bad debts	387,770,811	16,723,080	-	-	7,156,423	-	-	16,461,492	(261,797)	427,850,009
Other operating revenue	14,294,711	75,929	466,973	81,781	181	-	5,297,469	104,289	(11,400,826)	8,920,507
Net assets released from restrictions	391,312	-	-	-	-	-	-	-	-	391,312
Total unrestricted revenue, gains, and other support	402,456,834	16,799,009	466,973	81,781	7,156,604	-	5,297,469	16,565,781	(11,662,623)	437,161,828
Expenses										
Salaries and wages	180,771,993	5,795,750	227,790	-	3,971,381	125,626	538,992	6,510,264	-	197,941,796
Employee benefits and payroll taxes	45,789,378	1,901,030	75,751	-	1,265,599	43,868	175,926	2,152,950	(2,535,621)	48,868,881
Operating supplies and expenses	63,577,595	1,248,134	19,947	181	1,861,721	283	4,701,270	1,615,448	-	73,024,579
Professional services and consultant fees	10,991,526	402,198	-	-	34,992	85,872	-	20,004	(8,979,733)	2,554,859
Purchased services	40,917,366	1,357,006	46,382	108,570	804,471	52,942	4,559	1,112,072	-	44,403,368
Insurance	2,181,198	72,319	-	-	36,901	-	-	71,473	-	2,361,891
Utilities	4,253,581	132,749	-	-	-	-	-	391,070	-	4,777,400
Travel/Education	2,061,155	59,223	10,141	-	339,195	6,016	27,306	61,543	-	2,564,579
Repair, maintenance, and rental	18,284,789	438,097	-	-	200,871	-	42,783	550,839	(147,269)	19,370,110
Assessments	3,807,149	267,783	-	-	-	-	-	329,858	-	4,404,790
Depreciation and amortization	20,855,740	272,944	-	771,871	-	-	6,174	774,096	-	22,680,825
Interest expense	8,397,747	-	-	-	-	-	-	-	-	8,397,747
Corporate cost allocation	(9,857,979)	3,181,681	86,962	-	2,442,159	94,866	253,284	3,799,027	-	-
Total expenses	392,031,238	15,128,914	466,973	880,622	10,957,290	409,473	5,750,294	17,388,644	(11,662,623)	431,350,825
Operating Income (Loss)	10,425,596	1,670,095	-	(798,841)	(3,800,686)	(409,473)	(452,825)	(822,863)	-	5,811,003
Nonoperating Income (Loss)										
Interest income and net realized gains	2,005,809	36	91,341	-	-	-	-	55,576	-	2,152,762
Unrealized gains on trading securities	8,474,902	-	35,179	-	-	-	-	-	-	8,510,081
Other income (loss)	196,687	-	10,392	-	-	-	-	(12,379)	-	194,700
Total nonoperating income	10,677,398	36	136,912	-	-	-	-	43,197	-	10,857,543
Excess of Revenue Over (Under) Expenses	21,102,994	1,670,131	136,912	(798,841)	(3,800,686)	(409,473)	(452,825)	(779,666)	-	16,668,546
Net Assets Released from Restriction for Purchase of Capital Assets	92,586	-	-	-	-	-	-	-	-	92,586
Transfer (to) from Affiliate	(12,621,332)	(1,318,574)	47,101	3,869,897	3,907,438	3,691,170	2,174,272	250,028	-	-

Adena Health System and Subsidiaries

Consolidating Statement of Operations (Continued)

Year Ended December 31, 2016

	Adena Health System and Adena Medical Group	Greenfield Area Medical Center	Adena Health Foundation	Southern Ohio Health Care Network	Adena Home Care	Adena Health Plan	Adena Pharmacy	Adena Pike Community Hospital	Eliminating Entries	Total
Pension-related Changes Other than Net Periodic Cost	$ 1,913,600	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,913,600
Grant Income	-	-	-	-	-	-	-	17,744	-	17,744
Increase (Decrease) in Unrestricted Net Assets	**$ 10,487,848**	**$ 351,557**	**$ 184,013**	**$ 3,071,056**	**$ 106,752**	**$ 3,281,697**	**$ 1,721,447**	**$ (511,894)**	**$ -**	**$ 18,692,476**

APPENDIX B-2:

2015 CONSOLIDATED FINANCIAL REPORT OF ADENA HEALTH SYSTEM AND SUBSIDIARIES

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Adena Health System and Subsidiaries

Consolidated Financial Report
with Additional Information
December 31, 2015

Adena Health System and Subsidiaries

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Independent Auditor's Report

To the Board of Directors
Adena Health System and Subsidiaries

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Adena Health System and Subsidiaries (the "System"), which are comprised of the consolidated balance sheet as of December 31, 2015 and 2014 and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

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

Auditor's Responsibility

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

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

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

Praxity
MEMBER
GLOBAL ALLIANCE OF INDEPENDENT FIRMS

To the Board of Directors
Adena Health System and Subsidiaries

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Adena Health System and Subsidiaries as of December 31, 2015 and 2014 and the changes in their net assets and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Plante & Moran, PLLC

April 4, 2016

Adena Health System and Subsidiaries

Consolidated Balance Sheet

	December 31, 2015	December 31, 2014
Assets		
Current Assets		
Cash and cash equivalents	$ 40,204,259	$ 35,836,255
Short-term investments (Note 4)	-	5,319,335
Patient accounts receivable - Net (Note 3)	75,661,174	54,453,222
Other current assets	8,924,195	11,952,490
Estimated third-party payor settlements (Note 7)	2,616,338	2,572,019
Prepaid expenses and other	7,491,336	9,309,830
Inventory	5,735,699	7,226,585
Total current assets	140,633,001	126,669,736
Assets Limited as to Use (Note 4)	183,113,487	184,742,660
Property and Equipment - Net (Note 5)	149,466,647	151,249,060
Indefeasible Right-of-use Asset (Note 6)	15,429,426	16,207,830
Other Assets		
Notes and grants receivable	1,698,427	2,338,981
Bond issue costs	2,994,075	3,128,847
Other noncurrent assets	12,067,379	4,818,891
Total assets	**$ 505,402,442**	**$ 489,156,005**
Liabilities and Net Assets		
Current Liabilities		
Current portion of long-term debt (Note 10)	$ 4,049,871	$ 4,061,349
Accounts payable	15,395,933	14,269,568
Accrued liabilities and other:		
Accrued compensation	25,338,335	24,294,159
Deferred compensation	5,225,000	4,948,236
Accrued interest	686,250	697,502
Other accrued liabilities	1,806,233	2,058,435
Total current liabilities	52,501,622	50,329,249
Long-term Debt and Capital Lease Obligations - Net of current portion (Note 10)	159,755,559	163,805,430
Defined Benefit Plan Liability (Note 11)	600,290	1,783,505
Other Liabilities	17,423,712	8,198,539
Total liabilities	230,281,183	224,116,723
Net Assets		
Unrestricted	271,212,030	261,279,340
Temporarily restricted (Note 13)	3,730,029	3,580,742
Permanently restricted (Note 13)	179,200	179,200
Total net assets	275,121,259	265,039,282
Total liabilities and net assets	**$ 505,402,442**	**$ 489,156,005**

Adena Health System and Subsidiaries

Consolidated Statement of Operations

	Year Ended December 31, 2015	Year Ended December 31, 2014
Unrestricted Revenue, Gains, and Other Support		
Net patient service revenue	$ 457,508,306	$ 436,698,926
Provision for bad debts	(25,421,220)	(19,087,179)
Net patient service revenue less provision for bad debts	432,087,086	417,611,747
Other operating revenue	9,171,674	10,029,310
Net assets released from restrictions (Note 13)	339,419	474,879
Total unrestricted revenue, gains, and other support	441,598,179	428,115,936
Expenses		
Salaries and wages	200,451,617	197,720,619
Employee benefits and payroll taxes	48,287,038	49,452,983
Operating supplies and expenses	75,492,620	65,991,546
Professional services and consultant fees	3,268,136	1,944,826
Purchased services	43,425,935	43,030,985
Insurance	2,422,364	2,182,379
Utilities	4,551,399	4,930,043
Travel/Education	2,515,718	2,909,359
Repair, maintenance, and rental	19,470,326	19,422,455
Assessments	4,159,427	3,913,833
Depreciation and amortization	22,349,975	22,335,845
Interest expense	8,358,912	8,462,222
Total expenses (Note 15)	434,753,467	422,297,095
Operating Income	6,844,712	5,818,841
Nonoperating Income (Loss)		
Interest income and net realized gains (Note 4)	3,735,127	11,981,241
Unrealized losses on trading securities (Note 4)	(4,078,031)	(5,027,080)
Other income (loss)	322,788	(1,204,857)
Total nonoperating (loss) income	(20,116)	5,749,304
Excess of Revenue Over Expenses	6,824,596	11,568,145
Net Assets Released from Restriction for Purchase of Capital Assets (Note 13)	78,790	512,332
Pension-related Changes Other than Net Periodic Cost	3,019,905	851,647
Grant Income	9,399	1,431,204
Increase in Unrestricted Net Assets	**$ 9,932,690**	**$ 14,363,328**

Adena Health System and Subsidiaries

Consolidated Statement of Changes in Net Assets

	Year Ended December 31, 2015	Year Ended December 31, 2014
Unrestricted Net Assets		
Excess of revenue over expenses	$ 6,824,596	$ 11,568,145
Pension-related changes other than net periodic cost	3,019,905	851,647
Grant income (Note 6)	9,399	1,431,204
Net assets released from restriction for purchase of capital assets (Note 13)	78,790	512,332
Increase in Unrestricted Net Assets	9,932,690	14,363,328
Temporarily Restricted Net Assets		
Restricted contributions	516,009	847,638
Restricted investment income	69,943	139,229
Net realized and unrealized (losses) gains on investments	(4,802)	34,994
Net assets released from restriction (Note 13)	(431,863)	(956,350)
Increase in Temporarily Restricted Net Assets	149,287	65,511
Permanently Restricted Net Assets		
Net realized and unrealized gains on investments	18,860	30,861
Net assets released from restriction	(18,860)	(30,861)
Change in Permanently Restricted Net Assets	-	-
Increase in Net Assets	10,081,977	14,428,839
Net Assets - Beginning of year	265,039,282	250,610,443
Net Assets - End of year	**$ 275,121,259**	**$ 265,039,282**

See Notes to Consolidated Financial Statements.

Adena Health System and Subsidiaries

Consolidated Statement of Cash Flows

	Year Ended December 31, 2015	Year Ended December 31, 2014
Cash Flows from Operating Activities		
Increase in net assets	$ 10,081,977	$ 14,428,839
Adjustments to reconcile increase in net assets to net cash from operating activities:		
Depreciation and amortization	22,349,975	22,335,845
Net realized gains on investments	(510,355)	(10,230,582)
Unrealized net losses on trading securities	4,078,031	5,027,080
Grant income	(9,399)	(1,431,204)
Pension-related changes other than net periodic cost	(3,019,905)	(851,647)
Provision for bad debts	25,421,220	19,087,179
Changes in assets and liabilities that (used) provided cash:		
Patient accounts receivable	(46,629,172)	(22,871,159)
Other current assets	6,337,675	(4,853,821)
Other noncurrent assets	2,064,111	2,251,914
Accounts payable	1,126,365	(348,182)
Accrued liabilities and other	2,533,189	4,541,797
Estimated third-party payor settlements	(44,319)	(350,635)
Change in defined benefit plan liability	1,836,690	1,968,061
Net cash provided by operating activities	25,616,083	28,703,485
Cash Flows from Investing Activities		
Purchases of property and equipment	(20,573,652)	(16,419,248)
Proceeds from sale of property and equipment	6,090	18,411
Purchases of investments	-	(66,741,153)
Proceeds from sales and maturities of investments	3,380,832	59,591,110
Net cash used in investing activities	(17,186,730)	(23,550,880)
Cash Flows from Financing Activities - Principal payments on long-term debt	(4,061,349)	(3,898,387)
Net Increase in Cash and Cash Equivalents	4,368,004	1,254,218
Cash and Cash Equivalents - Beginning of year	35,836,255	34,582,037
Cash and Cash Equivalents - End of year	**$ 40,204,259**	**$ 35,836,255**
Supplemental Cash Flow Information		
Cash paid for interest - Net of capitalized amounts	$ 8,370,000	$ 8,681,000
Grant income	9,399	1,431,204

See Notes to Consolidated Financial Statements.

Note 1 - Nature of Business and Significant Accounting Policies

Organization - Adena Health System (the "System"), located in Ross County, Ohio, is a not-for-profit acute-care hospital operating 214 general acute-care beds. Adena Health System provides inpatient, outpatient, and emergency care services for residents of Ross County, Ohio and the surrounding communities.

In September 1999, Adena Health System became the sole member of Greenfield Area Medical Center (Greenfield), a 25-bed acute-care hospital located in Greenfield, Ohio. Greenfield has Section 501(c)(3) status with the IRS. Adena Health System, in its discretion as the sole member of Greenfield, may at any time amend the articles of incorporation and code of regulations of Greenfield in any manner and take any other action with respect to Greenfield that members of not-for-profit corporations may take under the Ohio not-for-profit corporation law. Effective June 1, 2001, Greenfield received federal critical access hospital (CAH) designation, which is awarded to select small, rural hospitals, which allows it to recoup Medicare-defined allowable costs for services provided to Medicare patients. The CAH designation gives Greenfield increased reimbursement so that it can better serve its community. To receive this designation, hospitals must meet specific criteria such as available beds, patient length of stay, and transfer agreements with other facilities.

On January 7, 2002, Adena Health System created the Adena Health Foundation (the "Foundation"). The purpose of the Foundation is to support Adena Health System and community programs to improve the health and well-being of the people served by Adena Health System. The Foundation received its 501(c)(3) status from the IRS on April 10, 2002.

On December 14, 2007, Adena Health System created Southern Ohio Health Care Network, Inc. (SOHCN). The purpose for which SOHCN was formed was to create an inclusive and sustainable broadband healthcare network open to all providers in the southern Ohio service area. The System was granted tax exemption for SOHCN during 2014.

On October 19, 2009, Adena Health System created Adena Medical Group, LLC (AMG). AMG is a disregarded entity with Adena Health System as its sole member. AMG was formed to employ physicians to provide patient care within the Adena Health System, and it became operational on April 1, 2010.

On January 1, 2010, Adena Health System created Adena Pharmacy, LLC (AP). AP is a disregarded entity with Adena Health System as its sole member. AP was formed to establish and operate a retail pharmacy within the Adena Health System, and it became operational on November 1, 2012.

Note 1 - Nature of Business and Significant Accounting Policies (Continued)

On August 11, 2010, Adena Health System created Adena Hospice, LLC, Adena Home Health LLC, Adena Home Infusion, and DME & Respiratory, LLC (collectively referred to as "Adena Home Care"). Adena Health System is the sole member of these entities. The entities were formed to provide hospice care, home health services, and DME equipment/services, respectively, to patients within the Adena Health System service area.

On November 10, 2011, Adena Health System created Adena Care, Inc., which is doing business as (d/b/a) Adena Health Plan. Adena Health System is the sole shareholder of Adena Care, Inc. Adena Health Plan functions as a taxable entity and was formed to market employee health insurance to organizations in Ohio.

On March 1, 2012, the System became the sole corporate member of Pike Health Services, Inc. (Adena Pike Community Hospital). The System took operational control effective March 1, 2012. Pike Health Services, Inc. is a not-for-profit hospital operating 25 beds in Waverly, Ohio that has received critical access hospital designation.

Basis of Consolidation - The accompanying consolidated financial statements include the accounts of Adena Health System and its subsidiaries, Greenfield Area Medical Center, Adena Health Foundation, Southern Ohio Health Care Network, Inc., Adena Medical Group, LLC, Adena Hospice, LLC, Adena Home Health LLC, Adena Home Infusion, DME & Respiratory, LLC, Adena Care, Inc. d/b/a Adena Health Plan, Adena Pharmacy, LLC, and Adena Pike Community Hospital (collectively, the "System"). All significant intercompany transactions and balances have been eliminated in consolidation.

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

Accounts Receivable - Accounts receivable for patients, insurance companies, and governmental agencies are based on gross charges. An allowance for uncollectible accounts is established on an aggregate basis by using historical write-off rate factors applied to unpaid accounts based on aging. Loss-rate factors are based on historical loss experience and adjusted for economic conditions and other trends affecting the System's ability to collect outstanding amounts. Uncollectible amounts are written off against the allowance for doubtful accounts in the period they are determined to be uncollectible. An allowance for contractual adjustments and interim payment advances is established based on expected payment rates from payors utilizing current reimbursement methodologies and payment rates. This amount also includes amounts received as interim payments against unpaid claims by certain payors.

Note 1 - Nature of Business and Significant Accounting Policies (Continued)

For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the System records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates, if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts in the period they are determined to be uncollectible.

Physician Receivables and Advances - The System has entered into agreements to advance money to physicians. Based upon the terms of the agreements, these advances are to be repaid by the physicians or fulfilled through providing services at the System for an agreed-upon time period. Most of these loans are expected to be satisfied by the physicians providing services at the System. These amounts are shown within other current assets on the consolidated balance sheet.

Investments - Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the consolidated balance sheet. Investment income or loss (including realized and unrealized gains and losses on investments, interest, and dividends) is included in excess of revenue over expenses unless the income or loss is restricted by donor or law.

Assets Limited as to Use - Assets limited as to use include assets designated by the board of directors for future capital improvement, over which the board retains control, and may, at its discretion, subsequently use for other purposes. Assets limited as to use also include assets held by trustees in connection with repayment of principal and interest on bond indebtedness, and funds designated for the professional liability self-insurance trust. Assets limited as to use include assets temporarily restricted or permanently restricted by the donor.

Inventory - Inventories, which consist of medical, surgical, and office supplies and pharmaceutical products, are stated at the lower of cost, determined on a first-in, first-out basis, or market.

Property and Equipment - Property and equipment amounts are recorded at cost. Donated property and equipment are recorded at the estimated fair market value at the time of donation. Depreciation is computed principally on the straight-line basis over the estimated useful lives of the assets. Costs of maintenance and repairs are charged to expense when incurred.

Indefeasible Right-of-use Asset - The indefeasible right-of-use asset is recorded at cost and is being amortized over the estimated useful life of the asset of 24 years.

Note 1 - Nature of Business and Significant Accounting Policies (Continued)

Bond Issuance Costs - Unamortized bond issuance costs are amortized over the term of the bonds.

Classification of Net Assets - Net assets of the System are classified as permanently restricted, temporarily restricted, or unrestricted depending on the presence and characteristics of donor-imposed restrictions limiting the System's ability to use or dispose of contributed assets or the economic benefits embodied in those assets. Donor-imposed restrictions that expire with the passage of time or that can be removed by meeting certain requirements result in temporarily restricted net assets. Permanently restricted net assets result from donor-imposed restrictions that limit the use of net assets in perpetuity. Earnings, gains, and losses on restricted net assets are classified as unrestricted unless specifically restricted by the donor or by applicable state law.

Excess of Revenue Over Expenses - The consolidated statement of operations includes excess of revenue over expenses. Changes in unrestricted net assets, which are excluded from excess of revenue over expenses, consistent with industry practice, include net assets released from restrictions for the acquisition of capital assets, permanent transfers of assets to and from affiliates for other than goods and services, indefeasible right-of-use (grant) income (loss), and pension-related changes other than net periodic cost.

Net Patient Service Revenue - The System has agreements with third-party payors that provide for payments to the System for services rendered at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge or service, reimbursed costs, discounted charges, and per diem payments. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactively calculated adjustments arising under reimbursement agreements with third-party payors are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods, as final settlements are determined.

Laws and regulations governing the Medicare and Medicaid programs are complex and subject to interpretation. Management believes that it is in compliance with all applicable laws and regulations. Final determination of compliance with such laws and regulations is subject to future government review and interpretation. Violations may result in significant regulatory action including fines, penalties, and exclusions from the Medicare and Medicaid programs.

Note 1 - Nature of Business and Significant Accounting Policies (Continued)

The System recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered. For uninsured patients that do not qualify for charity care, the System recognizes revenue on the basis of its standard rates for services provided (or on the basis of discounted rates, if negotiated or provided by policy). On the basis of historical experience, a significant portion of the System's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the System records a significant provision for bad debts related to uninsured patients in the period the services are provided. Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period from these major payor sources in total was $457,508,306 and $436,698,926 for the years ended December 31, 2015 and 2014, respectively. These amounts are made up of amounts from third-party payors of $443,622,083 and $417,094,183 for the years ended December 31, 2015 and 2014, respectively, and amounts from self-pay payors of $13,886,223 and $19,604,743 for the years ended December 31, 2015 and 2014, respectively.

Charity Care - The System provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than established rates. Because the System does not pursue collection of amounts determined to qualify as charity care, they are not reported in net patient service revenue.

Charity care is determined based on established policies using patient income and assets to determine payment ability. The amount reflects the cost of free or discounted health services, net of contributions and other revenue received, as direct assistance for the provision of charity care. The estimated cost of providing charity services is based on a calculation which applies a ratio of cost to charges to the gross uncompensated charges associated with providing care to charity patients. The ratio of cost to charges is calculated based on the System's total operating expenses divided by gross patient service revenue. The System estimates that it provided approximately $7,903,000 and $10,074,000 of services to indigent patients during 2015 and 2014, respectively. The System received approximately $3,340,000 and $4,755,000 in net distributions from the Ohio Medicaid HCAP program during 2015 and 2014, respectively, as assistance to offset the cost of charity care.

Litigation - The System is exposed to litigation arising in the course of business. The System has purchased excess coverage for these claims in excess of its self-insured retention. Settled claims related to the coverage have not exceeded the amount of insurance coverage in 2015 or 2014. The System accrues an estimate of the ultimate expense, including litigation and settlement expense, for incidents of potential improper professional service and other liability claims occurring during the year, as well as for those claims that have not been reported at year end.

Note 1 - Nature of Business and Significant Accounting Policies (Continued)

Contributions and Grants - The System reports gifts of cash and other assets as restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the consolidated statement of changes in net assets as net assets released from restrictions.

The System reports gifts of property and equipment as unrestricted support unless explicit donor stipulations specify how the donated assets must be used. Gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted support. Absent explicit donor stipulations about how long those long-lived assets must be maintained, the System reports the expiration of donor restrictions when the assets are placed in service.

Contributions and grants received for capital purposes are excluded from the performance indicator (excess of revenue over expenses) while grants received for operational purposes are included in other operating income.

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

Electronic Health Record Technology (EHR) - The American Recovery and Reinvestment Act of 2009 (ARRA) established funding in order to provide incentive payments to hospitals and physicians that implement the use of electronic health record (EHR) technology by 2015. The System may receive an incentive payment for up to four years, provided that the System demonstrates meaningful use of certified EHR technology for the EHR reporting period. The revenue from the incentive payments is recognized over the EHR reporting period when there is reasonable assurance that the System will comply with eligibility requirements during the EHR reporting period and an incentive payment will be received. The amounts are recorded within other operating revenue as the incentive payments are related to the System's ongoing and central activities, yet are not critical to the delivery of patient service.

The System attested to the Centers for Medicare and Medicaid Services (CMS) that it had met the second stage of the first year of meaningful use criteria. The incentive payments were recognized as income within other operating revenue in the amount of $2,040,000 and $3,787,000 during 2015 and 2014, respectively.

Note 1 - Nature of Business and Significant Accounting Policies (Continued)

Tax Status - Adena Health System and its subsidiaries (except for Adena Pharmacy, LLC, Adena Home Care, and Adena Care, Inc. d/b/a Adena Health Plan) are non-profit, tax-exempt entities. Adena Pharmacy, LLC and Adena Home Care are limited liability companies and, as such, federal and other income taxes are not provided for by these entities. The sole member, Adena Health System, may be taxed on the earnings, but taxes, if any, are not expected to be significant. Adena Care, Inc. is a taxable entity; however, Adena Care, Inc. has recorded operating losses and has an operating loss carryforward at December 31, 2015.

Accounting principles generally accepted in the United States of America require management to evaluate tax positions taken by the System and recognize a tax liability if the System has taken an uncertain position that more likely than not would not be sustained upon examination by the IRS or other applicable taxing authorities. Management has analyzed the tax positions taken by the System and has concluded that as of December 31, 2015 and 2014, there are no uncertain positions taken or expected to be taken that would require recognition of a liability or disclosure in the consolidated financial statements. The System is subject to routine audits by taxing jurisdictions; however, there are currently no audits for any tax periods in progress. Management believes that it is no longer subject to income tax examinations for years prior to December 31, 2012.

Fair Value of Financial Instruments - The following methods and assumptions were used by the System in estimating the fair value of its financial instruments:

- **Cash and Cash Equivalents** - The carrying amount reported in the consolidated balance sheet for cash and cash equivalents approximates fair value.
- **Assets Limited as to Use** - Fair values, which are the amounts reported in the consolidated balance sheet, are based on quoted market prices, if available, or estimated using quoted market prices for similar securities.
- **Short-term Investments** - Fair values, which are the amounts reported in the consolidated balance sheet, are based on quoted market prices, if available, or estimated using quoted market prices for similar securities.
- **Accounts Payable and Accrued Expenses** - The carrying amount reported in the consolidated balance sheet for accounts payable and accrued expenses approximates fair value.
- **Cost Report Settlements Receivable** - The carrying amount reported in the consolidated balance sheet for estimated cost report settlements receivable approximates fair value.

Note 1 - Nature of Business and Significant Accounting Policies (Continued)

- **Long-term Debt** - The fair value of the System's long-term debt is estimated using discounted cash flow analyses, based on the System's current incremental borrowing rates for similar types of borrowing arrangements. See Note 10.

New Accounting Pronouncement - During May 2014, the Financial Accounting Standards Board (FASB) released Accounting Standards Update (ASU) No. 2014-09, *Revenue from Contracts with Customers (Topic 606)*. The amendments in the ASU clarify the principles for recognizing revenue and develop a common revenue standard for U.S. generally accepted accounting principles that removes inconsistencies and weaknesses in revenue requirements, provides a more robust framework for addressing revenue issues, improves comparability of revenue recognition practices across entities, industries, jurisdictions and capital markets, provides more useful information to users of financial statements through improved disclosure requirements, and simplifies the preparation of financial statements by reducing the number of requirements to which an entity must refer. The System will be required to adopt and implement this accounting update as of and for the year ending December 31, 2018. Management has not yet assessed the effect of this accounting standards update on the consolidated financial statements.

Subsequent Events - The consolidated financial statements and related disclosures include evaluation of events up through and including April 4, 2016, which is the date that the consolidated financial statements were issued.

Note 2 - Cash in Excess of Insured Limits

The System and its subsidiaries maintain cash and investment balances at several financial institutions located in the vicinity of Chillicothe, Ohio. Accounts at each institution are insured by the Federal Deposit Insurance Corporation (FDIC) up to $250,000 per institution. As of December 31, 2015 and 2014, the consolidated uninsured cash balances total approximately $38,668,000 and $33,665,000, respectively.

Note 3 - Accounts Receivable

The details of patient accounts receivable are set forth below:

	2015	2014
Patient accounts receivable	$ 238,937,174	$ 188,637,222
Less allowance for uncollectible accounts	(48,819,000)	(32,820,000)
Less allowance for contractual adjustments	(114,457,000)	(101,364,000)
Net patient accounts receivable	$ 75,661,174	$ 54,453,222

Note 3 - Accounts Receivable (Continued)

The System grants credit without collateral to patients, most of whom are local residents and are insured under third-party payor agreements. The composition of receivables from patients and third-party payors was as follows as of December 31:

	2015	2014
Medicare	27 %	29 %
Medicaid	19	17
Commercial insurance and other	52	52
Self pay	2	2
Total	100 %	100 %

The System's allowance for doubtful accounts for self-pay patients is 95 percent and 97 percent of self-pay accounts receivable at December 31, 2015 and 2014, respectively. The System's charity policies were approved in December 2013 and became effective in January 2014. The System does not maintain a significant allowance for doubtful accounts from third-party payors, nor did it have significant write-offs from third-party payors.

On August 1, 2015, the System implemented a significant upgrade to its hospital facilities Electronic Health Record information systems platform. This upgrade positioned the System to meet and exceed federal and state "meaningful use" parameters. The upgrade also fundamentally changed the System's process for capturing patient charges in its hospital setting. These changes caused a delay in submittal of claims on surgical, laboratory, pharmacy, and radiology charges of up to 90 days. This delay in claims submission has resulted in the almost 50 percent increase in net accounts receivable. It is management's opinion that this increase is temporary and that net accounts receivable levels will be substantially reduced in the first quarter of 2016 and return to 2014 levels by June 30, 2016.

Note 4 - Investments

Assets Limited as to Use

The composition of assets limited as to use at December 31, 2015 and 2014 is set forth in the following table:

	2015	2014
Internally designated for capital acquisition and professional liability self-insurance trust:		
Money market accounts	$ 509,234	$ 684,343
Common stock	276,208	267,275
Mutual funds	168,893,466	170,500,619
Corporate bonds	1,655,707	1,511,515
Total	171,334,615	172,963,752
Held by trustee under indenture agreement for certain bond indebtedness principal and interest payments - Money market accounts	11,778,872	11,778,908
Total assets limited as to use	$183,113,487	$184,742,660

Short-term Investments

Other investments with maturities less than 270 days, stated at fair value as determined by quoted market prices at December 31, 2015 and 2014, include the following:

	2015	2014
U.S. corporate bonds	$ -	$ 5,319,335

Unrestricted investment income and gains for assets limited as to use, cash equivalents, and other investments are comprised of the following for the years ended December 31, 2015 and 2014:

	2015	2014
Interest income	$ 3,238,830	$ 1,754,792
Net realized gains on sales of securities	496,297	10,226,449
Net unrealized losses on securities	(4,078,031)	(5,027,080)
Total (loss) income	$ (342,904)	$ 6,954,161

Note 5 - Property and Equipment

The costs of property, plant, and equipment and depreciable lives are summarized as follows:

	2015	2014	Depreciable Life - Years
Land	$ 3,485,204	$ 3,485,204	-
Land improvements	6,886,538	6,859,031	5-25
Buildings and improvements	183,243,172	180,426,366	5-40
Equipment	193,713,626	203,724,422	5-20
Construction in progress	2,292,304	4,490,583	-
Total cost	389,620,844	398,985,606	
Accumulated depreciation	(240,154,197)	(247,736,546)	
Net property and equipment	$ 149,466,647	$ 151,249,060	

Depreciation on property and equipment totaled approximately $21,397,000 and $21,523,000 in 2015 and 2014, respectively.

Note 6 - Indefeasible Right-of-use Asset

During 2009, SOHCN received an award from the Federal Communications Commission (FCC) to develop a sustainable broadband healthcare network open to all providers in the southern Ohio service area. The award from the FCC was for a total of $15,765,417, which represented approximately 85 percent of the total contract value of the broadband fiber to be installed, with the remaining 15 percent being a required contribution from the System. At the same time, SOHCN entered into a contract with a broadband partner for that partner to install and maintain the broadband fiber network. The agreement stipulated that the broadband partner would own the fiber, but SOHCN would have an indefeasible right of use of the asset for the next 40 years. All funds from the FCC are to be paid directly to the broadband partner upon approval of fiber construction by the System. During 2011, the broadband partner began installing the fiber with a total cost of $15,562,000 as of December 31, 2011. Additional costs incurred and capitalized in 2015 and 2014 totaled $0 and $40,576, respectively. The asset will be amortized over its estimated useful life of 24 years; amortization commenced in November 2011, with amortization expense totaling $771,871 and $770,462 for the years ended December 31, 2015 and 2014, respectively. The System recognized $0 and $34,500 of the award into grant income in 2015 and 2014, respectively, which is a portion of the total grant income for the System.

Note 7 - Estimated Third-party Settlements

Approximately 52 percent of the System's net revenue from patient services is received from the Medicare and Medicaid programs. The System has agreements with these payors that provide for reimbursement to the System at amounts different from its established rates. Contractual adjustments under third-party reimbursement programs represent the difference between the System's established rates for services and amounts reimbursed by third-party payors. A summary of the basis of reimbursement with these third-party payors is as follows:

Medicare - For Adena Health System, inpatient acute-care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Inpatient capital costs are paid at prospectively determined rates per discharge. Most outpatient services and outpatient-defined capital costs related to Medicare beneficiaries are paid based on an ambulatory payment classification system (prospectively determined). Outpatient services for therapies and laboratory services are reimbursed on an established fee screen methodology. For Greenfield Area Medical Center and Adena Pike Community Hospital, the facilities will receive reasonable cost-based reimbursement for both inpatient and outpatient services provided to Medicare beneficiaries.

The professional services supplied by the employed physicians are reimbursed on an applicable fee schedule. These fee schedules are updated as regulations require or as contracts are negotiated in the case of some of Adena's Medicare Advantage plans.

Medicaid - For hospitals, inpatient acute-care services rendered to Medicaid program beneficiaries and capital costs are paid at prospectively determined rates per discharge. The hospitals are reimbursed for outpatient services on an established fee-for-service methodology.

The professional services supplied by the employed physicians are reimbursed on an applicable fee schedule. These fee schedules are updated as regulations require or as contracts are negotiated in the case of some of Adena's Medicaid Managed Care Plans.

Final reimbursement under these programs is subject to audit by fiscal intermediaries. Although these audits may result in some changes in these amounts, they are not expected to have a significant effect on the accompanying consolidated financial statements.

Note 7 - Estimated Third-party Settlements (Continued)

The Medicaid payment system in Ohio is a prospective one, whereby rates for the following state fiscal year beginning on July 1 are based upon filed cost reports for the preceding calendar year. The continuity of this system is subject to the uncertainty of the fiscal health of the State of Ohio, which can directly impact future rates and the methodology currently in place. Any significant change in rates, or the payment system itself, could have a material impact on the future Medicaid funding to providers.

Effective January 1, 2014, the State of Ohio extended Medicaid to more low-income patients, which resulted in patients previously classified as self pay being eligible for Medicaid. The provision for bad debts recorded in 2015 and 2014 was significantly affected by this program.

Commercial - The System also has entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the System under these agreements is typically discounts from established charges.

The professional services supplied by the employed physicians are reimbursed on an applicable fee schedule. These fee schedules are updated from time to time as negotiated.

RAC Audits - The Medicare program has initiated a recovery audit contractor (RAC) initiative, whereby claims subsequent to October 1, 2007 will be reviewed by contractors for validity, accuracy, and proper documentation. A demonstration project completed in several other states resulted in the identification of potential significant overpayments. The RAC program began for Ohio in 2009. The System has been audited during 2015 and a liability has been accrued within estimated third-party settlements based on written notice of the RAC audit take-backs of Medicare-reimbursed claims. If selected for further audits, the potential exists for significant liability for overpayment of claims. The System is unable to determine the extent of any overpayments or underpayments and resultant liabilities or assets for future audits, if any.

Note 8 - Medical Malpractice Claims

Based on the nature of its operations, the System is, at times, subject to pending or threatened legal actions which arise in the normal course of its activities.

The System has been insured with various providers. The System added coverage for integrated (employed) physicians to its policy in 1998, sharing primary limits of $1,000,000 per incident and $3,000,000 annual aggregate. Beginning with the 2000-2001 policy year, the physicians were covered under a separate occurrence policy with individual limits for each physician of $1,000,000 per occurrence and $3,000,000 annual aggregate. The coverages for the system and physicians were occurrence-based until 2005, at which time the System became insured on a claims-made basis.

Note 8 - Medical Malpractice Claims (Continued)

The System's medical malpractice coverage was renewed with a $250,000 deductible per claim on February 22, 2005, and the deductible increased to $500,000 per claim as of February 22, 2006. In addition, as of October 1, 2008, the System modified the physician coverages to include a deductible of $500,000 per claim.

On January 1, 2011, the System implemented a self-insured medical malpractice trust with shared retention limits for all medical providers of $1,000,000 per incident and $3,000,000 in the aggregate, annually. Excess policies in the amount of up to $20,000,000 in insurance coverage annually are layered on top of the System's self-insured retention.

At December 31, 2015, the System's management accrued its best estimate of the costs for claims arising prior to December 31, 2015. Based on changes to generally accepted accounting principles, system management has estimated the ultimate costs, if any, to settle these claims through an actuarial valuation and has accordingly allowed for them in the accrual for professional liability claims of approximately $11,000,000 and $10,000,000 for the years ended December 31, 2015 and 2014, respectively. These amounts are recorded in other liabilities on the consolidated balance sheet.

In addition, the System has estimated a receivable from its insurance carrier for payment of claims in excess of self-insured retention. The receivable is estimated at $1,900,000 and $1,400,000 for the years ended December 31, 2015 and 2014, respectively, in other current assets on the consolidated balance sheet. The System is not aware of any medical malpractice claims, either asserted or unasserted, that would exceed the policy limits.

Note 9 - Self-insured Benefits

The System is partially self insured under a plan covering substantially all employees for health benefits. The plan is covered by a stop-loss policy that covers claims over $225,000 and $200,000 per employee annually in 2015 and 2014, respectively, or total claims in excess of approximately $34,658,000 and $31,074,000 in 2015 and 2014, respectively. Claims and expenses charged to operations when incurred were approximately $25,063,000 and $26,889,000 for the years ended December 31, 2015 and 2014, respectively. The System has recorded a receivable of $1,578,000 and $3,293,000 for claims paid exceeding the self-insured retention due from its insurance carrier at December 31, 2015 and 2014, respectively, in other current assets on the consolidated balance sheet.

Note 10 - Long-term Debt

A summary of long-term debt obligations at December 31, 2015 and 2014 is as follows:

	2015	2014
County of Ross, Ohio, Hospital Facilities Revenue Bonds 2010 (maturing in December 2037)	$ 26,788,911	$ 27,680,423
County of Ross, Ohio, Hospital Facilities Revenue Bonds 2008 (maturing in December 2038)	133,070,000	135,450,000
County of Ross, Ohio, Hospital Facilities Revenue Bonds 1998 (maturing in December 2023)	3,700,000	4,075,000
Capital lease obligations for equipment purchases	246,519	661,356
Total	163,805,430	167,866,779
Less current portion	4,049,871	4,061,349
Long-term portion	$ 159,755,559	$ 163,805,430

In September 2010, the County of Ross, Ohio issued $30,000,000 Adjustable Rate Demand Hospital Facilities Revenue Bonds, Series 2010 (Adena Health System Project) (the "Series 2010 Bonds"). The Series 2010 Bonds are a private placement in which PNC Bank (PNC) purchased the Series 2010 Bonds and agreed to hold the Series 2010 Bonds until at least September 1, 2020. The Series 2010 Bonds were issued for the purpose of financing the construction of a cancer center and the renovation and equipping of certain other facilities. The debt has a final maturity date of September 1, 2037 and provides for the repayment of principal in increasing monthly principal payments beginning in 2012 through September 1, 2020, at which time the Series 2010 Bonds are subject to mandatory tender. As long as the interest rate remains at the initial fixed rate (bank rate) and no event of default occurs under the indenture, then the bonds cannot be redeemed by the bondholder until September 1, 2020; however, the System has an option to redeem bonds prior to September 1, 2020, subject to a prepayment premium.

If the System chooses to change the interest rate in accordance with the provisions of the indenture, then the bonds may be redeemable upon such conversion of rate as well. As long as there are no changes in the initial bank rate or early redemptions, then on and after September 1, 2020, the principal of the Series 2010 Bonds will be amortized pursuant to an agreement between the System and the new holder of the Series 2010 Bonds. While the interest rate of the bonds is adjustable based on various indices over the term of the bonds, PNC has agreed to fix the rate at 2.97 percent until September 1, 2020, after which time the rate will become a variable rate to be negotiated between the System and the debt holder, unless the System chooses to change the interest rate in accordance with the indenture before September 1, 2020.

Note 10 - Long-term Debt (Continued)

In July 2008, the System entered into an advance refunding plan with the County of Ross, Ohio (Ross County), in which Ross County issued $142,970,000 of Hospital Facilities Revenue Refunding and Improvement Bonds (the "Series 2008 Bonds"). The Series 2008 Bonds were issued for the purpose of refinancing previously issued debt and financing the acquisition, construction, renovation, and equipping of certain facilities. The debt matures in increasing semiannual principal payments beginning in 2009 through 2038. The interest rate per year ranges from 3.90 percent to 5.75 percent over the life of the bonds. The System has obtained bond insurance over the life of the bonds for a portion of the Series 2008 Bonds.

In September 1998, the System entered into an agreement with Ross County in which Ross County issued $8,175,000 of Hospital Facilities Revenue Bonds (Series 1998 Bonds) to (1) pay the costs of acquisition and construction of various improvements to the System, including the 60,000-square foot expansion of a medical office building to provide additional physicians' offices and hospital services and renovation of the women's and maternity unit, (2) pay the cost of acquisition and installation of certain movable equipment and a management information system, and (3) pay certain eligible expenses associated with the issuance of the Series 1998 Bonds. The bonds are secured by an irrevocable letter of credit issued by PNC Bank. The bonds are remarketed weekly and bear interest at variable market rates (0.02 percent and 0.05 percent at December 31, 2015 and 2014, respectively). Should the remarketing agent fail to remarket the bonds, funds would be drawn on the letter of credit to pay the bonds. The System is under no obligation to repay draws on the letter of credit until the 368th day after the occurrence of such draw. The letter of credit expires on October 15, 2018, at which time the System would become liable for draws on the letter of credit, if any.

Interest expense on all indebtedness totaled approximately $8,359,000 in 2015 and $8,597,000 in 2014. Cash paid for interest amounted to approximately $8,370,000 and $8,681,000 for 2015 and 2014, respectively.

In connection with the Series 1998, 2008, and 2010 Bonds, Ross County, as lessee, and the System, as lessor, entered into a master lease agreement for the System's premises. Ross County, as lessor, then entered into a sublease agreement with the System, as lessee, for the System's premises. The lease agreements expire on December 1, 2038, the mandatory retirement date of the Series 2008 Bonds. Under the terms of the lease and the indenture of trust related to the bonds, the System has pledged to Ross County a security interest in all present and future gross receipts, as defined. After final payment of the bonds, the System's facilities will be surrendered back to the System. Accordingly, such premises, together with the bond proceeds and bond indebtedness, are included in the accompanying consolidated financial statements as assets and liabilities of the System.

Note 10 - Long-term Debt (Continued)

The terms of the lease and the indenture of trust between Ross County, the System, and the trustee provide for the establishment and maintenance of certain funds under the control of the trustee into which the System is to make regular payments sufficient to cover principal and interest on the Series 1998, 2008, and 2010 Bonds. The balances of these funds as of December 31, 2015 and 2014 are reflected in the accompanying consolidated financial statements as assets limited as to use. In addition, the System is required to comply with certain financial and other restrictive covenants related to these bonds. For the year ended December 31, 2015, the maximum annual debt service is $12,719,883.

The fair value of the System's long-term debt for the Series 1998 and 2008 Bonds and for the revolving line of credit with PNC, estimated using discounted cash flow analysis based on the System's current incremental borrowing rates for similar obligations, totals approximately $150,882,000 and $156,114,000 as of December 31, 2015 and 2014, respectively. The fair value of the System's Series 2010 Bonds cannot be determined. Management has determined that there is not an available market for such debt in order to determine fair value.

Scheduled future minimum repayments on long-term debt and payments on capital lease obligations are as follows:

Years Ending December 31		Bonds	Capital Lease Obligations
2016		$ 3,803,352	$ 248,451
2017		3,971,002	-
2018		4,064,483	-
2019		4,328,823	-
2020		4,506,954	-
Thereafter		142,884,297	-
	Total	163,558,911	248,451
	Less amount representing interest under capital lease obligations	-	(1,932)
	Net	$ 163,558,911	$ 246,519

The cost of equipment under capital lease is $7,797,000 as of December 31, 2015 and 2014. Accumulated amortization on the equipment totaled approximately $7,473,000 and $7,015,000 as of December 31, 2015 and 2014, respectively.

Note 11 - Defined Benefit Plan

The System sponsors a defined benefit pension plan.

In January 2004, the board of directors of the System voted to freeze almost all employees' participation in the future accrual of benefits under the existing defined benefit plan, effective July 1, 2004. Approximately 100 employees who had obtained five years of service and were at least 55 years of age were allowed to continue with the existing plan. At the time the plan was frozen, employees vested in the plan earned a rate of return based on the 30-year United States Treasury rates. While the System has not expressed any intent to discontinue its contributions, it reserves and has the right at any time to terminate the plan. Upon termination, participants become 100 percent vested in their accrued benefits.

	Pension Benefits	
	2015	2014
Obligations and funded status:		
Benefit obligation at beginning of year	$ 54,860,639	$ 52,652,256
Service cost	34,370	46,552
Interest cost	2,186,922	2,596,060
Plan settlements	(3,154,969)	(3,330,169)
Benefits paid	(893,307)	(845,317)
Actuarial (gains) losses	(4,213,691)	3,760,519
Expenses	(19,604)	(19,262)
Benefit obligation at end of year	48,800,360	54,860,639
Change in plan assets:		
Fair value of plan assets at beginning of year	53,077,134	51,985,165
Actual return on plan assets	(809,184)	5,286,717
Plan settlements	(3,154,969)	(3,330,169)
Benefits paid	(893,307)	(845,317)
Expenses	(19,604)	(19,262)
Fair value of plan assets at end of year	48,200,070	53,077,134
Funded status at end of year	$ (600,290)	$ (1,783,505)

Note 11 - Defined Benefit Plan (Continued)

Amounts reducing unrestricted net assets which have not been included in net periodic benefit costs, reported outside the performance indicator, are as follows:

	Pension Benefits	
	2015	2014
Net loss	$ (11,627,792)	$ (14,639,238)
Prior service cost	(44,923)	(53,382)
Total	$ (11,672,715)	$ (14,692,620)

Information for pension plans with an accumulated benefit obligation in excess of plan assets is as follows:

	Pension Benefits	
	2015	2014
Projected benefit obligation	$ 48,800,360	$ 54,860,639
Accumulated benefit obligation	48,795,704	54,858,879
Fair value of plan assets	48,200,070	53,077,136

	Pension Benefits	
	2015	2014
Net Periodic Benefit Cost, Employer Contributions, Participant Contributions, and Benefits Paid		
Net periodic benefit cost	$ 1,836,690	$ 1,968,059
Benefits paid	893,307	845,317

	Pension Benefits	
	2015	2014
Net Periodic Benefit Cost		
Service cost	$ 34,368	$ 46,552
Interest cost	2,186,922	2,596,060
Expected return on plan assets	(2,599,043)	(2,722,926)
Amortization of prior service cost	8,459	8,560
Settlement loss recognized	751,418	888,168
Amortization of net loss	1,454,566	1,151,645
Total recognized in net periodic benefit cost	$ 1,836,690	$ 1,968,059

Note 11 - Defined Benefit Plan (Continued)

The estimated net loss and prior service cost for the defined benefit pension plans that will be amortized into net periodic benefit cost over the next fiscal year are $742,631.

Assumptions

Weighted average assumptions used to determine benefit obligations at December 31 are as follows:

	Pension Benefits	
	2015	2014
Discount rate	4.54 %	4.13 %
Rate of compensation increase	3.00	3.00

Weighted average assumptions used to determine net periodic benefit cost for the years ended December 31 are as follows:

	Pension Benefits	
	2015	2014
Discount rate	4.13 %	5.07 %
Expected long-term return on plan assets	5.50	5.75
Rate of compensation increase	3.00	3.00

The overall expected rate of return on plan assets represents a weighted average composite rate based on the historical rates of returns of the respective asset classes.

The following assumption changes have been made:

- The discount rate was increased from 4.13 percent as of December 31, 2014 to 4.54 percent as of December 31, 2015.
- The assumed interest rate to be applied to PEP account balances for the December 31, 2014 disclosure was 3.04 percent for the year 2015, 3.50 percent for the year 2016, 4.00 percent for the year 2017, 4.50 percent for the year 2018, and 5.00 percent per year in 2019 and thereafter.

  For the December 31, 2015 financial disclosure, this assumption has been changed to 3.03 percent for the year 2016, 3.25 percent for the year 2017, 3.50 percent for the year 2018, 3.75 percent for the year 2019, 4.00 percent for the year 2020, and 4.30 percent per year in 2021 and thereafter.
- The Mortality Assumption for healthy participants was changed from the RP-2014 generational mortality table using projection scale MP2014 to RP-2014 generational mortality table using projection scale MP2015.
- The annual inflation rate was changed from 2.50 percent to 2.25 percent.

Note 11 - Defined Benefit Plan (Continued)

- The interest rate for annuity conversion (based on long-term corporate bonds) was updated from 6.00 percent to 5.50 percent.
- The mortality improvement scale for annuity conversion was updated from MP2014 to MP2015.
- The expected return on asset assumption was increased from 5.50 percent to 6.00 percent for fiscal year ending December 31, 2016.

Pension Plan Assets

The goals of the pension plan investment program are to fully fund the obligation to pay retirement benefits in accordance with the plan documents and to provide returns that, along with appropriate funding from the System, maintain an asset/liability ratio that is in compliance with all applicable laws and regulations and assures timely payment of retirement benefits.

The System's overall investment strategy is to achieve a mix of approximately 50 percent of investments in fixed-income securities and 50 percent in equity securities in 2015 and 70 percent of investments in fixed-income securities and 30 percent in equity securities in 2014.

The fair values of the System's pension plan assets at December 31, 2015 and 2014 by major asset classes are as follows:

Fair Value Measurements at December 31, 2015

	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Short-term investments (a)	$ 226,445	$ 226,445	$ -	$ -
Mutual funds - Equity securities (b):				
Mercer emerging markets	210,222	-	210,222	-
U.S. large-cap passive funds	8,240,053	-	8,240,053	-
U.S. small-/mid-cap growth funds	1,021,579	-	1,021,579	-
U.S. small-/mid-cap value funds	982,040	-	982,040	-
Non-U.S. core funds	3,834,866	-	3,834,866	-
Mutual funds - Fixed-income funds (c):				
U.S. core opportunistic funds	2,145,321	-	2,145,321	-
Opportunistic fixed income	210,194	-	210,194	-
U.S. passive funds	6,815,041	-	6,815,041	-
Long-duration active funds	21,465,774	-	21,465,774	-
Long-duration passive funds	3,048,535	-	3,048,535	-
Total	$ 48,200,070	$ 226,445	$ 47,973,625	$ -

Note 11 - Defined Benefit Plan (Continued)

Fair Value Measurements at December 31, 2014

	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Short-term investments (a)	$ 222,393	$ 222,393	$ -	$ -
Mutual funds - Equity securities (b):				
Mercer emerging markets	246,909	-	246,909	-
U.S. large-cap passive funds	9,301,965	-	9,301,965	-
U.S. small-/mid-cap growth funds	1,160,971	-	1,160,971	-
U.S. small-/mid-cap value funds	1,094,437	-	1,094,437	-
Non-U.S. core funds	3,954,127	-	3,954,127	-
Mutual funds - Fixed-income funds (c):				
U.S. core opportunistic fund	2,376,166	-	2,376,166	-
Opportunistic fixed income	241,006	-	241,006	-
U.S. passive fund	7,366,697	-	7,366,697	-
Long-duration active fund	23,540,406	-	23,540,406	-
Long-duration passive fund	3,572,059	-	3,572,059	-
Total	$ 53,077,136	$ 222,393	$ 52,854,743	$ -

(a) This class invests primarily in fixed-income securities, including, but not limited to, bonds, notes, or other investments, such as government securities, commercial paper, certificates of deposit, master notes, or variable amount notes with the objective of providing high-current income consistent with the preservation of capital and the maintenance of liquidity. Short-term investments are valued at $1.00/unit, which approximates fair value.

(b) This class represents investments in actively managed common collective trust funds that invest primarily in equity securities, which may include common stocks, options, and futures. Investments are valued at the net asset value per share multiplied by the number of shares held as of the measurement date.

(c) This class represents investments in actively managed common collective trust funds that invest in a variety of fixed-income investments, which may include corporate bonds, both U.S. and non-U.S. municipal securities, interest rate swaps, options, and futures. Investments are valued at the net asset value per share multiplied by the number of shares held as of the measurement date.

The tables above present information about the defined benefit plan assets measured at fair value at December 31, 2015 and 2014 and the valuation techniques used by the System to determine those fair values. The investments measured at net asset value per share (or its equivalent) of the investment company do not have unfunded commitments or redemption periods.

In general, fair values determined by Level 1 inputs use quoted prices in active markets for identical assets that the System has the ability to access.

Note 11 - Defined Benefit Plan (Continued)

Fair values determined by Level 2 inputs use other inputs that are observable, either directly or indirectly. These Level 2 inputs include quoted prices for similar assets in active markets and other inputs such as interest rates and yield curves that are observable at commonly quoted intervals.

Level 3 inputs are unobservable inputs, including inputs that are available in situations where there is little, if any, market activity for the related asset.

In instances whereby inputs used to measure fair value fall into different levels in the above fair value hierarchy, fair value measurements in their entirety are categorized based on the lowest level input that is significant to the valuation. The System's assessment of the significance of particular inputs to these fair value measurements requires judgment and considers factors specific to each plan asset.

Cash Flow

Contributions

As the System has already met its funding requirements as of December 31, 2015, it does not expect to contribute anything additional to the plan in 2016. Additional discretionary contributions may be made upon further analysis of the retirement plan during the course of the year.

Estimated Future Benefit Payments

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid:

Years Ending December 31	Pension Benefits
2016	$ 3,315,712
2017	3,631,765
2018	3,372,988
2019	3,505,734
2020	5,031,288
2021-2025	17,433,420

Note 12 - Retirement Plan

The System maintains a contributory defined contribution plan 403(b) and a retirement savings plan 401(a) for qualified employees who meet certain service requirements.

Note 12 - Retirement Plan (Continued)

The System's contributions to the retirement savings plan 401(a) are board determined and can range from 3 percent to 6 percent of participants' base compensation. The related matching program currently funds 50 percent of employees' contributions, from the related 403(b) plan, up to a maximum of 6 percent of the employee's gross compensation. For the years ended December 31, 2015 and 2014, the retirement savings expense and the related match aggregated approximately $7,650,000 and $7,063,000, respectively.

Note 13 - Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are available for the following purposes or periods at December 31, 2015 and 2014:

	2015	2014
Purchase of equipment	$ 1,433,126	$ 1,109,815
Indigent care	972,715	1,055,869
Supplies	394,643	700,801
Healthcare education	576,864	572,937
Research	36,996	36,996
Community benefit	315,685	104,324
Total temporarily restricted	$ 3,730,029	$ 3,580,742

Permanently restricted net assets at December 31, 2015 and 2014 are restricted to the following:

	2015	2014
Investments to be held in perpetuity, the income from which is expendable to support the purchase of equipment or supplies	$ 179,200	$ 179,200

During 2015 and 2014, net assets were released from donor restrictions by incurring expenses satisfying the restricted purposes of health education and purchase of equipment in the amount of $418,209 and $987,211, respectively.

Note 14 - Operating Leases

The System is obligated under certain operating leases, primarily for medical office space and various medical equipment. Total rent expense under these leases was approximately $6,128,000 and $6,795,000 for the years ended December 31, 2015 and 2014, respectively.

Note 14 - Operating Leases (Continued)

The following is a schedule of future minimum lease payments under operating leases that have initial or remaining lease terms in excess of one year.

Future minimum rental commitments are approximated as follows:

Years Ending December 31	Amount
2016	$ 5,851,050
2017	2,768,349
2018	1,669,596
2019	1,537,979
2020	1,177,292
Thereafter	6,396,018
Total	$ 19,400,284

Note 15 - Functional Expenses

The System is a general acute-care facility that provides inpatient and outpatient healthcare services to patients in Ross County and the surrounding vicinity. Expenses related to providing these services for the years ended December 31, 2015 and 2014 are as follows:

	2015	2014
Healthcare services	$ 411,546,969	$ 378,049,884
General and administrative	23,206,498	44,247,211
Total	$ 434,753,467	$ 422,297,095

Note 16 - Fair Value

Accounting standards require certain assets and liabilities be reported at fair value in the consolidated financial statements and provide a framework for establishing that fair value. The framework for determining fair value is based on a hierarchy that prioritizes the inputs and valuation techniques used to measure fair value.

The following tables present information about the System's assets measured at fair value on a recurring basis at December 31, 2015 and 2014 and the valuation techniques used by the System to determine those fair values.

In general, fair values determined by Level 1 inputs use quoted prices in active markets for identical assets that the System has the ability to access.

Note 16 - Fair Value (Continued)

Fair values determined by Level 2 inputs use other inputs that are observable, either directly or indirectly. These Level 2 inputs include quoted prices for similar assets in active markets and other inputs such as interest rates and yield curves that are observable at commonly quoted intervals.

Level 3 inputs are unobservable inputs, including inputs that are available in situations where there is little, if any, market activity for the related asset.

In instances whereby inputs used to measure fair value fall into different levels in the above fair value hierarchy, fair value measurements in their entirety are categorized based on the lowest level input that is significant to the valuation. The System's assessment of the significance of particular inputs to these fair value measurements requires judgment and considers factors specific to each asset.

Assets Measured at Fair Value on a Recurring Basis at December 31, 2015

	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Balance at December 31, 2015
Assets limited as to use:				
Money market accounts	$ 12,288,106	$ -	$ -	$ 12,288,106
Common stock	276,208	-	-	276,208
Corporate bonds (a)	-	1,655,707	-	1,655,707
Mutual funds:	-	-	-	-
Fixed income - Core opportunistic fixed income (b)	86,791	103,255	-	190,046
Fixed income - Mercer opportunistic (b)	-	6,915,860	-	6,915,860
Fixed income - Mercer core fixed income (b)	-	2,198,206	-	2,198,206
Passive fixed income (b)	-	74,141,514	-	74,141,514
Large-cap growth equity (c)	249,414	15,596,832	-	15,846,246
Large-cap value equity (c)	102,809	296,800	-	399,609
Large-cap passive equity (c)	-	27,669,056	-	27,669,056
Small-/Mid-cap growth equity (c)	183,629	6,690,334	-	6,873,963
Small-/Mid-cap value equity (c)	-	6,443,023	-	6,443,023
Non-U.S. equity (d)	67,077	17,505,646	-	17,572,723
Emerging markets equity (d)	-	10,643,220	-	10,643,220
Total assets limited as to use	13,254,034	169,859,453	-	183,113,487
Total assets	$ 13,254,034	$ 169,859,453	$ -	$ 183,113,487

Note 16 - Fair Value (Continued)

Assets Measured at Fair Value on a Recurring Basis at December 31, 2014

	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Balance at December 31, 2014
Short-term investments -				
U.S. corporate bonds (a)	$ -	$ 5,319,335	$ -	$ 5,319,335
Assets limited as to use:				
Money market accounts	12,463,251	-	-	12,463,251
Common stock	267,275	-	-	267,275
Corporate bonds (a)	-	1,511,515	-	1,511,515
Mutual funds:	-	-	-	-
Fixed income - Core opportunistic fixed income (b)	85,997	118,366	-	204,363
Fixed income - Mercer opportunistic (b)	-	7,927,944	-	7,927,944
Fixed income - Mercer core fixed income (b)	-	2,148,788	-	2,148,788
Passive fixed income (b)	-	73,747,275	-	73,747,275
Large-cap growth equity (c)	244,615	15,038,686	-	15,283,301
Large-cap value equity (c)	108,141	315,177	-	423,318
Large-cap passive equity (c)	-	27,292,775	-	27,292,775
Small-/Mid-cap growth equity (c)	167,781	6,823,758	-	6,991,539
Small-/Mid-cap value equity (c)	-	6,618,399	-	6,618,399
Non-U.S. equity (d)	100,491	17,250,521	-	17,351,012
Emerging markets equity (d)	-	12,511,905	-	12,511,905
Total assets limited as to use	13,437,551	171,305,109	-	184,742,660
Total assets	$ 13,437,551	$ 176,624,444	$ -	$ 190,061,995

(a) This class invests primarily in fixed-income, corporate bond securities with a maturity of less than one year. The fair value of this investment has been estimated using quoted prices from the System's custodian bank.

(b) This class invests primarily in U.S. dollar-denominated investment-grade and government securities, U.S. high yield, non-U.S. bonds, and TIPS. The fair value of this investment has been estimated using the net asset value per share of the investment.

(c) This asset class invests primarily in common stock of large-cap and small- to mid-sized companies in the U.S. The fair value of this investment has been estimated using the net asset value per share of the investment.

(d) This asset class invests in companies operating in developed and emerging markets outside the U.S. The fair value of this investment has been estimated using the net asset value per share of the investment.

Note 16 - Fair Value (Continued)

The investments measured at net asset value per share (or its equivalent) of the investment company do not have unfunded commitments or redemption periods. The System has the ability to conduct transactions related to these funds at any time. The System's policy is to recognize transfers in and transfers out of Level 1, 2, and 3 fair value classifications as of the end of the reporting period. There were no transfers between levels for the years ended December 31, 2015 and 2014.

Additional Information

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Independent Auditor's Report on Additional Information

To the Board of Directors
Adena Health System and Subsidiaries

We have audited the consolidated financial statements of Adena Health System and Subsidiaries as of and for the years ended December 31, 2015 and 2014 and have issued our report thereon dated April 4, 2016, which contained an unmodified opinion on those consolidated financial statements. Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating balance sheet and consolidating statement of operations are presented for the purpose of additional analysis rather than to present the financial position, changes in net assets, and cash flows of the individual companies and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Plante & Moran, PLLC

April 4, 2016

Praxity
MEMBER
GLOBAL ALLIANCE OF INDEPENDENT FIRMS

Adena Health System and Subsidiaries

Consolidating Balance Sheet
December 31, 2015

	Adena Health System	Greenfield Area Medical Center	Adena Health Foundation	Southern Ohio Health Care Network, Inc.	Adena Medical Group, LLC	Adena Home Care	Adena Health Plan	Adena Pharmacy	Adena Pike Community Hospital	Eliminating Entries	Total
Assets											
Current Assets											
Cash and cash equivalents	$ 38,857,294	$ 155,649	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,191,316	$ -	$ 40,204,259
Patient accounts receivable - Net	64,080,668	2,264,557	-	-	5,890,832	542,310	-	359,803	2,523,004	-	75,661,174
Other current assets	7,694,857	118,350	-	-	671,550	-	-	-	439,438	-	8,924,195
Estimated third-party payor settlements	3,773,124	(114,321)	-	-	-	-	-	-	(1,042,465)	-	2,616,338
Prepaid expenses and other	5,324,627	575,196	-	-	-	-	-	-	1,591,513	-	7,491,336
Inventory	4,009,232	233,602	-	-	-	818,299	-	398,736	275,830	-	5,735,699
Intercompany	8,794,808	-	179,543	-	-	-	-	-	-	(8,974,351)	-
Total current assets	132,534,610	3,233,033	179,543	-	6,562,382	1,360,609	-	758,539	4,978,636	(8,974,351)	140,633,001
Assets Limited as to Use	178,112,976	1,112,727	3,887,784	-	-	-	-	-	-	-	183,113,487
Property and Equipment - Net	140,226,662	3,153,288	-	-	-	-	-	58,157	6,028,540	-	149,466,647
Indefeasible Right-of-use Asset	-	-	-	15,429,426	-	-	-	-	-	-	15,429,426
Other Assets											
Notes and grants receivable	1,698,427	-	-	-	-	-	-	-	-	-	1,698,427
Bond issue costs	2,994,075	-	-	-	-	-	-	-	-	-	2,994,075
Other noncurrent assets	10,093,726	-	34,653	-	-	-	-	-	1,939,000	-	12,067,379
Total assets	**$ 465,660,476**	**$ 7,499,048**	**$ 4,101,980**	**$ 15,429,426**	**$ 6,562,382**	**$ 1,360,609**	**$ -**	**$ 816,696**	**$ 12,946,176**	**$ (8,974,351)**	**$ 505,402,442**

Adena Health System and Subsidiaries

Consolidating Balance Sheet (Continued)
December 31, 2015

	Adena Health System	Greenfield Area Medical Center	Adena Health Foundation	Southern Ohio Health Care Network, Inc.	Adena Medical Group, LLC	Adena Home Care	Adena Health Plan	Adena Pharmacy	Adena Pike Community Hospital	Eliminating Entries	Total
Liabilities and Net Assets (Deficit)											
Current Liabilities											
Current portion of long-term debt	$ 4,049,871	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,049,871
Accounts payable	14,763,080	194,826	6,243	9,382	165,406	16,018	5,160	-	235,818	-	15,395,933
Intercompany liabilities	-	-	-	3,843,543	-	-	3,270,971	1,859,837	-	(8,974,351)	-
Accrued liabilities and other:											
Accrued compensation	16,105,947	558,106	15,552	-	7,596,239	332,894	13,221	43,389	672,987	-	25,338,335
Deferred compensation	5,225,000	-	-	-	-	-	-	-	-	-	5,225,000
Accrued interest	685,483	767	-	-	-	-	-	-	-	-	686,250
Other accrued liabilities	1,806,233	-	-	-	-	-	-	-	-	-	1,806,233
Total current liabilities	42,635,614	753,699	21,795	3,852,925	7,761,645	348,912	3,289,352	1,903,226	908,805	(8,974,351)	52,501,622
Long-term Debt and Capital Lease Obligations - Net of current portion	159,755,559	-	-	-	-	-	-	-	-	-	159,755,559
Defined Benefit Plan Liability	600,290	-	-	-	-	-	-	-	-	-	600,290
Other Liabilities	17,423,712	-	-	-	-	-	-	-	-	-	17,423,712
Total liabilities	220,415,175	753,699	21,795	3,852,925	7,761,645	348,912	3,289,352	1,903,226	908,805	(8,974,351)	230,281,183
Net Assets (Deficit)											
Unrestricted	243,667,285	5,626,277	2,868,044	11,576,501	(1,199,263)	1,011,697	(3,289,352)	(1,086,530)	12,037,371	-	271,212,030
Temporarily restricted	1,578,016	939,872	1,212,141	-	-	-	-	-	-	-	3,730,029
Permanently restricted	-	179,200	-	-	-	-	-	-	-	-	179,200
Total net assets (deficit)	245,245,301	6,745,349	4,080,185	11,576,501	(1,199,263)	1,011,697	(3,289,352)	(1,086,530)	12,037,371	-	275,121,259
Total liabilities and net assets (deficit)	**$ 465,660,476**	**$ 7,499,048**	**$ 4,101,980**	**$ 15,429,426**	**$ 6,562,382**	**$ 1,360,609**	**$ -**	**$ 816,696**	**$ 12,946,176**	**$ (8,974,351)**	**$ 505,402,442**

Adena Health System and Subsidiaries

Consolidating Statement of Operations
Year Ended December 31, 2015

	Adena Health System	Greenfield Area Medical Center	Adena Health Foundation	Southern Ohio Health Care Network, Inc.	Adena Medical Group, LLC	Adena Home Care	Adena Health Plan	Adena Pharmacy	Adena Pike Community Hospital	Eliminating Entries	Total
Unrestricted Revenue, Gains, and Other Support											
Net patient service revenue	$ 353,020,114	$ 16,104,462	$ -	$ -	$ 63,252,113	$ 6,023,992	$ -	$ -	$ 19,507,221	$ (399,596)	$ 457,508,306
Provision for bad debts	(19,222,671)	(994,425)	-	-	(3,639,051)	(9,980)	-	-	(1,555,093)	-	(25,421,220)
Net patient service revenue less provision for bad debts	333,797,443	15,110,037	-	-	59,613,062	6,014,012	-	-	17,952,128	(399,596)	432,087,086
Other operating revenue	3,371,121	84,876	404,933	65,329	24,911,609	388	976,441	5,367,070	150,916	(26,161,009)	9,171,674
Net assets released from restrictions	339,419	-	-	-	-	-	-	-	-	-	339,419
Total unrestricted revenue, gains, and other support	337,507,983	15,194,913	404,933	65,329	84,524,671	6,014,400	976,441	5,367,070	18,103,044	(26,560,605)	441,598,179
Expenses											
Salaries and wages	105,100,986	5,758,842	206,462	-	77,586,202	4,071,043	225,716	507,584	6,994,782	-	200,451,617
Employee benefits and payroll taxes	39,140,832	1,941,097	67,790	-	7,100,181	1,321,089	78,963	168,264	2,326,376	(3,857,554)	48,287,038
Operating supplies and expenses	65,935,635	985,325	5,372	-	540,803	1,521,576	95	4,732,937	1,770,877	-	75,492,620
Professional services and consultant fees	22,182,652	504,503	-	-	2,927,303	100,008	85,872	-	164,047	(22,696,249)	3,268,136
Purchased services	37,878,867	1,457,156	24,714	116,387	835,350	923,325	1,090,322	-	1,100,564	(750)	43,425,935
Insurance	1,151,998	64,815	-	-	1,108,920	32,578	-	-	64,053	-	2,422,364
Utilities	4,038,251	137,015	-	-	329	-	-	-	375,804	-	4,551,399
Travel/Education	1,315,597	83,495	2,735	-	625,227	391,730	10,239	8,324	78,371	-	2,515,718
Repair, maintenance, and rental	18,208,334	402,437	-	-	26,951	280,590	-	24,037	527,977	-	19,470,326
Assessments	3,571,302	261,933	-	-	-	-	-	-	332,244	(6,052)	4,159,427
Depreciation and amortization	20,504,500	288,938	-	771,871	-	-	-	9,570	775,096	-	22,349,975
Interest expense	8,358,912	-	-	-	-	-	-	-	-	-	8,358,912
Corporate cost allocation	(19,109,028)	2,450,208	97,860	-	10,718,508	2,211,288	176,856	150,948	3,303,360	-	-
Total expenses	308,278,838	14,335,764	404,933	888,258	101,469,774	10,853,227	1,668,063	5,601,664	17,813,551	(26,560,605)	434,753,467
Operating Income (Loss)	29,229,145	859,149	-	(822,929)	(16,945,103)	(4,838,827)	(691,622)	(234,594)	289,493	-	6,844,712
Nonoperating Income (Loss)											
Interest income and net realized gains	3,511,431	84	159,361	-	-	-	-	-	64,251	-	3,735,127
Unrealized losses on trading securities	(3,901,946)	-	(176,085)	-	-	-	-	-	-	-	(4,078,031)
Other income	4,790	1,635	235,628	-	-	-	-	-	80,735	-	322,788
Total nonoperating (loss) income	(385,725)	1,719	218,904	-	-	-	-	-	144,986	-	(20,116)
Excess of Revenue Over (Under) Expenses	28,843,420	860,868	218,904	(822,929)	(16,945,103)	(4,838,827)	(691,622)	(234,594)	434,479	-	6,824,596
Net Assets Released from Restriction for Purchase of Capital Assets	78,790	-	-	-	-	-	-	-	-	-	78,790
Transfer (to) from Affiliate	(18,591,536)	185,598	-	-	17,733,923	3,824,157	-	-	(3,152,142)	-	-
Pension-related Changes Other than Net Periodic Cost	3,019,905	-	-	-	-	-	-	-	-	-	3,019,905
Grant Income	-	-	-	-	-	-	-	-	9,399	-	9,399
Increase (Decrease) in Unrestricted Net Assets	**$ 13,350,579**	**$ 1,046,466**	**$ 218,904**	**$ (822,929)**	**$ 788,820**	**$ (1,014,670)**	**$ (691,622)**	**$ (234,594)**	**$ (2,708,264)**	**$ -**	**$ 9,932,690**

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APPENDIX C

SUMMARY OF CERTAIN BOND DOCUMENTS

APPENDIX C

SUMMARY OF CERTAIN BOND DOCUMENTS

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APPENDIX C

SUMMARY OF CERTAIN BOND DOCUMENTS

The following are summaries of the Master Indenture, the Lease, the Sublease, the Bond Indenture and the Tax Regulatory Agreement. The summaries do not purport to set forth all of the provisions of such documents, to which reference is made for the complete and actual terms thereof.

DEFINITIONS OF CERTAIN TERMS

The terms defined below are among those used in this Official Statement and in the summaries of the Master Indenture, the Lease, the Sublease, the Bond Indenture and the Tax Regulatory Agreement which follow:

"Act" means Chapter 140 of the Ohio Revised Code, as from time to time supplemented and amended.

"Additional Bonds" means any Related Bonds authorized to be issued under the Master Indenture, subsequent to the issuance of the Series 2017 Bonds.

"Adjusted Annual Revenue" means, as of any date of determination thereof, the total revenues (other than gains or losses upon defeasance of Indebtedness) of the members of the Obligated Group for the Fiscal Year in question, including contributions of Current Assets to members of the Obligated Group by Affiliates, less net revenues derived from property financed with the proceeds of Non-Recourse Indebtedness, bad debt allowances, contractual adjustments with third party payors and adjustments for free hospital and medical services provided by members of the Obligated Group to third parties relating to such Fiscal Year and, to the extent otherwise included therein, gifts, grants or bequests of a non-recurring nature to the extent such gifts, grants and bequests exceed the arithmetic mean of the gifts, grants and bequests of a non-recurring nature received by members of the Obligated Group during the two immediately preceding Fiscal Years.

"Affiliate" means (a) any corporation, association, business trust, joint venture, partnership or other legal entity organized on a for-profit basis under the laws of any state, of which the Corporation (or its members or Governing Body) possesses, directly or indirectly, in excess of 50% of the voting rights with respect thereto, provided that the ability to acquire voting rights shall not be treated as possession of such rights until the rights are acquired, or (b) any other corporation, association, business trust, joint venture, partnership or other legal entity organized on a nonprofit basis under the laws of any state, the articles of incorporation, by-laws, articles of association or similar organizational documents of which require or expressly permit the Corporation (or its members or Governing Body) to exercise control thereof, whether through (i) appointment of officers or employees of the Corporation (or its members or Governing Body) to a majority of its governing body on an ex-officio basis (with voting rights), (ii) appointment of a majority of members of such governing body by the Corporation (or its members or Governing Body) or (iii) authority of the Corporation (or its members or Governing Body) to remove a majority of members of such governing body.

"Assumed Amortization Period" means, with respect to any Indebtedness, the principal and interest requirements of which are to be recast for purposes of a calculation of the Debt Service Coverage Ratio or in connection with the incurrence of Interim Indebtedness the period of time determined, at the election of the Obligated Group Representative, pursuant to either (a) or (b) hereafter: (a) twenty-five (25) years, or (b) the period of time, not exceeding thirty (30) years, set forth in an opinion delivered to the Master Trustee of an investment banker selected by the Obligated Group Representative and experienced in underwriting indebtedness of the type being recast, or of another Independent Person selected by the Obligated Group Representative and experienced in the issuance and sale of indebtedness of such type, as being the maximum period of time over which indebtedness having comparable terms and security issued or incurred by institutions of comparable credit standing would, if then being offered, be marketable on reasonable and customary terms.

"Assumed Interest Rate" means, with respect to any Indebtedness, the principal and interest requirements of which are to be recast for purposes of a calculation of the Debt Service Coverage Ratio, or in connection with the incurrence of Interim Indebtedness, the rate per annum determined in accordance with the applicable paragraph set forth below:

(a) With respect to Variable Rate Indebtedness, the rate per annum which is the twelve month average of the rate which has been in effect on such Variable Rate Indebtedness or if no such Variable Rate Indebtedness has been issued or incurred, the twelve month average of the 11-Bond General Obligation Index as published by The Bond Buyer;

(b) With respect to other Indebtedness, the rate per annum determined as of the last day of the calendar month next preceding the month in which the determination of Assumed Interest Rate is being made and determined at the election of the Obligated Group Representative, pursuant to clause (i) or clause (ii) below:

(i) A rate per annum equal to (A) ninety percent (90%), if interest on the Indebtedness is exempt from Federal income taxation, or (B) one hundred ten percent (110%), if interest on the Indebtedness is subject to Federal income taxation, of the most recently published daily yields to maturity of United States Treasury obligations adjusted to a constant maturity of 30 years as published by the Board of Governors of the Federal Reserve System; or

(ii) The rate per annum set forth in an opinion delivered to the Master Trustee of an investment banker selected by the Obligated Group Representative and experienced in underwriting indebtedness of the type being recast, or of another Independent Person selected by the Obligated Group Representative and experienced in the issuance and sale of indebtedness of such type, as being the lowest rate of interest (which may be a rate which reflects the exemption of such interest from Federal income taxation if such exemption is then available) at which indebtedness having comparable terms and security, amortized on a level debt service basis over a period of time equal to the Assumed Amortization Period, and issued or incurred by similar institutions of comparable credit standing would, if being offered as of such last day of the calendar month, be

marketable on reasonable and customary terms; provided that such rate shall not be less than the rate specified in the "Twenty Bond Index" published in The Bond Buyer, or any successor index, as in effect on the date of such opinion.

"Authorized Corporation Representative" means such person at the time, and from time to time, designated by written certificate of the Corporation furnished to the Issuer and the Bond Trustee containing the specimen signature of such person and signed on behalf of the Corporation by an authorized officer. Such certificate may designate an alternate or alternates.

"Basic Rent" means that portion of the Rent described as such under the heading "SUMMARY OF THE SUBLEASE – Payments to the Bond Trustee" herein.

"Bond Fund" means the fund by that name created the Bond Indenture.

"Bondholder" or "owner" means the registered owner of any Series 2017 Bond.

"Bond Indenture" means the Indenture of Trust (Bond Indenture) dated as of June 1, 2017 between the Issuer and the Bond Trustee.

"Bond Insurer" means, with respect to any series of Insured Bonds, an insurance company which has issued a Municipal Bond Insurance Policy with respect thereto.

"Bond Trustee" means The Huntington National Bank.

"Book Value" (a) when used in connection with Property of an Obligated Issuer, means the value of such Property, net of accumulated depreciation, as it is carried on the books of account of such Obligated Issuer and in conformity with Generally Accepted Accounting Principles and (b) when used in connection with Property of the Obligated Group shall mean the aggregate of the values so determined with respect to Property of each member of the Obligated Group, but calculated so that no portion of such value of Property of any member of the Obligated Group is included more than once.

"Capitalization" means the principal amount of all outstanding Long-Term Indebtedness plus the equity accounts of the Obligated Issuers (i.e. unrestricted fund balances). In the case of Long-Term Indebtedness issued or incurred at a discount, such Long-Term Indebtedness shall be valued at the accreted value thereof.

"Capitalized Interest Account" means the separate account in the Bond Fund by that name created by the Bond Indenture.

"Completion Indebtedness" means any Long-Term Indebtedness or Interim Indebtedness incurred or issued by any member of the Obligated Group for the purpose of financing (a) the improvement, replacement or renovation of or substitutions for, or additions to, facilities for which Long-Term Indebtedness or Interim Indebtedness has been incurred, necessitated by faulty design, damage to or destruction of such facilities or (b) the completion of a project for which Long-Term Indebtedness or Interim Indebtedness has already been issued or incurred.

"Convertible Indebtedness" means Indebtedness which by its terms permits the borrower on one or more occasions to establish or to modify the period for which the rate of interest thereon shall be fixed.

"Corporation" means Adena Health System, a nonprofit corporation incorporated under the laws of the State of Ohio, and its successors and assigns.

"Corporation Documents" means, collectively, the Lease and the Sublease.

"Credit Enhanced Indebtedness" means Indebtedness the principal of or interest on which is secured by the proceeds of an irrevocable letter of credit, bond, insurance policy or other credit facility or arrangement with a Person not a member of the Obligated Group.

"Current Assets" means cash and cash equivalent deposits, marketable securities, accounts receivable, accrued interest receivable and any other assets of the Obligated Group which at the time of computation thereof are considered current assets under Generally Accepted Accounting Principles (including those set forth under the heading of other assets which otherwise would qualify therefor) except that, regardless of Generally Accepted Accounting Principles, Current Assets shall include cash and cash equivalent deposits and marketable securities ("Board Designated Assets") that have been designated as such by the Governing Body of any member of the Obligated Group except for assets that have been contractually committed by action of such Governing Body to pay part of the costs of a particular capital project with respect to which Indebtedness has been incurred and the completion of which capital project has not been abandoned by action of such Governing Body; provided that funds held by trustees for the self-insurance of professional liability shall be treated as Current Assets, notwithstanding the characterization to the contrary on the balance sheets of the Obligated Group.

"Debt Service Coverage Ratio" means the ratio of Net Income Available for Debt Service for the period in question to the Maximum Annual Debt Service, consisting of principal payments (whether at maturity or pursuant to sinking fund redemption requirements) and interest payments of the Obligated Group on Outstanding Long-Term Indebtedness (including Interim Indebtedness and including Long-Term Indebtedness arising from Guarantees) for the then current or any succeeding Fiscal Year; provided, however, that for purposes of calculating such ratio:

(a) principal and interest requirements on Long-Term Indebtedness, or portions thereof, shall not be included in the computation of the Maximum Annual Debt Service (i) until the Fiscal Year in which such principal or interest, or portions thereof, first becomes payable, and with respect to the Fiscal Year in which it first shall become payable, only to the extent it shall be payable, from sources other than amounts deposited in trust, escrowed or otherwise set aside for the payment thereof at the time of incurrence of Indebtedness (including without limitations, so as to prevent the double-counting of any Indebtedness in the computation of the Maximum Annual Debt Service, capitalized interest and accrued interest so deposited into trust, escrowed or otherwise set aside) with the Master Trustee, a Related Bond Trustee or another Person approved by the Master Trustee, and (ii) following deposit of amounts in trust, escrowed or otherwise set aside

with the Master Trustee, any Related Bond Trustee or another Person approved by the Master Trustee which are sufficient in time and amount to pay such principal and interest;

(b) any Long-Term Indebtedness having a single principal maturity and no sinking fund redemption requirements, or having a principal amount due in any Fiscal Year in an amount equal to 20% or more of the principal amount of such Long-Term Indebtedness and with no mandatory sinking fund redemption requirements shall be deemed to bear interest at the Assumed Interest Rate determined in accordance with paragraph (b) of the definition of Assumed Interest Rate and shall be deemed to be amortized on a level debt service basis over a period equal to the Assumed Amortization Period;

(c) the interest on any Variable Rate Indebtedness shall be calculated in accordance with paragraph (a) of the definition of Assumed Interest Rate;

(d) the annual principal and interest payments on Indebtedness arising from any Guaranty shall be taken into account as follows:

(i) if at any time within the 18 months immediately preceding the computation date, the obligee of the guaranteed indebtedness shall have demanded that the guarantor pay all or a portion of principal of or interest on the guaranteed indebtedness and if within thirty (30) calendar days of the guarantor's receipt of such demand, the Obligated Group Representative shall have failed to deliver to the Master Trustee an Opinion of Counsel to the effect that the guarantor is not legally obligated to honor such demand, then 100% of the portion of annual principal and interest payments scheduled to become due on the guaranteed indebtedness which the guarantor shall be obligated to pay; or

(ii) otherwise, twenty percent (20%) of the annual principal and interest payments scheduled to become due on the guaranteed indebtedness;

(e) notwithstanding the requirements of paragraph (d) hereof, principal and interest requirements on outstanding Long-Term Indebtedness arising from any Guaranty by a member of the Obligated Group shall not be taken into account if such member or any other member of the Obligated Group is the obligor of the guaranteed indebtedness;

(f) principal and interest requirements on Long-Term Indebtedness, or portions thereof, shall not be included in the computation of the Maximum Annual Debt Service due in any Fiscal Year to the extent that a Federal, state or local government has absolutely, unconditionally and irrevocably committed to make payments in such Fiscal Year to or for the benefit of a member of the Obligated Group and the application of such payments is limited to the payment of such principal and interest; provided, however, that the exclusion set forth in this subparagraph (f) shall apply only if an Officer's Certificate shall be delivered to the Master Trustee describing the amount to be excluded and the year of such exclusion and such Officer's Certificate shall be accompanied by a copy of the contract, commitment letter or other evidence of the Federal, state or local government's commitment together with an Opinion of Counsel to the effect that such

commitment is absolute, unconditional and irrevocable and that the amounts so committed are legally and validly restricted to the payment of principal and/or interest on Long-Term Indebtedness;

(g) debt service on Optional Tender Indebtedness shall not include amounts payable upon exercise by the holder thereof of the option to tender such Indebtedness for payment to the extent and for so long as a Person other than an Obligated Issuer is required to provide the moneys necessary for such payment (the "Liquidity Backer"), shall be deemed to include any periodic fees of the Liquidity Backer and shall not be based upon the terms of any reimbursement obligation to the Liquidity Backer except to the extent and for periods during which payments have been required to be made pursuant to such reimbursement obligation due to the Liquidity Backer advancing funds and not being reimbursed;

(h) debt service on Convertible Indebtedness shall be determined based upon the type of Indebtedness the Convertible Indebtedness will be at the time of calculation if each of the following tests is satisfied: (i) the Obligated Issuer incurring such Indebtedness has no current intention or expectation that the conversion option of such Indebtedness will be exercised at any particular future time, (ii) the conversion option has been included to provide flexibility in reacting to future circumstances, (iii) the conversion option has not been included for the purpose of avoiding any limit or restriction herein on the incurrence of Indebtedness of a type into which such Convertible Indebtedness may by its terms be converted and (iv) the Officer's Certificate required by the Master Indenture with respect to Convertible Indebtedness has been filed with the Master Trustee. If any one or more of the foregoing tests are not satisfied, debt service on Convertible Indebtedness shall be calculated at the higher of the debt service at the time of calculation or debt service upon conversion;

(i) debt service on Credit Enhanced Indebtedness shall be deemed to include all periodic payments to the Credit Enhancer but shall not be based upon the terms of any reimbursement obligation to the Credit Enhancer except to the extent and for periods during which payments have been required to be made pursuant to such reimbursement obligation due to the Credit Enhancer advancing funds and not being reimbursed. Any Obligated Issuer which also is undertaking any contingent repayment obligation to a Person other than an Obligated Issuer who has undertaken to provide moneys necessary for payment to holders of such Credit Enhanced Indebtedness (the "Credit Enhancer") shall not also be deemed to be incurring separate Indebtedness to the Credit Enhancer; and

(j) anything in the Master Indenture to the contrary notwithstanding, any portion of any Indebtedness of any Obligated Issuer for which an Interest Rate Hedge has been obtained by such Obligated Issuer shall be deemed to bear interest for the period of time that such Interest Rate Hedge is in effect at a net rate which takes into account the interest payments made by such Obligated Issuer on such Indebtedness and the payments made or received by such member on such Interest Rate Hedge; provided that the long-term credit rating of the provider of such Interest Rate Hedge (or any guarantor thereof) is in one of the three highest rating categories of each nationally recognized rating agency

which then rates any Related Bonds (without regard to any refinements of gradation of rating category by numerical modifier or otherwise) or is at least as high as that of long-term, unenhanced Indebtedness of the Corporation; in addition, so long as any Indebtedness is deemed to bear interest at a rate taking into account an Interest Rate Hedge, any payments made by an Obligated Issuer on such Interest Rate Hedge shall be excluded from total expenses of the Obligated Issuer and any payments received by such an Obligated Issuer on such Interest Rate Hedge shall be excluded from Adjusted Annual Revenues, in each case for all purposes of the Master Indenture.

"Defeasance Obligations", as used in the Bond Indenture, means (a) direct general obligations of the United States of America; and (b) evidences of ownership of proportionate interests in future interest or principal payments on obligations specified in clause (a) of this definition held by a bank or trust company as custodian, under which the owner of the investment is the real party in interest and has the right to proceed directly and individually against the obligor on the underlying obligations described in clause (a) of this definition, and which underlying obligations are not available to satisfy any claim of the custodian or any person claiming through the custodian or to whom the custodian may be obligated.

"Electronic Means" means facsimile transmission, email transmission or other similar electronic means of communication providing evidence of transmission, including a telephone communication confirmed by any other method set forth in this definition.

"Escrow Deposit Agreement" means the Escrow Deposit Agreement dated as of June 1, 2017, between the Corporation and the Escrow Trustee.

"Escrow Fund" means the fund by that name created pursuant to the Escrow Deposit Agreement.

"Escrow Trustee" means The Huntington National Bank, as escrow trustee.

"Excluded Property" means (a) the Property described in Exhibit B to the Master Indenture, as amended or supplemented from time to time in accordance therewith (see APPENDIX A: "INFORMATION CONCERNING ADENA HEALTH SYSTEM AND THE OBLIGATED GROUP – Organizational Structure - Excluded Property") and (b) Real Property financed solely with the proceeds of Non-Recourse Indebtedness.

"Existing Facilities" means the Existing Real Property and all Hospital Facilities acquired, constructed and installed on the Existing Real Property, including, without limitation, the Project.

"Existing Notes" means collectively (a) the Adena Health System Series 1998A Note, (b) the Adena Health System Series 2010 Note, and (c) the Adena Health System Series 2010B Note, each of which constitutes a Note under the Master Indenture.

"Existing Real Property" means the real estate described in Exhibit A of the Sublease as of the date of the original execution of the Bond Indenture.

"Expense Fund" means the fund by that name created by the Bond Indenture.

"Fair Market Value" means the value established for Property pursuant to an appraisal made by an Independent Person appointed by the Obligated Group Representative and experienced in appraising the value of assets similar or identical to the Property; provided, however, that if at the time a determination of Fair Market Value is required under any provision of the Master Indenture the Debt Service Coverage Ratio for the then most recently completed Fiscal Year for which financial statements are available is not less than 2.00, then such appraisal may be made by any Person, otherwise qualified under the foregoing provisions of this definition and without regard to whether or not such Person shall be an officer or employee of any member of the Obligated Group or an employee or elected official of any Related Issuer.

"Fiscal Year" means, with respect to each member of the Obligated Group, that period of twelve complete, consecutive calendar months determined by the Obligated Group Representative (which determination shall be made by delivery of written notice thereof to the Master Trustee) to be the fiscal year of the members of the Obligated Group and which period shall have been reported on by an Independent Certified Public Accountant.

"Generally Accepted Accounting Principles" means accounting principles generally accepted in the United States of America.

"Governing Body" means, with respect to each Obligated Issuer, the board of directors or board of trustees of such Obligated Issuer, or if there is no board of trustees or board of directors, then such Person or body which pursuant to law or the organizational documents of the Obligated Issuer is vested with powers similar to those vested in a board of trustees or a board of directors; the term also encompasses any committee empowered to act on behalf of such board or body.

"Governmental Regulations" means state or Federal laws or regulations or administrative interpretations of such laws or regulations then in existence, cost containment requirements or restrictions on rates, charges and/or revenues of the members of the Obligated Group, or reimbursement regulations and policies which may be imposed by third-party payors (whether governmental or private).

"Government Obligations" means the following:

(a) direct obligations of, or obligations the principal of and interest on which are unconditionally guaranteed as to full and timely payment by, the United States of America;

(b) obligations issued by a person controlled or supervised by and acting as an instrumentality of the United States of America, the payment of the principal of and interest on which is fully and unconditionally guaranteed as a full faith and credit obligation of the United States of America (including any securities described in clause (a) above issued or held in book-entry form in the name of the paying agent only on the books of the Department of Treasury of the United States of America);

(c) any certificates or any other evidences of an ownership interest in obligations or specified portions thereof (which may consist of specified portions of the interest thereon) of the character described in clause (a) or (b) above, which obligations

are held by a bank or trust company organized and existing under the laws of the United States of America or any state thereof in the capacity of custodian; and

(d) obligations of any state or political subdivision thereof or any agency or instrumentality of such a state or political subdivision, provided that cash, obligations described in clause (a), (b) or (c) above, or a combination thereof have been irrevocably pledged to and deposited into a segregated escrow account for the payment when due of the principal or redemption price of and interest on such obligations, and provided further that, at the time of purchase, such obligations are rated by the Rating Service in its highest rating category.

"Gross Receipts" means all cash and other receipts, present and future accounts, receivables, contracts and contract rights (including particularly contracts, agreements, contract rights and agreement rights, particularly those between any member of the Obligated Group and the State of Ohio with respect to Medicaid, any member of the Obligated Group and third-party insurers of patients of any members of the Obligated Group and any member of the Obligated Group and the United States of America with respect to Medicare, and all other equivalent insurance programs, or any state or federal program substituted in lieu thereof), general intangibles, documents and instruments, which are now owned or hereafter acquired by the Obligated Group, and all proceeds therefrom, whether cash or noncash, derived by the Obligated Group from the conduct of all or any part of its operations, and all revenue and income of the Obligated Group from whatever source derived from any and all facilities now or hereafter acquired, leased or used by the Obligated Group, income from and the principal of investments, leases and income received from leases, and grants received by the Obligated Group from any source and excluding only (i) grants, gifts, bequests, contributions and other donations, to the extent specifically restricted by the donor or grantor to a special object or purpose so as to preclude use thereof for payment of principal or interest on the Notes, (ii) the proceeds of any borrowing or any funds held in trust by a trustee as security for such borrowing, (iii) revenues, income, receipts and money received by a member of the Obligated Group as agent for and on behalf of a Person other than a member of the Obligated Group, and (iv) any Property that is the subject of a lien or encumbrance permitted by the Master Indenture or that has been conveyed or otherwise disposed of as permitted by the Master Indenture.

"Guaranty" means a loan commitment or obligation of any Obligated Issuer which loan commitment or obligation guarantees in any manner whether directly or indirectly any obligation of any other Person which obligation would, if such other Person were an Obligated Issuer, constitute Indebtedness under the Master Indenture; provided, however, that notwithstanding the foregoing, none of the following shall be deemed to constitute a Guaranty: (a) the endorsement in the ordinary course of business of negotiable instruments for deposit or collection; (b) rentals payable in future years under leases, other than leases properly capitalized under Generally Accepted Accounting Principles; (c) any indemnification agreement entered into by an Obligated Issuer in connection with surety bonds, performance bonds, bid bonds, material bonds, labor bonds, stay bonds, appeal bonds and other similar bonds except to the extent any of such bonds requires reimbursement of reserves; (d) any income maintenance agreement with or on behalf of physicians or employees of the Corporation or any Affiliate in connection with recruiting or other staff requirements; (e) the discount or sale with recourse of any such Person's notes

receivable or accounts receivable; and (f) any obligation of such Person guaranteeing or in effect guaranteeing any obligation of the primary obligor which does not constitute a sum certain.

"Improvements" means any additions, extensions, improvements, equipment, machinery or other facilities to, of or for the Existing Facilities or the Existing Real Property (other than those for which the Issuer shall issue the Series 2017 Bonds) and which constitute "hospital facilities" as defined in Section 140.01, Ohio Revised Code.

"Indebtedness" means, without duplication, (a) all indebtedness of the Obligated Group and each member thereof for borrowed moneys which is shown, under Generally Accepted Accounting Principles, on the balance sheet of that member as a liability; (b) all indebtedness for borrowed moneys, no matter how created, secured by Property (other than Excluded Property) of any member of the Obligated Group, whether or not such indebtedness is assumed by any member of the Obligated Group; (c) the liability of any member of the Obligated Group under any lease of real or personal property which is properly capitalized on the balance sheet of any member of the Obligated Group in accordance with Generally Accepted Accounting Principles; and (d) any Guaranty; provided that if more than one instrument represents the same obligation to make payments it shall be counted only once; and provided further that Indebtedness shall not include (i) payments required to be deposited into any reserve funds pursuant to the provisions of any indenture or other agreement securing Indebtedness or Related Bonds; (ii) any obligation owed by one member of the Obligated Group to another member of the Obligated Group; (iii) Non-Recourse Indebtedness; (iv) any continuing obligation of any member of the Obligated Group to pay principal of and interest on Indebtedness on Related Bonds which are deemed discharged or defeased in accordance with the agreement or instrument creating or evidencing such Indebtedness or Related Bonds; (v) any obligation to reimburse any Person for the payment of Indebtedness or the payment of debt service on any Related Bonds; (vi) dividends which have been declared with respect to stock of an Obligated Issuer unless and until such dividends shall remain unpaid on the date established for the payment thereof; (vii) Indebtedness for which moneys or obligations are on deposit in an irrevocable escrow and such moneys or obligations (including, where appropriate, the earnings or other investment to accrue thereon) are required to be applied solely to pay on a timely basis such amounts and such moneys or obligations so required to be applied are sufficient to pay such amounts; (viii) deferred compensation agreements between Obligated Issuers and employees of such Obligated Issuers, to the extent that payments under such deferred compensation agreements are secured by, or are otherwise to be made from, assets of such Obligated Issuers of equal or greater value, which are segregated for such purpose; (ix) accounts payable obligations of Obligated Issuers arising in the ordinary course of business; and (x) obligations of Obligated Issuers under Interest Rate Hedges. As of any date of computation, the principal amount of any Indebtedness arising from any Guaranty shall be deemed to be an amount calculated as follows:

(A) if at any time within the 18 months immediately preceding the computation date, the obligee of the guaranteed indebtedness shall have demanded that the guarantor pay all or a portion of principal of or interest on the guaranteed indebtedness, and if within thirty (30) calendar days of the guarantor's receipt of such demand the Obligated Group Representative shall have failed to deliver to the Master Trustee an Opinion of Counsel to the effect that the guarantor is not legally obligated to

honor such demand, then 100% of the outstanding principal balance of the guaranteed indebtedness; or

(B) otherwise, twenty percent (20%) of the then outstanding principal balance of the guaranteed indebtedness.

"Independent Certified Public Accountant" means an Independent Person qualified as a certified public accountant.

"Independent Consultant" means an Independent Person (which may be an Independent Certified Public Accountant) with experience in the health care field (or other appropriate experience if the Obligated Issuer is not in the health care field) appointed by the Obligated Group Representative and not unsatisfactory to the Master Trustee and while a Municipal Bond Insurance Policy shall be in full force and effect with respect to part or all of any series of Indebtedness or while a Bond Insurer shall own any Indebtedness, approved by such Bond Insurer, qualified to pass upon questions relating to the financial affairs of facilities of the type or types operated by the members of the Obligated Group and having a favorable reputation for skill and experience in the financial affairs of such facilities.

"Independent Engineer" means an Independent Person qualified to practice the profession of architecture or engineering.

"Independent Insurance Consultant" means any Independent Person, appointed by the Obligated Group Representative and not unsatisfactory to the Master Trustee or, while a Municipal Bond Insurance Policy shall be in full force and effect with respect to part or all of any series of Indebtedness or while a Bond Insurer shall own any Indebtedness, such Bond Insurer, qualified to survey risks and to recommend insurance coverage for facilities of the type or types operated by the members of the Obligated Group and services and organizations engaged in like operations and having a favorable reputation for skill and experience in such surveys and such recommendations.

"Independent Person" means a Person in which no partner (treating a shareholder of a professional association which is a partner as though such shareholder were a partner), director, officer or employee is a member, stockholder, partner, director, officer or employee of a member of the Obligated Group.

"Interest Account" means the separate account in the Bond Fund by that name created by the Bond Indenture.

"Insured Bonds" means any series of Related Bonds the payment of principal and interest on which is insured by a Bond Insurer.

"Insured Indebtedness" means any series of Indebtedness the payment of principal and interest on which is insured by a Bond Insurer.

"Interest Rate Exchange Agreement" means an agreement, commonly known as an "interest rate swap," whereby an Obligated Issuer agrees with another Person to pay such Person interest on a mutually agreed-upon notional amount in exchange for such Person's agreement to

pay that Obligated Issuer interest on such amount, all at such interest rates and over such periods of time as may be mutually agreed upon; provided, however, that no such agreement shall entail any exchange of principal or any assumption of liability for the payment of the principal of or interest on any particular indebtedness of that Obligated Issuer or such other Person, as the case may be.

"Interest Rate Hedge" means an agreement, expressly identified in an Officer's Certificate as being entered into in order to hedge the interest payable on all or a portion of any Indebtedness, which agreement may include, without limitation, an Interest Rate Exchange Agreement, a forward or futures contract or an option (e.g. a call, put, cap, floor or collar) and which agreement does not constitute an obligation to repay money borrowed, credit extended or the equivalent thereof.

"Interim Indebtedness" means Indebtedness incurred or assumed in anticipation of being refinanced or refunded with Long-Term Indebtedness.

"Issuer" means the City of Chillicothe, Ohio.

"Lease" means the Agreement of Lease, dated as of June 1, 2017 by and between the Corporation and the Issuer.

"Lien" means any Mortgage or other encumbrance on, any property of any Obligated Issuer which secures any Indebtedness or any other obligation of any Obligated Issuer other than an obligation to any other Obligated Issuer; provided, however, that any lien applicable to Property in which any Obligated Issuer has only a leasehold interest shall be deemed a "Lien" only if such lien secures Indebtedness.

"Long-Term", when used in connection with Indebtedness, means Indebtedness (including that evidenced or collateralized by Notes) having an original maturity greater than one year (including demand notes with alternative stated maturities of less than one year unless and until a demand for the payment thereof shall have been made) or renewable at the option of the obligor for a period greater than one year from the date of original incurrence or issuance thereof, which shall not include the current portion of such Long-Term Indebtedness as determined in accordance with Generally Accepted Accounting Principles.

"Master Trustee" means The Huntington National Bank.

"Maximum Annual Debt Service", as used in the Master Indenture, means the aggregate maximum annual scheduled payments of principal (including mandatory sinking fund redemption requirements) and interest on Long-Term Indebtedness, computed in accordance with clauses (a) through (j) of the definition of Debt Service Coverage Ratio due in any succeeding Fiscal Year.

"Mortgage" means any mortgage, deed of trust, collateral assignment of lease, security interest and other lien, charge or encumbrance on or pledge of Property given as security for the payment of Indebtedness or the performance of other obligations.

"Municipal Bond Insurance Policy" means the policy of a Bond Insurer with respect to the Insured Indebtedness or Insured Bonds, providing for the payment of that portion of the principal of and interest on the Insured Indebtedness or Insured Bonds which shall become due for payment but shall be unpaid by reason of nonpayment by the issuer of such Insured Indebtedness or Insured Bonds.

"Net Income Available for Debt Service" means, with respect to any period of calculation, the excess of total Adjusted Annual Revenue of the Obligated Group over total expenses of the Obligated Group (including without limitation all property, franchise, income, sales, use and other taxes, assessments and governmental charges) other than (i) expenses directly incurred with respect to Property the acquisition of which has been financed from the proceeds of Non-Recourse Indebtedness, (ii) depreciation, amortization and interest on Long-Term Indebtedness (including the current portion thereof) and (iii) all Federal, state and local taxes assessed with respect to the income of any member of the Obligated Group if and to the extent that such income shall not have been included in the determination of Adjusted Annual Revenue, all as determined in accordance with Generally Accepted Accounting Principles consistently applied and as applied in the manner provided in the Master Indenture, which may be determined on a consolidated or combined basis, but excluding from Adjusted Annual Revenue: (a) material balances and transactions between or among members of the Obligated Group; (b) all insurance proceeds payable as a result of casualty or other similar circumstances (other than the proceeds of medical and health insurance received for services rendered by a member of the Obligated Group or by a physician on behalf of such member, the proceeds of casualty insurance but only to the extent that the loss resulting from the casualty is included in the total expenses of the Obligated Group with respect to the period in question, and the proceeds of business interruption insurance); (c) gains and losses from the sale of capital assets; (d) gains and losses attributable to refundings, advance refundings and other early extinguishments of Indebtedness or Non-Recourse Indebtedness; (e) unrealized gains and losses on investments; (f) changes in the value of Interest Rate Hedges; and (g) all other noncash revenue or expense transactions.

"Non-Recourse Indebtedness" means any Indebtedness secured by and payable from sources limited solely to the revenues and/or Property associated with the project financed by such Indebtedness; provided, however, that the instrument evidencing such Indebtedness shall provide that it is with no recourse, directly or indirectly, to any other Property (except Excluded Property) or revenues of any member of the Obligated Group; provided, however, that such Property (except Excluded Property) shall not be Property to which any member of the Obligated Group has title as of the date of delivery of the Master Indenture.

"Note" means any Note issued, authenticated and delivered under the Master Indenture. References to Notes of a series or such series shall mean the Notes or series issued pursuant to, and in the form set forth in, the Related Supplemental Indenture authorizing their issuance.

"Noteholder" or "holder of Notes" or "owner of Notes" means the Registered Owner of a Note.

"Obligated Group" means all Obligated Issuers.

"Obligated Group Representative" means any one of such officer or officers of the Corporation as may be designated pursuant to a written notice delivered to the Master Trustee executed on behalf of the Corporation by the president, any vice president or treasurer.

"Obligated Issuer" means the Corporation, Adena Medical Group, LLC and any Person which has become an Obligated Issuer under the Master Indenture.

"Officer's Certificate" means, in the case of any Obligated Issuer which is a corporation, a certificate signed by the president or any vice president of such Obligated Issuer; in the case of the entire Obligated Group, by the Obligated Group Representative; or in the case of any Obligated Issuer which is not a corporation, by the managing partner or other Person in which the power to act on behalf of such Person is vested by law, the organizational documents of such Obligated Issuer or by subsequent action of its governing body.

"Opinion of Bond Counsel" means an opinion in writing signed by a firm of attorneys which shall be nationally recognized as experienced in matters pertaining to the validity of obligations of governmental issuers (as such term is defined within the definition of the term "Related Bonds") and the exemption from Federal income taxation of interest on such obligations.

"Optional Tender Indebtedness" means any portion of Indebtedness a feature of which is an option on the part of the holders of such Indebtedness to tender for purchase at a stated purchase price prior to its stated due date all or a portion of such Indebtedness to one or more members of the Obligated Group or an agent, or a trustee or other fiduciary for such holders, or other party whom one or more members of the Obligated Group are obligated to reimburse.

"Outstanding" or "Series 2017 Bonds Outstanding", as used in the Bond Indenture, means all Series 2017 Bonds which have been duly authenticated, and delivered by the Bond Trustee under the Bond Indenture, except:

(a) Series 2017 Bonds cancelled after purchase in the open market or because of payment at or redemption prior to maturity;

(b) Series 2017 Bonds paid or deemed to be paid under the Bond Indenture;

(c) Series 2017 Bonds in lieu of which others have been authenticated under the Bond Indenture; and

(d) Series 2017 Bonds owned by any member of the Obligated Group.

"Permitted Encumbrances" means:

(a) Liens created by the Master Indenture or any Supplemental Indenture, all Related Bond Indentures and any loan, lease, sublease, guaranty, sale or similar agreement entered into in connection with the issuance of and providing for or securing the payment of Related Bonds or any reimbursement agreement, liquidity facility or Interest Rate Hedge related to the above;

(b) Liens arising by reason of good faith deposits by any Obligated Issuer in connection with tenders, leases of real estate, or tangible personal property, bids or contracts (other than contracts for the payment of money), deposits by any Obligated Issuer to secure public or statutory obligations, or as security for a Bond Insurer or an issuer of, or in lieu of, Bond Insurer, performance bonds, bid bonds, material bonds, labor bonds, stay bonds, appeal bonds or other similar bonds and deposits as security for the payment of taxes or assessments or other similar charges;

(c) any Lien arising by reason of deposits with, or the giving of any form of security to, any governmental agency or any body created or approved by law or governmental regulation for any purpose at any time as required by law or governmental regulation (i) as a condition to the transaction of any business or the exercise of any privilege or license, or (ii) to enable any Obligated Issuer to maintain self-insurance or to participate in any funds established to cover any insurance risks or in connection with worker's compensation, unemployment insurance, old age pension or other social security, or to share in the privileges or benefits required for companies participating in such arrangements;

(d) any judgment Lien against any Obligated Issuer, so long as the finality of such judgment is being contested and execution thereon is stayed or provision for payment of the judgment has been made in accordance with applicable law or by the deposit of cash or Federal Securities with the Master Trustee or a commercial bank or trust company acceptable to the Master Trustee;

(e) (i) rights reserved to or vested in any municipality or public authority by the terms of any right, power, franchise, grant, license, permit or provision of law, affecting any Property, to (A) terminate such power, franchise, grant, license or permit, or (B) purchase, condemn, appropriate or recapture, or designate a purchaser of, such Property; (ii) any Liens on any Property for taxes, assessments, levies, fees, water and sewer rents, and other governmental and similar charges and any liens of mechanics, materialmen, laborers, suppliers or vendors for work or services performed or materials furnished in connection with such Property, which are not due and payable or which are not delinquent or which, or the amount or validity of which, are being contested and execution thereon is stayed; (iii) easements, rights-of-way, servitudes, restrictions and other defects, encumbrances, and irregularities in the title to any Property which do not materially impair the use of such Property or materially and adversely affect the value thereof (for purposes of this clause (iii) the absence of such material impairment or such material and adverse effect can be conclusively established by an Officer's Certificate delivered to the Master Trustee); (iv) rights reserved to or vested in any municipality or

public authority to control or regulate any Property or to use such Property in any manner; and (v) landlord's liens;

(f) encumbrances arising from grants, loans or guarantees of the United States of America pursuant to 42 U.S.C. §291 et seq. (the "Hill-Burton Act") or 42 U.S.C. §300 et seq.; and other existing encumbrances arising from grants or loans from, or guarantees of Indebtedness by Federal, state and local governments or agencies thereof certified in an Officer's Certificate to be similar in nature to the encumbrances described in the first part of this clause (f);

(g) Liens for taxes and special assessments not then delinquent or being contested in accordance with the provisions of the Master Indenture;

(h) any Mortgage permitted by the Master Indenture;

(i) any lease or sublease of real or personal property or space within its real or personal property to any Person; provided that where the application of Generally Accepted Accounting Principles would require the Person leasing such real or personal property or such space from any member of the Obligated Group to treat the lease as Indebtedness (were such Person a member of the Obligated Group), the lease or sublease shall be treated as a disposition of Property by a member of the Obligated Group which must qualify under paragraphs (a) or (b) under the caption "SUMMARY OF THE MASTER INDENTURE – Covenants of the Obligated Group - Restrictions on Transfers of Property";

(j) other mortgages, security interests, liens, charges and encumbrances expressly permitted by the terms of the Master Indenture;

(k) reservations contained in patents from the United States of America;

(l) Liens existing on Property when received by an Obligated Issuer through gifts, grants or bequests; provided that no such Lien may be extended, renewed or modified so as to apply to any Property of any Obligated Issuer not previously subject to such Liens, unless such Lien, as so extended, renewed or modified otherwise qualifies as a Permitted Encumbrance under the Master Indenture;

(m) Liens on moneys deposited by patients or others with any Obligated Issuer as security for or as prepayment for the cost of patient care;

(n) Liens on Current Assets due to rights of third party payors for recoupment of amounts paid to any Obligated Issuer;

(o) Liens, encumbrances and other matters affecting title existing on the date of execution and delivery of the Master Indenture which are described in the Master Indenture;

(p) Liens in favor of a lessor, vendor, or lender extending credit to an Obligated Issuer (including, without limitation, any Related Bond Trustee or Related

Issuer with respect to Indebtedness permitted under the Master Indenture) for the acquisition by an Obligated Issuer of the Property which is the subject of the Lien (whether or not such Lien constitutes a purchase money mortgage or purchase money security interest under applicable state or local law), the acquisition of which Property has not been financed, directly or indirectly, with moneys representing the proceeds of Notes or Related Bonds, which Liens may be prior to, or on a parity with, the lien of the Master Indenture;

(q) Liens which are security only for Non-Recourse Indebtedness and which do not extend to any Property other than that acquired with the proceeds of Non-Recourse Indebtedness and revenues derived therefrom;

(r) Liens on the Property of a Person (other than the Corporation or any other Person who or which on the date of execution and delivery of the Master Indenture is an Affiliate) which Liens exist on the date such Person shall become a member of the Obligated Group and Liens existing on the date Property, which has not theretofore been owned by any member of the Obligated Group or by an Affiliate, is acquired by a member of the Obligated Group;

(s) Liens on Excluded Property, which Liens may be prior to, or on a parity with, the lien of the Master Indenture;

(t) Any other Mortgage provided that the aggregate Book Value of the Property of the Obligated Group securing all Mortgages under this clause (t) does not, after giving effect to the Mortgage then to be imposed, exceed 3% of the Book Value of all Property (excluding Current Assets and Excluded Property) of the Obligated Group.

(u) Any Lien on accounts receivable arising as a result of the sale or pledge of such accounts receivable with or without recourse, provided that the aggregate principal amount of Indebtedness secured by any such Lien does not exceed by more than 5% the aggregate face amount of all of the Obligated Group's accounts receivable;

(v) Any other Lien created or incurred in the ordinary course of business that does not secure, directly or indirectly, Indebtedness and that, individually or in the aggregate, does not materially impair the value or the utility of the Property subject to such Lien or encumbrance;

(w) Any Lien on proceeds of Indebtedness (or on income from the investment of such proceeds) that secure payment of such Indebtedness, including any money or obligations deposited to fund a debt service fund in an amount not exceeding the amount of the Indebtedness to which such debt service fund relates plus a reasonable carryover amount or deposited to a reserve fund in accordance with the instrument under which such Indebtedness may be secured;

(x) Any Lien on debt instruments owned by such Person which have been purchased under a credit or liquidity facility issued to secure or support other Indebtedness or Related Bonds;

(y) Any Lien resulting from pooling, utilization, repressurization, community and other types of agreements and leases relating to the exploration, development, operation, sale or conservation of minerals or other natural resources, including, without limitation, oil, gas, coal, liquid or gaseous hydrocarbons, sale, sulfur and metal that do not materially impair the use of such Property for its intended purpose or materially and adversely affect the value thereof; provided, that such member of the Obligated Group which owns the Property which contains the minerals or other natural resources has delivered an Officer's Certificate evidencing that the Governing Body of such member of the Obligated Group has determined that performance of such agreement or lease will not so impair such use or adversely affect such value;

(z) Any Lien on Current Assets of any member of the Obligated Group securing any Interest Rate Hedge; and

(aa) Any Lien on Current Assets to secure lines of credit or similar instruments whereby an Obligated Issuer draws on such instrument from time to time, to the extent that the Fair Market Value of the Current Assets so encumbered does not exceed 20% of the Fair Market Value of all Current Assets of the Obligated Group, determined at the time such Lien is imposed.

"Person" means an individual, a corporation, a partnership, an association, a joint stock company, a joint venture, a trust, an unincorporated organization, or a government or any agency or political subdivision thereof.

"Principal Fund" means the separate account in the Bond Fund by that name created by the Bond Indenture.

"Prior Bonds" means means the $142,970,000 County of Ross, Ohio Hospital Facilities Revenue Refunding Bonds, Series 2008 (Adena Health System) dated September 17, 2008.

"Project Fund" means the City of Chillicothe, Ohio (Adena Health System Obligated Group Project) Project Fund, a special fund created and so designated by the provisions of the Bond Indenture.

"Property", when used in connection with a particular Person or group of Persons, means any and all rights, titles and interests of a particular person or group of persons in and to any and all property, whether real or personal, tangible or intangible, and wherever situated.

"Property, Plant and Equipment" means all Property of the members of the Obligated Group which is property, plant and equipment under Generally Accepted Accounting Principles.

"Qualified Investments" means dollar denominated investments in any of the following:

(a) Government Obligations;

(b) debt obligations which are (i) issued by any state or political subdivision thereof or any agency or instrumentality of such state or political subdivision, and (ii) at the time of purchase, rated "AAA" by Standard & Poor's Rating Services ("Standard &

Poor's") and rated "Aaa" by Moody's Investors Services ("Moody's") without regard to any refinement or gradation of rating category by numerical modifier or otherwise;

(c) any bond, debenture, note, participation certificate or other similar obligation which is either (i) issued by the Federal National Mortgage Association, the Federal Home Loan Bank System, the Federal Home Loan Mortgage Corporation, the Federal Farm Credit Bank, or (ii) backed by the full faith and credit of the United States of America;

(d) U.S. denominated deposit accounts, trust deposits, demand deposits, including interest bearing money market accounts and banker's acceptances with domestic commercial banks, including the Bond Trustee and any of its affiliates, which have a rating on their short-term certificates of deposit on the date of purchase of "A-1+" by Standard & Poor's or "P-1" by Moody's, without regard to gradation, and which matures not more than 360 days after the date of purchase;

(e) commercial paper which is rated at the time of purchase within the classification or higher, "A-1" by Standard & Poor's or "P-1" by Moody's, without regard to gradation, and which matures not more than 270 days after the date of purchase;

(f) investment agreements with banks, including the Bond Trustee and any of its affiliates, that at the time such agreement is executed are rated by Standard & Poor's and Moody's in one of the two highest rating categories assigned by Standard & Poor's and Moody's (without regard to any refinement or gradation of rating category by numerical modifier or otherwise) or investment agreements with non-bank financial institutions which, (1) all of the unsecured, direct long-term debt of either the non-banking financial institution or the related guarantor of such non-bank financial institution that is rated by Standard & Poor's and Moody's at the time such agreement is executed is rated in one of the two highest rating categories (without regard to any refinement or gradation of rating category by numerical modifier or otherwise) for obligations of that nature; or (2) if such non-bank financial institutions have no outstanding long-term debt that is rated, all of the short-term debt of either the non-banking financial institution or the related guarantor of such non-bank financial institution that is rated by Standard and Poor's and Moody's in the highest rating category (without regard to any refinement or gradation of the rating category by numerical modifier or otherwise) assigned to short term indebtedness by Standard & Poor's and Moody's;

(g) repurchase agreements with respect to and secured by United States Treasury obligations or obligations of the Government National Mortgage Association ("GNMA"), the Federal National Mortgage Association ("FNMA") or the Federal Home Loan Mortgage Corporation ("FHLMC"), which agreements may be entered into with a bank (including without limitation the Master Trustee or the Bond Trustee or any their affiliates), a trust company, financial services firm or a broker dealer which is a member of the Securities Investors Protection Corporation, provided that (i) the Bond Trustee or a custodial agent of the Bond Trustee has possession of the collateral and that the collateral is, to the knowledge of the Bond Trustee, free and clear of third party claims, (ii) a master

repurchase agreement or specific written repurchase agreement governs the transaction, (iii) the collateral securities are valued no less frequently than monthly, and (iv) the fair market value of the collateral securities in relation to the amount of the repurchase obligation, including principal and interest, is equal to at least 102%, if the collateral securities consist of United States Treasurer Obligations, 103%, if the collateral securities consist of obligations of GNMA, and 104%, if the collateral securities consist of obligations of FNMA or FHLMC, and (v) such obligations must be held in the custody of the Bond Trustee or the Bond Trustee's agent; and

(h) investments in a money market fund rated "AAAm" or "AAAm-G" or better by Standard & Poor's, including without limitation, investments in a money market fund rated "AAAm" or "AAAm-G" or better by Standard & Poor's, including those advised by any affiliate of the Bond Trustee, which affiliate receives a fee, provided that such funds shall be invested solely in obligations or securities as described in clauses (a) through (h) above, or any other mutual fund for which the Bond Trustee or an affiliate of the Bond Trustee serves as investment manager, administrator, shareholder, servicing agent, and/or custodian or subcustodian, notwithstanding that (a) the Bond Trustee or an affiliate of the Bond Trustee receives fees from such funds for services rendered, (b) the Bond Trustee charges and collects fees for services rendered pursuant to the Bond Indenture, which fees are separate from the fees received from such funds, and (c) services performed for such funds and pursuant to the Bond Indenture may at times duplicate those provided to such funds by the Bond Trustee or its affiliates.

"Rating Category" or "Rating Categories" means one or more of the generic rating categories of a Rating Service without regard to any refinement or gradation of such rating category or categories by numerical modifier or otherwise.

"Rating Service", as used in the Bond Indenture, means Moody's, if the Series 2017 Bonds are rated by such at the time, and Standard & Poor's, if the Series 2017 Bonds are rated by such at the time, and their successors and assigns, or if either shall be dissolved or no longer assigning credit ratings to long-term debt, then any other nationally recognized entity assigning credit ratings to long-term debt designated by the Obligated Group Representative.

"Rating Service," as used in the Master Indenture, means Moody's Investors Service and Standard & Poor's Ratings Group, a division of The McGraw-Hill Corporations, both corporations and organized under the laws of the States of Delaware and New York, respectively, and their successors and assigns, or if either shall be dissolved or no longer assigning credit ratings to long-term debt, then any other nationally recognized entity assigning credit ratings to long-term debt designated by the Obligated Group Representative and satisfactory to the Bond Trustee.

"Rebate Fund" means the fund by that name created under the Tax Regulatory Agreement.

"Real Property" means that Property which under the laws of the jurisdiction in which such Property is located is deemed to be "real property".

"Refunding Indebtedness" means any Indebtedness issued for the purpose of refunding outstanding Interim Indebtedness or Long-Term Indebtedness.

"Related Bonds" means the bonds or other obligations issued by any Obligated Issuer or any state of the United States of America or any municipal corporation or political subdivision formed under the laws thereof or any body corporate and politic or any constituted authority of any of the foregoing empowered to issue obligations on behalf thereof ("governmental issuer") pursuant to a single Related Bond Indenture, the proceeds of which are loaned or otherwise made available to or for the benefit of (a) one or more members of the Obligated Group, directly or indirectly, in consideration, in whole or in part, of the execution, authentication and delivery of a Note or Notes to or for the order of such governmental issuer or the Related Bond Trustee or (b) any Person other than the Corporation or any other Obligated Issuer in consideration of issuance to such governmental issuer or trustee for such obligations (i) by such person or any indebtedness or other obligation of such person and (ii) by the Corporation or any other Obligated Issuer of a Guaranty issued under the Master Indenture in respect of such indebtedness or other obligation.

"Related Bond Indenture" means any instrument pursuant to which a series of Related Bonds is issued.

"Related Bond Trustee" means the trustee and its successors under any Related Bond Indenture.

"Related Issuer" means the issuer of any issue of Related Bonds.

"Related Supplemental Indenture", when used with reference to Notes of a particular series, means the Supplemental Indenture creating such series.

"Series 2017 Bonds" means the $145,570,000 Hospital Facilities Revenue Refunding and Improvement Bonds, Series 2017 (Adena Health System Obligated Group Project) of the Issuer dated as of their date of issuance.

"Series 2017A Note" means the Adena Health System Series 2017A Note dated the date of delivery, issued under the Master Indenture to secure the payment of the Series 2017 Bonds.

"Series 2017B Note" means the Adena Health System Series 2017B Note dated the date of delivery, issued under the Master Indenture to secure the payment of a taxable loan provided by PNC Bank, N.A.

"Short-Term", when used in connection with Indebtedness (including Notes), means having an original maturity less than or equal to one year and not renewable at the option of the obligor for a term greater than one year beyond the date of original incurrence or issuance.

"Significant Obligated Issuer" means any member of the Obligated Group which for the three Fiscal Years (for which financial statements are available) immediately preceding the occurrence of certain events of bankruptcy or insolvency involving such member or preceding the withdrawal of such member from the Obligated Group, as the case may be, either shall have had average Adjusted Annual Revenue (determined solely with reference to such member)

greater than or equal to 5% of the average Adjusted Annual Revenue for such three Fiscal Years or shall have owned or leased Property having a Book Value greater than or equal to five percent (5%) of the Book Value of the Property of the Obligated Group for such three Fiscal Years.

"Sublease" means the Sublease dated as of June 1, 2017 between the Issuer and the Corporation.

"Subordinated Indebtedness" means Indebtedness (including Notes) which contains provisions substantially in the form set forth in Exhibit A to the Master Indenture.

"State" means the State of Ohio.

"Supplemental Indenture" means an indenture supplemental to, and authorized and executed pursuant to the terms of, the Master Indenture for the purpose of creating a particular series of Notes issued thereunder, or amending or supplementing the terms thereof.

"Value" means, with respect to any Property of the Obligated Group, at the option of the Obligated Group Representative, either the Book Value thereof or the Fair Market Value thereof.

"Variable Rate Indebtedness" means any portion of Indebtedness the rate of interest on which is not established at the time of incurrence as one or more numerical rates applicable throughout the term thereof or for specified periods during the term thereof, with the result that at the time of incurrence the numerical rate of interest which will be in effect during any portion of the term thereof cannot be determined.

SUMMARY OF THE MASTER INDENTURE

Accounting Principles

If the character or amount of any asset or liability or item of income or expense is required to be determined, or any consolidation, combination or other accounting computation is required to be made for the purposes of the Master Indenture or any agreement, document or certificate executed and delivered in connection with or pursuant to the Master Indenture, that determination or computation shall be made in accordance with Generally Accepted Accounting Principles in effect on, at the sole option of the Obligated Group Representative, (i) the date such determination or computation is made for any purpose of the Master Indenture, or (ii) the date of signing and delivery of the Master Indenture, if in the case of clause (ii) the Obligated Group Representative delivers an Officer's Certificate to the Master Trustee describing why the then-current Generally Accepted Accounting Principles is inconsistent with the intent of the parties on the date of signing and delivery of the Master Indenture; provided that the requirements set forth herein shall prevail if inconsistent with Generally Accepted Accounting Principles. For the purpose of preparing consolidated or combined financial information for two or more entities, transactions between those entities shall be eliminated and the specific provisions of the Master Indenture shall prevail over any inconsistent Generally Accepted Accounting Principles. Unless otherwise expressly provided herein, for the purpose of determining the amount of assets, liabilities, equity or capital, or revenues, expenses, income, losses or gains of an Obligated Issuer or the Obligated Group the amount of the respective item shall be determined on a consolidated basis, in accordance with Generally Accepted Accounting Principles, consistently applied. For

the purpose of determining any consolidated financial information with respect to an Obligated Issuer, or the Obligated Group, any reference shall be made, unless that information is otherwise available as audited on a combined or consolidated basis, to audited combining or consolidating financial information set forth as other financial information within an audit report in which audited financial statements are set forth on a consolidated or combined basis that reflects financial information of one or more entities that are not to be taken into account hereunder in the determination of financial information with respect to an Obligated Issuer, or the Obligated Group, for the same Fiscal Year. For the avoidance of doubt, it is the intent of the parties on the date of the signing and delivery of the Master Indenture that any operating lease, as defined by the Financial Accounting Standards Board on the date of signing and delivery of the Master Indenture, and any renewal of such operating lease, shall be governed in accordance with Generally Accepted Accounting Principles in effect on the date of signing and delivery of the Master Indenture and shall not be treated as the incurrence of Indebtedness or the disposition of Property, unless otherwise elected by the Obligated Group Representative.

Authorization and Issuance of Notes

There is no limit on the aggregate principal amount of Notes that may be issued, but no Notes may be issued unless the provisions of the Master Indenture are followed.

Covenants of the Obligated Group

Each member of the Obligated Group covenants that for so long as any Note is outstanding:

Payment of Principal, Premium and Interest; Interest on Overdue Payments. It shall duly and punctually pay the principal of, the premium, if any, and the interest on each Note at the times and at the place and in the manner provided in such Note, the Related Supplemental Indentures and the Master Indenture. If any such payment is not so received, the Master Trustee shall notify the Obligated Group Representative by telephone, telegram, express mail or other expeditious means. To the extent permitted by applicable law, each Note shall bear interest, at the rate specified in the Related Supplemental Indenture, on any part of the principal thereof or the premium, if any, or interest thereon not paid when due for any period when the same shall be overdue.

Insurance. It shall maintain insurance covering such risks and in such amounts as, in its reasonable judgment, is adequate to protect it and its properties and operations. Each member of the Obligated Group which owns or operates hospital facilities or other health care facilities shall also maintain insurance covering the risk of professional and medical malpractice in such amounts as, in its reasonable judgment, taking into account any self-insurance, is adequate to protect it and its operations. The insurance required to be maintained pursuant to the Master Indenture shall be subject to the biennial review and approval of an Independent Insurance Consultant, and such member shall follow any recommendations of the Independent Insurance Consultant to the extent feasible.

An Obligated Issuer may, upon resolution adopted in good faith by its Governing Body and upon the recommendations of an Independent Insurance Consultant, adopt alternative risk

management programs which shall be in compliance with applicable governmental rules and regulations including, without limitation, the right: to self-insure in whole or in part; to organize captive insurance companies; to participate in programs of captive insurance companies organized by others; to establish self-insurance trust funds; to participate in mutual or other cooperative insurance or other risk management programs with others; to participate in or enter into agreements with local, state or federal governments in order to achieve such insurance; to take advantage of state or federal statutes or laws limiting medical and malpractice liability; or to participate in other alternative risk management programs as shall be recommended by such Independent Insurance Consultant.

Tax Exempt Status. It shall not take any action or omit to take any action which is lawful and within its power to take, and which, if taken or omitted, would cause previously tax-exempt interest on any series of Related Bonds to become subject to Federal income taxation.

Restrictions as to Incurrence of Indebtedness. Other than in connection with the issuance of the Existing Notes, the Series 2017A Note and the Series 2017B Note under the Master Indenture, it will incur Indebtedness only as follows; provided that (1) at the time of incurrence thereof no Event of Default or event which with notice or lapse of time, or both, would constitute an Event of Default shall have occurred or be continuing unless such event will be cured upon incurrence of such Indebtedness and application of the proceeds thereof and the placing in service of any facilities hereby, and (2) prior to the incurrence thereof the Obligated Group Representative's certificate to the effect that the Obligated Group has given its consent to the incurrence of such indebtedness in accordance with the agreements and rules of the Obligated Group with respect to matters arising under the Master Indenture shall be delivered to the Master Trustee:

(a) Long-Term Indebtedness provided that:

(1) such Obligated Issuer shall certify in an Officer's Certificate delivered to the Master Trustee the intended uses of the proceeds of such Long-Term Indebtedness and, if such intended uses include the acquisition or improvement of Real Property, the estimated cost thereof; and

(2) such Obligated Issuer shall have delivered to the Master Trustee either:

(i) A report or opinion of an Independent Certified Public Accountant to the effect that for the most recent Fiscal Year for which financial statements are available, the Debt Service Coverage Ratio was not less than 1.20 for all Outstanding Long-Term Indebtedness (exclusive of any Outstanding Indebtedness which is to be refunded with proceeds of the Indebtedness proposed to be incurred) and the Long-Term Indebtedness then proposed to be incurred; or

(ii) The following reports or opinions:

(x) a report or opinion of an Independent Certified Public Accountant to the effect that for the most recent

Fiscal Year for which financial statements are available, the Debt Service Coverage Ratio was not less than 1.20 for all Outstanding Long-Term Indebtedness other than the Long-Term Indebtedness then proposed to be incurred; and

(y) a report or opinion of an Independent Consultant to the effect that the estimated Debt Service Coverage Ratio for the first full Fiscal Year following the completion of the acquisition, construction, renovation or replacement being paid for with the proceeds of such additional Long-Term Indebtedness, or following the incurrence of Long-Term Indebtedness for other purposes, is not less than 1.25 for all Long-Term Indebtedness to be Outstanding after giving effect to the incurrence of such additional Long-Term Indebtedness and the application of the proceeds thereof; provided that an Officer's Certificate may be delivered instead of a report or opinion of an Independent Consultant if the estimated Debt Service Coverage Ratio is not less than 1.40; or

(iii) an Officer's Certificate that as of the date of the incurrence of such Long-Term Indebtedness the sum of the proposed Long-Term Indebtedness and the existing Long-Term Indebtedness of the Obligated Group does not exceed 66-2/3% of the Capitalization of the Obligated Group; or

(iv) an Officer's Certificate that the aggregate principal amount of Long-Term Indebtedness incurred in reliance on the test set forth in this clause (iv) that is Outstanding on the date of delivery of such Officer's Certificate, plus the Long-Term Indebtedness then proposed to be incurred in reliance on the test set forth in this clause (iv), does not exceed 10% of the Adjusted Annual Revenue for the most recent Fiscal Year preceding the date of the proposed issuance of such Long-Term Indebtedness for which audited financial statements are available; provided, however, that, for purposes of this subparagraph (iv), Indebtedness represented by a Guaranty shall be calculated as equal to 20% of the outstanding principal amount of the obligation guaranteed, so long as no member of the Obligated Group has made any payments pursuant to such Guaranty within 18 months preceding the date of calculation, and otherwise shall be calculated as equal to 100% of the outstanding principal amount of the obligation guaranteed.

In the event that an Independent Consultant shall deliver a report to the Trustee to the effect that Governmental Regulations do not permit or by their application make it impracticable for the Obligated Group to produce the required ratios set forth in subparagraph (a)(2) above, then such ratios shall be reduced to the highest practicable ratios then permitted by such Governmental Regulations but in no event less than 1.00.

(b) Completion Indebtedness.

(c) Refunding Indebtedness (i) which has Maximum Annual Debt Service no greater than 120% of the Maximum Annual Debt Service of the Indebtedness refunded thereby, (ii) which results in a reduction in total debt service or (iii) which will be used to refund Interim Indebtedness described in subparagraph (f) below.

(d) Short-Term Indebtedness; provided that (i) the combined Outstanding principal amount of such Short-Term Indebtedness does not exceed fifteen percent (15%) of the Adjusted Annual Revenue as shown on or calculable from the audited financial statements of the Obligated Group for the most recent Fiscal Year for which financial statements are available, or (ii) if the combined Outstanding principal amount of Indebtedness incurred pursuant to this subparagraph shall at any time thereafter exceed the fifteen percent (15%) limitation, then the combined Outstanding principal amount of Indebtedness incurred pursuant to this subparagraph shall be reduced to an amount not exceeding such fifteen percent (15%) limitation not later than ninety (90) days after the date such limitation shall have been exceeded.

(e) Non-Recourse Indebtedness.

(f) Interim Indebtedness provided that, at the time such Interim Indebtedness is incurred or assumed, there shall be delivered to the Master Trustee:

(i) an Officer's Certificate setting forth the information required by paragraph (a)(1) above and an Officer's Certificate stating that the anticipated financing thereof by the issuance of Long-Term Indebtedness is reasonably expected to be completed within the next sixty (60) months; and

(ii) reports or opinions of the type required by any of the subparagraphs (a)(2)(i) through (a)(2)(iv) above demonstrating that all requirements of such subparagraphs would be met if such Interim Indebtedness were then being issued as Long-Term Indebtedness maturing over a term equal to the Assumed Amortization Period with level annual combined payments of principal and interest and having an interest rate equal to the Assumed Interest Rate.

(g) Subordinated Indebtedness.

(h) Any continuing obligation of any member of the Obligated Group to pay principal of and interest on Indebtedness or Related Bonds which are deemed to be discharged or defeased in accordance with the terms of the instrument or instruments creating or evidencing such Indebtedness or Related Bonds, as the case may be; provided, however, that there is delivered to the Master Trustee a letter from a nationally recognized firm of Independent Certified Public Accountants verifying the adequacy of any escrow established in connection with the discharge or defeasance of such Indebtedness or Related Bonds.

(i) Indebtedness which constitutes Indebtedness for which money for the payment of which is on deposit in a construction fund or another restricted fund.

(j) Indebtedness of any member of the Obligated Group to any other member thereof.

(k) Indebtedness representing a loan to any member of the Obligated Group of moneys on deposit in accumulated capital reserve accounts or depreciation reserve accounts created under Supplemental Master Indentures or Related Bond Indentures.

Completion Indebtedness, Refunding Indebtedness, Non-Recourse Indebtedness and Subordinated Indebtedness which would otherwise be Long-Term Indebtedness shall not be subject to the tests in (a) above of this caption "Restrictions as to Incurrence of Indebtedness", unless the Obligated Group elects to treat such Indebtedness as issued as Long-Term Indebtedness pursuant to (a) above. In addition, any Indebtedness issued or guaranteed by any member of the Obligated Group pursuant to any of the preceding paragraphs may at any time and from time to time, if the same shall be permitted to be issued or guaranteed pursuant to another paragraph, be reclassified by the Obligated Group as having been issued or guaranteed by the member pursuant to such other paragraph.

For purposes of the Master Indenture:

(i) Indebtedness shall generally be deemed to be "incurred" by a Person whenever such Person shall create, assume, guarantee, or otherwise become liable in respect thereof;

(ii) the sale or other transfer of indebtedness of any member of the Obligated Group by the member which holds such indebtedness to any Person not a member of the Obligated Group shall be deemed to be the incurrence of Indebtedness as of the date of sale or transfer;

(iii) outstanding Indebtedness of any Person which becomes a member of the Obligated Group shall be deemed to be incurred on the date such Person becomes a member; and

(iv) in the case of Indebtedness which is subject to conversion, at the option of the Obligated Group, with respect to term and interest rate, any such conversion shall be deemed not to be the incurrence of Indebtedness.

Debt Service Coverage Ratio. If the Debt Service Coverage Ratio as calculated at the end of any Fiscal Year is below 1.20, the Obligated Group covenants to retain within six months of the end of such Fiscal Year an Independent Consultant to make recommendations (which may include, without limitation, increasing rates and charges, reducing operating costs, adjusting the patient mix, altering the intensity or scope of services or any combination of the foregoing) to increase the Debt Service Coverage Ratio to at least 1.20 or if, in the opinion of the Independent Consultant, achieving such coverage is impracticable due to law or regulation then in effect, to the highest practicable level permitted by such laws or regulations. So long as the Obligated Group shall retain an Independent Consultant and each member of the Obligated Group shall

follow such Independent Consultant's recommendations with respect to such member to the extent feasible, this requirement shall be deemed to have been complied with even if the Debt Service Coverage Ratio for any subsequent Fiscal Year is below 1.20, which event will not constitute an Event of Default under the Master Indenture unless and until such Debt Service Coverage Ratio falls below 1.00.

Consolidation, Merger, Sale or Conveyance. Each member of the Obligated Group covenants that it will not merge or consolidate with any other person not a member of the Obligated Group or sell or convey all or substantially all of its assets to any person not a member of the Obligated Group unless

(a) either such Obligated Issuer shall be the continuing Person, or the successor Person (if other than such Obligated Issuer) shall be a Person organized and existing under the laws of the United States of America or a state thereof and such Person shall expressly assume the due and punctual payment of the principal of and premium, if any, and interest on all Notes issued by such Obligated Issuer under the Master Indenture according to their tenor and the due and punctual performance and observance of all of the covenants and conditions of the Master Indenture to be performed and observed by such Obligated Issuer by supplemental indenture satisfactory to the Master Trustee, executed and delivered to the Master Trustee by such Person;

(b) such Obligated Issuer shall have delivered an Officer's Certificate to the Master Trustee to the effect that such Obligated Issuer or such successor Person, as the case may be, shall not, immediately after such merger or consolidation, or such sale or conveyance, be in default in the performance or observance of any such covenant or condition;

(c) such Obligated Issuer, or such successor Person, as the case may be, demonstrates, in a report of an Independent Consultant delivered to the Master Trustee, that the Debt Service Coverage Ratio for each of the two Fiscal Years immediately succeeding the proposed date of such merger, consolidation, sale or conveyance is expected to be (i) at least 1.20 or (ii) if less than 1.20, greater than the Debt Service Coverage Ratio would have been in the absence of such merger, consolidation, sale or conveyance;

(d) if there are any Outstanding Related Bonds bearing interest that is excludable from gross income for federal income tax purposes, there shall have been delivered to the Master Trustee an Opinion of Bond Counsel, in form and substance satisfactory to the Master Trustee, to the effect that under then existing law the consummation of such merger, consolidation, sale or conveyance would not cause the interest payable on such Related Bonds to become included in gross income of the holders thereof for federal income tax purposes; and

(e) there shall have been delivered to the Master Trustee either (i) an Opinion of Counsel, in form and substance satisfactory to the Master Trustee, to the effect that such merger, consolidation, sale or conveyance would not give rise to a right of recovery under the Hill-Burton Act, 42 USC §291(i) or that such right of recovery has been validly and

effectively waived or (ii) a report of an Independent Certified Accountant confirming that the amount of any such recovery has been fully and adequately reserved on the books of the Obligated Issuer.

Restrictions on Transfers of Property. (a) Any member of the Obligated Group may sell or otherwise voluntarily dispose of any of its Property (i) to another member of the Obligated Group, (ii) in payment of Indebtedness, (iii) which is Excluded Property, or (iv) in the ordinary course of business, provided that, with respect to sales or dispositions of accounts receivable and contract rights in the ordinary course of business, such sale or other disposition is also on terms not less favorable to the transferor than in an arms-length transaction.

(b) Except as provided in the Master Indenture, each member of the Obligated Group agrees that it will not sell or otherwise voluntarily dispose of any of its Property (other than Current Assets) unless one of the tests listed in (i) through (iv) below has been met and the sale or disposition of such Property will not impair the structural soundness, efficiency or economic value of the remaining Property of that member:

(i) in the judgment of the Obligated Group such Property has, or within the next succeeding 24 calendar months is reasonably expected to, become inadequate, obsolete, worn out, unsuitable, unprofitable, undesirable or unnecessary; or

(ii) the sale or disposition of such Property was pursuant to the reasonable requirements of the Obligated Group and for consideration, in the form of cash or securities in an amount, or real or personal property having a Fair Market Value, at least equal to the Fair Market Value of such Property sold or disposed of, except in the case of a bargain sale, in which case to the extent the Fair Market Value of such Property sold or disposed of exceeds the consideration received, the disposition of an amount equal to such excess must qualify under clause (iii) or clause (iv) below; or

(iii) after giving effect to such transaction, the conditions described in subparagraphs (a)(2)(i) or (ii) under the heading "Restrictions as to Incurrence of Indebtedness" above would be met for the incurrence of one dollar of Long-Term Indebtedness, and that:

(A) the Debt Service Coverage Ratio, as reported by the Obligated Group's independent certified public accountants or an Independent Consultant, for the most recent Fiscal Year preceding the proposed date of such transaction for which audited financial statements are available, assuming such transaction actually occurred at the beginning of such Fiscal Year, would not have been reduced or, if reduced, would not have been reduced by more than 25% or to less than 1.20; or

(B) the Debt Service Coverage Ratio, as reported by the Obligated Group's independent certified public accountants or an Independent Consultant, for each of the two Fiscal Years immediately following the proposed date of such transaction is expected to be:

(1) greater than 1.25 and not less than 75% of the Debt Service Coverage Ratio for the most recent Fiscal Year preceding the proposed date of such transaction for which audited financial statements are available; or

(2) higher than it would have been had such transactions not been effected; or

(iv) the aggregate Value of such Property sold or otherwise disposed of pursuant to this paragraph in any one Fiscal Year does not exceed 5% of the aggregate Value of all Property (other than Current Assets) of the Obligated Group.

(c) Except as provided in (a) hereof, each member of the Obligated Group agrees that it will not sell or otherwise voluntarily dispose of any of its Current Assets, unless (i) with respect to Current Assets being invested or reinvested, the investment or reinvestment thereof is deemed to be reasonably prudent by the member of the Obligated Group making such investment or reinvestment, or (ii) one of the tests in (A) through (C) below has been met:

(A) the Fair Market Value of the Property being acquired in exchange for such disposition equals or exceeds the amount of such Current Assets, except in the case of a bargain sale, in which case to the extent that the amount of Current Assets exchanged exceeds the Fair Market Value of the Property being acquired, the disposition of an amount equal to such excess must qualify under clause (B) or clause (C) of this clause (c)(ii); or

(B) the amount of current assets being transferred or disposed of in that Fiscal Year is equal to or less than five percent (5%) of Adjusted Annual Revenue for the immediately preceding Fiscal Year; or

(C) the Debt Service Coverage Ratio, as reported by the Obligated Group's independent certified public accountants or an Independent Consultant, for the most recent Fiscal Year of the Obligated Group for which audited financial statements are available would not be reduced below 1.5 if the amount of "Net Transfers of Current Assets" for the current Fiscal Year were deducted from Net Income Available for Debt Service for such most recent Fiscal Year. For purposes of this clause (C), "Net Transfers of Current Assets" means (1) the amount of Current Assets transferred during the current Fiscal Year from a member of the Obligated Group to any Person which is not a member of the Obligated Group minus (2) the amount of Current Assets transferred to any member of the Obligated Group during the current Fiscal Year by any Person which is not a member of the Obligated Group, which transfers to any member of the Obligated Group would not, under Generally Accepted Accounting Principles consistently applied, have any effect on Net Income Available for Debt Service.

(d) Any member of the Obligated Group may lease or sublease to any Person its real or personal property or space within its real or personal property; provided that where the application of Generally Accepted Accounting Principles would require the Person leasing such real or personal property or such space from any member of the Obligated Group to treat the

lease as Indebtedness (were such Person a member of the Obligated Group), the lease shall be treated as a disposition of Property by a member of the Obligated Group which must qualify under (a) or (b) hereof and not as a lease under this paragraph (d).

(e) A certificate of the Obligated Group Representative shall be delivered to the Master Trustee within five months after the end of each Fiscal Year (commencing with the Fiscal Year ending December 31, 2017) to the effect that all dispositions of Property during that Fiscal Year were permitted under the provisions of the Master Indenture.

(f) No member of the Obligated Group shall designate any Property as Excluded Property unless:

(i) a certificate of the Obligated Group Representative has been delivered to the Master Trustee to the effect that one of the tests listed in clause (iii) or (iv) of clause (b) above has been met; and

(ii) a Supplemental Master Indenture designating such Property as Excluded Property has been executed and delivered.

Members of the Obligated Group

(a) Any Person may, at any time that it shall be deemed desirable by the Corporation and such Person, become a member of the Obligated Group by complying with paragraphs (b) and (c) below.

(b) To become a member to the Obligated Group, such Person shall deliver to the Master Trustee (i) an appropriate instrument, reasonably satisfactory to the Master Trustee, containing an agreement of such person (A) to become an Obligated Issuer and be subject to compliance with all provisions of the Master Indenture pertaining to an Obligated Issuer, including the performance of the obligations of an Obligated Issuer under the Master Indenture, and (B) agreeing with the Master Trustee and each other member of the Obligated Group that it shall be jointly and severally obligated to pay all Indebtedness evidenced by Notes theretofore or thereafter issued and at any time outstanding and that such Indebtedness will be paid in accordance with the terms thereof and of the Master Indenture when due; (ii) an Opinion of Counsel, addressed to and reasonably satisfactory to the Master Trustee, (1) to the effect that each such Person has the power and authority to execute and deliver such instruments and to perform its obligations thereunder and such instruments have been duly authorized, executed and delivered by all parties thereto and constitutes valid and binding obligations of each of such parties enforceable in accordance with its terms, except as limited by bankruptcy laws, insolvency laws and other similar laws affecting creditors' rights generally and general principles of equity, and (2) as to such matters incidental to such Person becoming a member of the Obligated Group as the Master Trustee may reasonably deem necessary; and (iii) a certificate of the Obligated Group Representative consenting to the inclusion of such Person in the Obligated Group.

(c) The Master Trustee shall also have received (i) a report by an Independent Consultant which demonstrates that, immediately upon any Person's becoming an

Obligated Issuer as part of such transaction, the Obligated Group considered as a pro forma consolidated or combined group for purposes of the Master Indenture, with the elimination of material balances and transactions between or among members of the Obligated Group: (A) would not be in default in the performance or observance of any covenant or condition to be performed or observed by the Obligated Group, and (B) either would meet the conditions for the incurrence of one dollar of Long-Term Indebtedness, or if it would not so meet the conditions then in the opinion of such Independent Consultant such transaction shall be in the best interest of the Noteholders and after giving effect to such transaction the Debt Service Coverage Ratio for the first Fiscal Year following the effective date thereof would be greater than what it would have been for such Fiscal Year if such transaction would not have occurred; and (ii) if any Related Bonds then shall be Outstanding, an Opinion of Bond Counsel, in form and substance satisfactory to the Master Trustee, to the effect that the consummation of such transaction would not adversely affect the exclusion from gross income for federal income tax purposes of interest payable on any issue of Related Bonds then outstanding under a Related Bond Indenture and the interest on which was excludable from gross income for Federal income tax purposes.

Withdrawal from the Obligated Group. Any Person that has become an Obligated Issuer may, upon ten (10) days' prior written notice to the Master Trustee, withdraw from the Obligated Group, and the Master Trustee, if so requested by such Obligated Issuer and at such Obligated Issuer's expense, shall execute and deliver an appropriate instrument releasing such from any liability or obligation under the provisions of the Master Indenture provided that prior to such release the Master Trustee shall be furnished with:

(a) evidence satisfactory to the Master Trustee that either (i) such Person is not a Significant Obligated Issuer or (ii) there are no Notes Outstanding issued by such Person;

(b) the Obligated Group Representative shall have consented to the withdrawal of such person;

(c) one or more Notes executed by one or more members of the Obligated Group in substitution for all Outstanding Notes, if any, executed by such Obligated Issuer;

(d) an Officer’s Certificate confirming that after giving effect to the withdrawal, no Event of Default or event which with the giving of notice or lapse of time or both shall constitute an Event of Default shall have occurred and be continuing;

(e) evidence that after giving effect to the withdrawal and release, the Obligated Group either would meet the conditions for the incurrence of one dollar of Long-Term Indebtedness or, if it would not be so permitted, then evidence that after giving effect to the withdrawal the Debt Service Coverage Ratio for the most recent Fiscal Year for which financial statements are available would be greater than it would have been for such Fiscal Year if the withdrawal had not occurred; and

(f) an Officer's Certificate demonstrating that the "net worth" of the Obligated Group, immediately after the date on which such Obligated Issuer will cease to be an Obligated Issuer, will not be less than ninety percent (90%) of the "net worth" of the Obligated Group immediately preceding such date (for the purposes of this paragraph, "net worth" shall mean the excess of total assets, including board designated funds, over total liabilities).

Pledge of Gross Receipts

Unless otherwise provided with respect to any series of Notes created by any Supplemental Indenture, to secure the prompt payment of the principal of, premium, if any, and the interest on the Notes authorized by the Master Indenture and the performance by the Obligated Group of its other obligations hereunder, each Obligated Issuer pledges and assigns to the Master Trustee for the equal and ratable benefit of the holders of the Notes authorized by the Master Indenture and from time to time in accordance with the Master Indenture, a security interest in all Gross Receipts. In order to become an Obligated Issuer, each Obligated Issuer, to the extent permitted by law, must grant to the Master Trustee, for the equal and ratable benefit of the holders, from time to time, of the Notes authorized by the Master Indenture for the payment of the principal of, premium, if any, and the interest on the Notes a security interest in all of the Gross Receipts.

Negative Pledge

Other than the pledge of Gross Receipts, Property of the Obligated Group, other than Excluded Property, shall not be subject to any Lien except for:

(i) Permitted Encumbrances;

(ii) Liens on Property, other than Excluded Property, so long as prior to or contemporaneously with the attachment thereof, such member of the Obligated Group owning such property shall have entered into a Lien with the Master Trustee granting it a Lien prior to or on a parity with such other Lien and shall have taken all action necessary to perfect the Lien granted to the Master Trustee; and

(iii) Other mortgages, security interests, liens, charges and encumbrances expressly permitted by the terms of the Master Indenture.

Substitution of Notes

The Obligated Group and the Master Trustee may, without the consent of or notice to any of the Holders of Notes, amend or supplement the Master Indenture to modify, amend, change or remove any covenant, agreement, term or provision of the Master Indenture in order to effect the affiliation of the Obligated Group with another entity or entities and the inclusion of the members of the Obligated Group in another obligated group (the "New Obligated Group") under a new master trust indenture (the "New Master Indenture") executed by the members of the New Obligated Group and an independent corporate trustee (the "New Master Trustee") meeting the eligibility requirements of the Master Indenture (such transaction is referred to collectively

herein as the "Obligated Group Transaction"), subject to the following requirements and conditions:

(a) The modifications, amendments, changes and removals permitted by this paragraph shall include those necessary or appropriate to implement the Obligated Group Transaction and to effect (i) the inclusion of the members in the New Obligated Group, or (ii) the issuance of new or replacement Note or Notes (the "Replacement Notes") of the New Obligated Group under the New Master Indenture to evidence or secure any Indebtedness or Related Bonds, which Replacement Note or Notes would constitute joint and several obligations of the members of the New Obligated Group, or (iii) the release or discharge-of any collateral securing any Note or Related Bonds, including any mortgage, any equipment lien, any pledge of revenues and receivables, or any debt service reserve fund, in consideration for the issuance of a Replacement Note or Notes of the New Obligated Group under the New Master Indenture to secure any Indebtedness or Related Bonds, or (iv) the replacement of all or a portion of the Obligated Group's financial and operating covenants and related definitions set forth in the Master Indenture with the New Obligated Group's financial and operating covenants and related definitions set forth in the New Master Indenture.

(b) The Obligated Group may implement the Obligated Group Transaction, and the Master Trustee upon the request of the Obligated Group Representative shall implement the Obligated Group Transaction, if:

(i) the Obligated Group Representative gives written notice of the substance of such proposed Obligated Group Transaction to each Rating Service that has in effect a rating for any Notes or Related Bonds then Outstanding prior to the date such Obligated Group Transaction is to take effect, and either

(A) (I) each such Rating Service (or, if no Rating Service has in effect a rating for any Notes or Related Bonds then Outstanding at least one Rating Service selected by the Obligated Group Representative) shall confirm in writing prior to the implementation of the Obligated Group Transaction that the ratings on any such Replacement Notes or Related Bonds of the New Obligated Group immediately subsequent to the Obligated Group Transaction (X) will be not less than "A3" or "A-" or its equivalent, or (Y) if the then current rating of any Related Bonds or Master Notes (without giving effect to any credit facility) is less than "A3" or "A-", then such rating will be not less than the then current rating of the Related Bonds or Notes, and (II) the Obligated Group Representative delivers an Officer's Certificate certifying that (A) after giving effect to such Replacement Notes and assuming that the New Obligated Group constituted the Obligated Group under the Master Indenture, the New Obligated Group could demonstrate compliance with the provisions of subparagraphs (a)(2)(i), (ii) or (iii) above in "Covenants of the

Obligated Group – Restrictions on the Incurrence of Indebtedness", assuming the incurrence of $1.00 of additional Long-Term Indebtedness, and (III) the New Master Indenture contains a pledge of Gross Receipts substantially similar to the pledge of Gross Receipts in the Master Indenture as of the date thereof; or

(B) (I) the Obligated Group Representative delivers an Officer's Certificate certifying that after giving effect to such Replacement Obligations and assuming that the New Obligated Group constituted the Obligated Group under the Mater Indenture, the New Obligated Group could demonstrate compliance with the provisions of subparagraphs (a)(2)(i), (ii) or (iii) above in "Covenants of the Obligated Group – Restrictions on the Incurrence of Indebtedness", assuming the incurrence of one dollar of additional Long-Term Indebtedness provided, however, for purposes of Long-Term Indebtedness, the Long-Term Debt Service Coverage Ratio shall not be less than 1.20 or the total Long-Term Indebtedness of the Obligated Group outstanding on the last day of the most recent Fiscal Year shall not be greater than 66-2/3% of the Capitalization of the New Obligated Group, and (II) the New Master Indenture contains a pledge of Gross Receipts substantially similar to the pledge of Gross Receipts in the Master Indenture as of the date thereof; and

(ii) an original executed counterpart of the New Master Indenture is delivered to the New Master Trustee; and

(iii) original Replacement Notes for all Notes Outstanding under the Master Indenture are delivered to the New Master Trustee, which Replacement Notes are issued by or on behalf of the New Obligated Group under and pursuant to and secured by the New Master Indenture and shall have been duly authenticated by the New Master Trustee under the terms of the New Master Indenture; and

(iv) at or prior to the implementation of the Obligated Group Transaction, there shall also be delivered to the Master Trustee, each Related Bond Issuer and each Related Bond Trustee, (A) an Opinion of Bond Counsel to the effect that under then-existing law the implementation of the Obligated Group transaction and the execution of the amendments or supplements contemplated in this paragraph, in and of themselves, would not adversely affect the validity of any Outstanding Related Bonds or the exclusion from federal income taxation of interest payable on such Related Bonds, and (B) an Opinion of Counsel to the effect that (I) the Replacement Note or Notes of the New Obligated Group to be delivered to secure any Indebtedness or Related Bonds constitute legal, valid and binding obligations of the members of the New Obligated Group enforceable in accordance with their terms subject to customary exceptions, and (II) the issuance

of the Replacement Note or Notes will not cause such Related Bonds or such Replacement Note or Notes to become subject to the registration requirements pursuant to the Securities Act of 1933, as amended (or that such Related Bonds or Notes have been so registered if registration is required) and will not subject the New Master Indenture to the qualification provisions of the Trust Indenture Act of 1939, as amended (or that the New Master Indenture has been so qualified if qualification is required).

(c) In addition not less than 15 days prior to the implementation of the Obligated Group Transaction, the Obligated Group Representative shall direct each Related Bond Trustee to give written notice thereof, by first-class mail, to each Related Bond Issuer and to all owners of the Related Bonds then Outstanding.

Events of Default

The following are Events of Default under the Master Indenture:

(a) failure of any Obligated Issuer to make any payment of the principal of, the premium, if any, or interest on any Indebtedness evidenced by Notes issued and outstanding as the same shall become due and payable, whether at maturity, by acceleration or otherwise, in accordance with the terms thereof, of the Master Indenture and the Related Supplemental Indenture and the continuance of such default beyond the period of grace, if any, set forth in the Related Supplemental Indenture and if such Note or Notes collateralize Related Bonds, then in the Related Bond Indenture ;

(b) failure of any Obligated Issuer to observe or perform any other covenant or agreement contained in the Master Indenture for a period of ninety (90) days after the date on which written notice of such failure has been given to the members of the Obligated Group and to the Obligated Group Representative by the Master Trustee, or to the members of the Obligated Group and the Master Trustee by the holders of at least twenty-five percent (25%) in aggregate principal amount of Notes then outstanding; provided that if any such default can be cured by the Corporation or any Obligated Issuer but cannot be cured within the 90-day curative period described above, it shall not constitute an Event of Default if corrective action is instituted by any Obligated Issuer within such 90-day period and diligently pursued until the default is corrected; and provided further, that if the performance, observation or compliance with any of the terms, covenants, conditions or provisions referred to in this paragraph shall be prevented by the application of Governmental Regulations, and such member of the Obligated Group shall have complied in full with its obligation described above under the caption "SUMMARY OF THE MASTER INDENTURE - Debt Service Coverage Ratio", the inability to perform, observe or comply with any such term, covenant, condition or provision shall not constitute an Event of Default under the Master Indenture;

(c) default of any Obligated Issuer in the payment of any Indebtedness (other than Non-Recourse Indebtedness and other than Indebtedness the principal amount of which is less than 3% of its Adjusted Annual Revenue for the most recent Fiscal Year as of the date of such default), whether such Indebtedness now exists or shall hereafter be

created, and any period of grace with respect thereto shall have expired, or an event of default as defined in any mortgage, indenture or instrument, under which there may be issued, or by which there may be secured or evidenced, such Indebtedness, whether such Indebtedness now exists or shall hereafter be created, shall occur, which default in payment or event of default shall result in such Indebtedness becoming or being declared due and payable prior to the date on which it would otherwise become due and payable; provided that any such failure by an Obligated Issuer will not be an Event of Default under this paragraph if such Obligated Issuer is diligently contesting in good faith its obligation to pay such Indebtedness and has provided the Master Trustee with an Officer's Certificate of the member of the Obligated Group that should the member of the Obligated Group fail in such efforts contesting its obligation to pay such Indebtedness, the member of the Obligated Group shall have the ability to and shall pay such Indebtedness declared due and payable;

(d) other than as provided in (e) below, a decree or order by a court having jurisdiction in the premises shall have been entered adjudging any Significant Obligated Issuer as bankrupt or insolvent, or approving as properly filed a petition seeking reorganization or arrangement of any Significant Obligated Issuer under the Federal Bankruptcy Code or any other similar applicable Federal or state law, and such decree or order shall have continued undischarged and unstayed for a period of ninety (90) days; or a decree or order of a court having jurisdiction in the premises for the appointment of a receiver or trustee or assignee in bankruptcy or insolvency of any Significant Obligated Issuer or of its Property, or for the winding up or liquidation of its affairs, shall have been entered, and such decree or order shall have remained in force undischarged and unstayed for a period of ninety (90) days; or

(e) any Significant Obligated Issuer shall institute proceedings to be adjudicated a voluntary bankrupt, or shall consent to the institution of a bankruptcy proceeding against it, or shall file a petition or answer or consent seeking reorganization or arrangement under the Federal Bankruptcy Code or any other similar applicable Federal or state law, or shall consent to the filing of any such petition, or shall consent to the appointment of a receiver or trustee or assignee in bankruptcy or insolvency of it or of its Property, or shall make assignment for the benefit of creditors, or shall admit in writing its inability to pay its debts generally as they become due, or corporate action shall be taken by any Significant Obligated Issuer in furtherance of any of the aforesaid purposes; or

(f) any representation or warranty with respect to the due authorization, execution and delivery of the Notes, the Master Indenture and any Related Supplemental Indenture which proves untrue in any material respect as of the date of issuance or making thereof and shall not be made good within sixty (60) days after written notice thereof to the Obligated Group Representative by the Master Trustee; or

(g) (i) any judgment, writ or warrant of attachment or of any similar process in an amount in excess of three percent (3%) of its Adjusted Annual Revenue for the most recent Fiscal Year which shall be entered or filed against any Obligated Issuer or against any of its Property (other than Excluded Property) and remains unvacated,

unpaid, unbonded, uninsured or unstayed for a period of ninety (90) days, and (ii) failure of the Obligated Group to deposit with the Master Trustee within thirty (30) calendar days of the Obligated Group Representative's receipt of written notice from the Master Trustee that such an event has occurred, an amount sufficient to pay in full such judgment, writ or warrant of attachment or similar process.

Remedies. Upon the occurrence of an Event of Default, then and in each and every such case, unless the principal of all Notes then Outstanding shall have already become due and payable, the Master Trustee may declare, by notice in writing to the Obligated Group Representative and all members of the Obligated Group, the principal of all Notes then Outstanding to be due and payable immediately. If an Event of Default shall arise from the failure of any Obligated Issuer to pay the principal of, premium or interest on any Note, then upon receipt of a written request therefor from the holders (or one or more Related Bond Trustees acting on behalf of the holders) of not less than twenty-five percent (25%) in aggregate principal amount of the Notes, the Master Trustee shall declare the principal of all Notes to be due and payable immediately. If an Event of Default arises for a reason other than that stated in the immediately preceding sentence, then upon receipt of a written request therefor from the holders (or one or more Related Bond Trustees acting on behalf of the holders) of not less than fifty percent (50%) in aggregate principal amount of all Notes then Outstanding, the Master Trustee shall declare the principal of all Notes then Outstanding to be due and payable immediately. Each such declaration shall be in writing and sent to all of the members of the Obligated Group. Upon any such declaration the same shall become and shall be immediately due and payable, anything in the Master Indenture or in the Notes contained to the contrary notwithstanding. This provision, however, is subject to the condition that if, at any time after the principal of all Notes shall have been so declared due and payable and before any judgment or decree for the payment of the moneys due shall have been obtained or entered as hereinafter provided, the members of the Obligated Group shall pay or shall deposit with the Master Trustee a sum sufficient to pay all matured installments of interest upon all such Notes and the principal and premium, if any, of all such Notes that shall have become due otherwise than by acceleration (with interest on overdue installments of interest and on such principal and premium, if any, at the rate specified in the Related Supplemental Indenture) and the expenses of the Master Trustee, and any and all Events of Default under the Master Indenture, other than the nonpayment of principal of and accrued interest on such Notes that shall have become due by acceleration, shall have been remedied, the Master Trustee may waive, and upon the written request of the holders of (i) a majority of the aggregate principal amount of Notes of each series then Outstanding in respect of which default in the payment of principal, premium or interest occurred (other than by reason of acceleration) either on such Notes or any Indebtedness evidenced, collateralized or secured by such Notes, or (ii) a majority of the aggregate principal amount of Notes then Outstanding shall waive all Events of Default and rescind and annul such declaration and its consequences; but no such waiver or rescission and annulment shall extend to or affect any subsequent Event of Default, or shall impair any right consequent thereon.

In case any Obligated Issuer fails to pay the amounts due on any Note, after such nonpayment has become an event of default within five business days of demand therefore, the Master Trustee, in its own name and as trustee of an express trust, shall be entitled and empowered to institute any actions or proceedings at law or in equity for the collection of the sums so due and unpaid.

Suit by Noteholders. No holder of a Note shall have any right by virtue or by availing of any provision of the Master Indenture to institute any suit, action or proceeding in equity or at law upon or under or with respect to the Master Indenture or for the appointment of a receiver or trustee, or any other remedy under the Master Indenture, unless such holder previously shall have given to the Master Trustee written notice of default and of the continuance thereof, as provided in the Master Indenture, and unless also (a) the holders of not less than a majority in aggregate principal amount of Notes of any series, if such event of default arises by reason of the failure of any member of the Obligated Group to pay the principal of or premium or interest on any Note of such series, or (b) the holders (or one or more Related Bond Trustees acting on behalf of the holders) of not less than a majority in aggregate principal amount of all Notes then Outstanding, if such event of default arises for any other reason, shall have made written request upon the Master Trustee to institute such action, suit or proceeding in its own name as Master Trustee under the Master Indenture and shall have offered to the Master Trustee such reasonable indemnity as it may require against the costs, expenses and liabilities to be incurred therein or thereby, and the Master Trustee, for thirty (30) days after its receipt of such notice, request and offer of indemnity, shall have neglected or refused to institute any such action, suit or proceeding and no direction inconsistent with such written request shall have been given to the Master Trustee pursuant to the Master Indenture; it being understood and intended, and being expressly covenanted by the taker and holder of a Note with every other taker and holder of a Note and the Master Trustee, that no one or more holders of Notes shall have any right in any manner whatever by virtue or by availing of any provision of the Master Indenture to affect, disturb or prejudice the rights of any other holder of a Note or to obtain or seek to obtain priority or preference to any other such holder, or to enforce any right under the Master Indenture, except in the manner provided in the Master Indenture and for the equal, ratable and common benefit of all holders of Notes.

Supplements and Amendments to the Master Indenture

The Master Indenture may be supplemented or amended, without the consent of any Noteholder, to add additional Excluded Property in accordance with the terms of the Master Indenture, to evidence the succession of another Person to any Obligated Issuer, to add to the covenants and restrictions imposed on any Obligated Issuer, to cure any ambiguities or defects in the Master Indenture or any Supplemental Indenture, to qualify the Master Indenture under the Trust Indenture Act of 1939, to evidence additions to or withdrawals from membership in the Obligated Group in accordance with the provisions of the Master Indenture, to substitute another trustee for the Master Trustee or to add co-trustees as provided in the Master Indenture, to permit the issuance of Notes not evidenced by physical certificates or in coupon form, to make any other change which, in the judgment of an Independent Consultant, a copy of whose report shall be sent to the Master Trustee, is in the best interest of the Obligated Group and does not materially adversely affect the Noteholders taken as a group, to pledge or assign additional revenues and/or property under the Master Indenture, to permit the Master Trustee to comply with any duties imposed upon it by law, to achieve compliance of the Master Indenture with any applicable federal securities or tax law, to issue additional Notes in accordance with the Master Indenture and to make necessary or advisable amendments or additions in connection with the issuance of additional Notes which do not affect adversely the interests of Holders of Outstanding Notes, and in connection with any other change therein which, in the judgment of the Master Trustee, is not to the prejudice of the Noteholders or the Master Trustee.

With the consent of the holders of not less than a majority in aggregate principal amount of Notes Outstanding, the Master Indenture may be changed in any manner; provided, however, that no supplemental indenture shall (a) change the times, amounts or currency of payment of the principal of, premium, if any, or interest on any Note or reduce the principal amount or redemption price of any Note or the rate of interest thereon, without the consent of the holder of such Note, or (b)(i) reduce the percentage of Notes, the holders of which are required to consent to any such supplemental indenture, or (ii) permit the preference or priority of any Note or Notes over any other Note or Notes, without the consent of the holders of all Notes then Outstanding, or (c) modify the right of the holders of not less than 25% in aggregate principal amount of any series of Notes, if any Note in that series is in default as to payment of principal, premium or interest to compel the Master Trustee to declare the principal of all Notes then Outstanding to be due and payable, without the consent of the holders of a majority in aggregate principal amount of the Notes of such series then Outstanding.

Satisfaction and Discharge

If, when the Notes shall become due and payable and the whole amount of the principal of, premium, if any, and interest due and payable upon all of the Notes shall be paid or provided for, together with all other sums payable under the Master Indenture, then the right, title and interest of the Master Trustee to the property securing performance of the obligations of the Obligated Group pledged under the Master Indenture and all covenants, agreements and other obligations of the members of the Obligated Group to the Noteholders shall thereupon cease, terminate and become void and become discharged and satisfied.

All or any part of the Outstanding Notes of any one or more series shall, prior to the maturity or redemption date thereof, be deemed to have been paid under the Master Indenture if (a) in case said Notes or portions of Notes are to be redeemed on any date prior to their maturity, the Obligated Group Representative shall have given to the Master Trustee irrevocable instructions to give notice of redemption of such Notes on said redemption date, (b) there shall have been deposited with the Master Trustee either moneys in an amount which shall be sufficient, or Defeasance Obligations which shall not contain provisions permitting the redemption thereof at the option of the issuer, or any other person other than the holder thereof, the principal of and the interest on which when due, and without any reinvestment thereof, will provide moneys which shall be sufficient to pay when due the principal of, premium, if any, and interest due and to become due on said Notes (or portions of Notes) on and prior to the redemption date or maturity date thereof, as the case may be, (c) in the event said Notes (or portions of Notes) are not by their terms subject to redemption within the next forty-five (45) days, the members of the Obligated Group shall have given the Master Trustee irrevocable instructions to give a notice to the holders of such Notes that the deposit required by (b) above has been made with the Master Trustee and that said Notes are deemed to have been paid in accordance with the Master Indenture and stating such maturity or redemption date upon which moneys are to be available for the payment of the principal of, premium, if any, and interest on said Notes, and (d) unless said Notes secure Related Bonds or by their terms are subject to redemption within the next forty-five (45) days, there is delivered to the Master Trustee the report of an Independent Certified Public Accountant to the effect that such Defeasance Obligations will be sufficient to pay, as the same becomes due at maturity or upon redemption, the principal of and interest and premium, if any, on said Notes.

SUMMARY OF THE AGREEMENT OF LEASE

Conveyance and Term

The Lease provides that the Corporation shall lease to the Issuer the Existing Facilities owned by the Corporation. The term of the Lease commenced on commences on the date of delivery of the Series 2017 Bonds and terminates on December 1, 2047, unless extended or sooner terminated in accordance with the terms of the Lease.

Rent

As rent for the Existing Facilities the Issuer shall pay the Corporation total rent of One Dollar ($1.00), plus other valuable consideration.

SUMMARY OF THE SUBLEASE

In connection with the issuance of the Series 2017 Bonds, the Issuer and the Corporation will enter into the Sublease with respect to the Existing Facilities. The term of the Sublease commences on the date of delivery of the Series 2017 Bonds, and shall terminate on December 1, 2047, unless extended or terminated earlier pursuant to the provisions of the Sublease.

Payments to the Bond Trustee

The Corporation covenants and agrees to make the following Basic Rent payments to the Bond Trustee for deposit into the following funds and accounts established by the Bond Indenture on the following dates:

(a) Interest Account Deposits: On or before the fifth business day next preceding the first day of each month, commencing the fifth business day next preceding August 1, 2017, an amount equal to one-fifth (1/5) of the interest to become due on the Series 2017 Bonds on December 1, 2017, and on or before the fifth business day next preceding the first day of each month thereafter an amount equal to one-sixth (1/6) of the interest to become due on the Series 2017 Bonds on the next succeeding interest payment date thereon; provided that no such payment need be made to the extent that moneys are on hand in the Interest Account for that purpose.

(b) Principal Account Deposits. On or before the fifth business day next preceding the first day of each month, commencing the fifth business day next preceding January 1, 2021, an amount equal to one-twelfth (1/12) of the principal coming due on the Series 2017 Bonds on the next succeeding principal payment date whether at maturity or by mandatory sinking fund redemption; provided that no such payment need be made to the extent that moneys are on hand in the Principal Account for that purpose.

The Corporation shall pay to the Bond Trustee or the Issuer, as the case may be, when due and payable, as Additional Rent, such of the following costs and expenses properly incurred by the Bond Trustee or the Issuer as are not paid out of the proceeds of the Series 2017 Bonds:

(i) the reasonable fees and other costs incurred for services of such Independent Engineers, architects, attorneys, and accountants as are employed to make examinations and/or render opinions and reports required under the Sublease or the Bond Indenture;

(ii) reasonable fees and other costs, not otherwise paid under the Sublease or the Bond Indenture, incurred by the Issuer in connection with its administration and enforcement of, and compliance with, the Sublease and the Bond Indenture;

(iii) amounts advanced by the Issuer or the Bond Trustee under authority of the Sublease or the Bond Indenture and which the Corporation is obligated to repay; and

(iv) if the issuance of the Series 2017 Bonds shall prevent the City from designating other of its obligations as "qualified tax exempt obligations" under Section 265(b) of the Code, the present value basic economic cost to the City of the loss of such designation on its obligations, as calculated by the financial advisor to the City.

If other Related Bonds are issued for the benefit of the Corporation, payments of rent may be made to the trustee under the Related Bond Indenture securing the other series of Related Bonds.

Corporation's Obligations Unconditional

The Corporation shall bear all risk of damage or destruction, in whole or in part, to the Existing Facilities or any part thereof, including, without limitation, any loss, complete or partial, or interruption in the use, occupancy or operation of the Existing Facilities, or any manner or thing which for any reason interferes with, prevents or renders burdensome the use or occupancy of the Existing Facilities or the compliance by the Corporation with any of the terms of the Sublease. The Corporation agrees that its obligations to make payments under the Sublease will be absolute and unconditional and that the Corporation will not be entitled to any abatement, diminution, set-off, abrogation, waiver or modification thereof nor to any termination of the Sublease by any reason whatsoever, regardless of any rights of set-off, recoupment or counterclaim that the Corporation might otherwise have against the Issuer, the Master Trustee or the Bond Trustee or any other party or parties and regardless of any contingency, act of God, event or cause whatsoever.

Use of the Existing Facilities

The Corporation will use the Existing Facilities only in furtherance of the lawful corporate purposes of the Corporation. The Corporation further agrees that it will not use the Existing Facilities, or permit the Existing Facilities to be used by any non-exempt person in such manner as would result in the loss of the exclusion from gross income for federal income tax purposes of interest on the Series 2017 Bonds otherwise afforded under Section 103(a) of the Code.

Repairs, Maintenance and Alterations

The Corporation shall at its own cost and expense keep the Existing Facilities in good repair and order, reasonable wear and tear excepted, and in as reasonably safe condition as its operations will permit and will make all necessary repairs thereto, interior and exterior, structural and nonstructural, ordinary as well as extraordinary and foreseen as well as unforeseen, and all necessary replacements or renewals, subject in all respects to the receipt by the Corporation of all necessary governmental permits and approvals therefor, and subject, further, to the provisions of the Master Indenture.

The Corporation shall have the right from time to time at its sole cost and expense to make repairs, restorations, replacements, additions, alterations and changes, whether structural or nonstructural (collectively, "alterations") in or to the Existing Facilities; provided, however, that no alteration of any kind shall be made which would result in a violation of the provisions of the Sublease.

Insurance

The Corporation shall take out and continuously maintain in effect insurance against such risks, both generally and specifically with respect to the Existing Facilities, as are customarily insured against by hospitals of similar size and character, taking into account any self-insurance, paying as the same become due all premiums in respect thereto, all in the manner and to the extent provided in the Master Indenture.

Effecting Changes in the Existing Facilities

The Corporation its own cost and expense may make such additions, renewals, replacements or improvements to or alterations of the Existing Facilities or may construct or place on the Existing Facilities such additional or renewal or replacement facilities, furnishings or equipment as the Corporation may deem desirable to effectuate the purposes contemplated in the Sublease; provided that such additions, renewals, replacements, improvements, alterations, facilities, furnishings or equipment will not materially impair the structural soundness or the usefulness of the Existing Facilities nor adversely affect the purposes of the Sublease.

The Corporation may select an architect, construction manager and such other consultants and contractors as it determines advisable to provide services related to and for the construction of the Project and any alteration of the Existing Facilities. The Corporation's agreement with the construction manager may provide for the provision of construction management services, the entry into trade contracts by the construction manager for the construction of the Project, a guaranteed maximum price, payment to the construction manager for the cost of the work and a fee, changes in the Project, insurance for the Project during construction, and such other matters as the Corporation determines to be advisable. The trade contracts into which the construction manager enters shall provide for all of the work necessary for the completion of the Project through multiple contractors, except to the extent the Corporation elects to provide equipment or materials.

The Corporation may cause the construction manager to seek private bids for the work to be performed by the trade contractors through public advertisement or otherwise, open and

review the bids privately, and then based upon such factors as the construction manager determines to be important for the timely and proper construction of the Project, select one or more bidders with which to negotiate contracts for each division of the work. The form of the trade contracts will be in the form selected by the construction manager and acceptable to the Corporation. The bidding, awarding and entry into the trade contracts, the selection and entry into the architect's and construction manager's agreements, division of the work, surety bonding requirements, and all other procedures used in and requirements applicable to the construction of the Project shall be as selected by the Corporation in its sole discretion. To the extent permitted by law, the City and the Corporation agree that the Corporation will not be required to comply with the laws and regulations applicable to the bidding, award and construction of improvements by municipal corporations or other political subdivisions of the State.

The Issuer covenants that, except as the Sublease, the Lease and the Bond Indenture otherwise permit, it will not, during the term of the Sublease sell or otherwise dispose of or encumber the Existing Facilities or any part thereof or permit the Existing Facilities or any part thereof to be sold, demolished, removed or otherwise disposed of or encumbered.

Easements

The Issuer and the Corporation shall, subject to the provisions of the Sublease, at any time or times lawfully grant or release, as the case may be, with or without consideration, such easements, rights of way, licenses or other rights over, upon or beneath the surface of the land constituting a part of the Existing Real Property as shall constitute Permitted Encumbrances under the Master Indenture, provided that the efficient operation of the Existing Facilities or reasonable ingress thereto and egress therefrom shall not be thereby materially impaired.

Release of Land

The parties to the Sublease reserve the right, by mutual written consent at any time and from time to time, to amend the Sublease for the purpose of effectuating the release of one or more parcels of or interests in land constituting a part of the Existing Real Property or any other portion of the Existing Facilities and the removal from the purview of the Sublease and from the leasehold estate created by the Sublease of such parcel or parcels of or interest in land or portion of the Existing Facilities to the extent permitted by the conditions and requirements of the Sublease and the Master Indenture.

Events of Default

The occurrence and continuance of any of the following events shall constitute an "event of default" under the Sublease:

(a) failure of the Corporation to pay any installment of Basic Rent when the same shall become due and payable; or

(b) except as noted in clause (c) below, failure by the Corporation faithfully and efficiently to administer, maintain and operate the Existing Facilities as Hospital Facilities or failure to provide the services thereof without regard to race, creed, color or

national origin, or discrimination by the Corporation in the provision of such services by reason of race, creed, color or national origin; or

(c) the Corporation shall fail duly to observe, comply with or perform any covenant, representation, warranty or agreement on its part under the Sublease for a period of 90 days after the date on which written notice of such failure, requiring the same to be remedied, shall have been given to the Corporation and the Bond Trustee by the holders of at least 25% in aggregate principal amount of Series 2017 Bonds then Outstanding; provided, however, if said default be such that it cannot be corrected within the applicable period, it shall not constitute an event of default if corrective action is instituted by the Corporation within the applicable period and diligently pursued until the default is corrected; and provided, further that if the performance, observation or compliance with any of the terms, covenants, conditions or provisions referred to in clause (b) and this clause shall be prevented by the application of federal or State wage and price controls, economic stabilization, cost containment requirements, or restrictions on rates, charges and/or revenues of the Corporation, or reimbursement regulations and policies, which may be imposed by third-party payors (whether governmental or private), and the Corporation shall have complied in full with its obligation described above under the caption "SUMMARY OF THE MASTER INDENTURE – Covenants of the Obligated Group - Debt Service Coverage Ratio", the inability to perform, observe or comply with any such term, covenant, condition or provision shall not constitute an event of default under the Sublease; or

(d) an event of default shall occur under the Bond Indenture; or

(e) if the principal of all Notes shall have been declared by the Master Trustee to be immediately due and payable pursuant to the Master Indenture.

The provisions of clause (c) above are subject to the following limitations: If by reason of acts of God; fires; epidemics; landslides; floods; strikes; lockouts or other industrial disturbances; acts of public enemies; acts or orders of any kind of any governmental authority; insurrections; riots; civil disturbances; explosions; breakage or accident to machinery, transmission pipes or canals; partial or entire failure of utilities; or any cause or event not reasonably within the control of the Corporation, the Corporation is unable in whole or in part to carry out its agreements on its part, pay taxes and to carry insurance, the Corporation shall not be deemed in default during the continuance of such inability. The Corporation shall, however, use its best efforts to remedy with all reasonable dispatch the cause or causes preventing the Corporation from carrying out its agreements; provided, that the Corporation shall in no event be required to settle strikes, lockouts or other industrial disturbances by acceding to the demands of the opposing party or parties when such course is, in the judgment of the Corporation, unfavorable to the Corporation.

During the occurrence and continuance of any event of default, the Bond Trustee shall have the following rights and remedies, in addition to any other remedies in the Sublease or by law provided, which rights and remedies (except for the acceleration of the payment of Basic Rent and the Bond Trustee's rights as a Noteholder) the Bond Trustee shall exercise solely at the express direction of the Master Trustee:

I. Acceleration of Maturity; Waiver of Default and Rescission of Acceleration. The Bond Trustee may, by written notice to the Corporation, declare the Rent (if not then due and payable) to be due and payable immediately, and upon any such declaration the Rent shall become and be immediately due and payable, anything in the Sublease to the contrary notwithstanding. This provision, however, is subject to the condition that if, at any time after the Rent shall have been so declared and become due and payable and all arrears of Rent and the expenses of the Issuer and the Bond Trustee shall be paid by the Corporation, and every other default in the observance or performance of any covenant, condition or agreement in the Sublease and the Bond Indenture shall be made good, or be secured, to the satisfaction of the Bond Trustee, or provision deemed by the Bond Trustee to be adequate shall be made therefore, then and in every such case the Bond Trustee by written notice to the Corporation shall waive the event of default by reason of which the Rent shall have been so declared and become due and payable, and may rescind and annul such declaration and its consequences; but no such waiver, rescission or annulment shall extend to or affect any subsequent event of default or impair any right consequent thereon.

II. Right to Bring Suit. The Bond Trustee may in its discretion, but with the consent of the Master Trustee and subject to its right to be indemnified to its satisfaction, proceed to protect and enforce its rights by a suit or suits in equity or at law, whether for damages or for the specific performance of any covenant or agreement contained in the Sublease, or in aid of the execution of any power granted; provided, however, that all costs incurred by the Bond Trustee shall be paid to the Bond Trustee by the Corporation on demand.

III. Right of Noteholder. The Bond Trustee may take any other action permitted of a Noteholder under the Master Indenture.

Before any of the foregoing remedies are exercised by the Issuer or its designee if an event of default under clause (b) above occurs, the Issuer shall give written notice to the Corporation that it believes an event of default under that clause has occurred, specifying the charges or circumstances constituting the event of default in sufficient detail that the Corporation will be fully advised of the nature of the charges made against it and able to adequately prepare a response thereto. If the Corporation elects to contest such notice of an event of default, such notice shall fix a date, time and place for a hearing before a hearing officer who shall be a member of the American Arbitration Association or any organization which is nationally recognized as performing the functions now performed by that Association who is knowledgeable concerning health care facilities reasonably comparable in size and type to the Existing Facilities and who shall be mutually acceptable to the Corporation and the Issuer. The hearing shall be held to determine whether an Event of Default has occurred. That date shall not be sooner than 30 days following the giving of that notice.

At the date, time and place specified in the notice, unless the Issuer shall have withdrawn the notice, the Corporation shall be heard on the charges specified in the notice, shall be confronted with the evidence of the alleged Event of Default, shall have the right to examine and to cross-examine witnesses, and may introduce any other evidence and testimony with respect to the alleged Event of Default which the Corporation desires. After the hearing is concluded, the

hearing officer shall consider whether an Event of Default has occurred and shall report his findings or determinations to the Issuer and the Corporation.

If the hearing officer determines that an Event of Default has occurred, the Issuer may give notice to the Corporation, the Master Trustee and the Bond Trustee of its intention to terminate the Sublease on the basis of such Event of Default and effective as of a date not earlier than the 30th day following the giving of the notice. If on the date specified for termination, the determination of such Event of Default shall not have been appealed by the Corporation, Bond Trustee or Master Trustee to any judicial authority or suspended or waived by the Issuer, the Sublease shall be terminated, subject to reinstatement pursuant to the Sublease. If that determination has been appealed, the Sublease shall not be terminated until the 30th day following the expiration of all periods for judicial review or appeal.

Payment of Defaulted Amounts on Demand

In case the Corporation shall fail to pay any installment of Rent when and as the same shall become due and payable, whether at maturity or upon designation for prepayment or by declaration, or otherwise, then, upon written demand of the Issuer or the Bond Trustee, the Corporation will pay to the Bond Trustee the whole amount which then shall have become due and payable with interest at the rate borne by the Series 2017 Bonds until paid, and in addition thereto such further amount as shall be sufficient to cover the cost and expenses of collection, including a reasonable compensation to the Issuer, the Bond Trustee and their agents, attorneys and counsel, and any expenses or liabilities incurred by the Issuer or the Bond Trustee.

Bond Trustee May Enforce Demand

In case the Corporation shall have failed to pay such Basic Rent upon demand, the Bond Trustee may, with the written consent of the Master Trustee, and subject to its right to be indemnified to its satisfaction, institute such action or proceedings at law or in equity for the collection of the amounts so due and unpaid, and may prosecute any such action or proceedings to judgment or final decree, and may enforce any such judgment or final decree against the Corporation and collect the moneys adjudged or decreed to be payable out of the property of the Corporation, wherever situated, in the manner provided by law.

The Bond Trustee shall, if permitted by law, be entitled to recover judgment as aforesaid either before or after or during the pendency of any proceedings for the enforcement of the Sublease; and the right of the Bond Trustee to recover such judgment shall not be affected by the exercise of any other right, power or remedy for the enforcement of the provisions of the Sublease.

No recovery of any judgment by the Bond Trustee shall affect any rights, powers or remedies of the Issuer or the Bond Trustee, but such rights, powers or remedies of the Issuer and the Bond Trustee shall continue unimpaired as before.

Any moneys thus collected by the Bond Trustee shall be applied by the Bond Trustee as provided in the Bond Indenture.

Reinstatement

Notwithstanding any termination of the Sublease, the Corporation may, with the prior written consent of the Master Trustee**,** at any time after such termination pay all accrued unpaid Basic Rent plus any costs to the Issuer and the Bond Trustee occasioned by the default including all interest required to be paid in accordance with the Bond Indenture on overdue principal and, to the extent lawful, on any overdue interest, and on the principal of Series 2017 Bonds not redeemed in accordance with the Bond Indenture by reason of any default by the Corporation in the payment of Basic Rent, and fully cure, all other defaults then capable of being cured. Upon such payment and cure, the Sublease shall be fully reinstated, as if it had never been terminated, and the Corporation shall be restored to the use, occupancy and possession of the Existing Facilities.

SUMMARY OF THE BOND INDENTURE

Creation of Trust

In connection with the issuance of the Series 2017 Bonds the Issuer and the Bond Trustee will execute and deliver the Indenture of Trust (Bond Indenture) (the "Bond Indenture"). In order to secure payment of the principal of, premium, if any, and interest on the Series 2017 Bonds, and to secure the other obligations of the Issuer set forth in the Bond Indenture, the Issuer has pledged, assigned and transferred to the Bond Trustee:

(a) All right, title and interest of the Issuer (other than Unassigned Rights) in and to the Lease and the Sublease, and all of the Basic Rent received or to be received under the Sublease, provided that the Bond Trustee's rights under the Sublease, including the exercise by the Bond Trustee of any remedies under the Sublease, shall be on a parity basis with any subsequent assignment by the State or any municipal corporation or political subdivision formed under the laws thereof or any constituted authority or agency or instrumentality of any of the foregoing, in connection with the issuance of Related Bonds;

(b) All moneys and securities on deposit from time to time in the funds established under the provisions of the Bond Indenture which permit the application thereof for the purposes and on the terms and conditions set forth in the Bond Indenture; and

(c) Any and all other property of every kind and nature from time to time hereafter, by delivery or by writing of any kind pledged, assigned or transferred as and for additional security by the Issuer or by anyone on its behalf to the Bond Trustee, which is authorized to receive the same at any time as additional security;

to hold in trust, however, for the equal and proportionate benefit, security and protection of all owners of the Bonds issued under the Bond Indenture.

Application of Series 2017 Bond Proceeds and Other Moneys

The Issuer shall deposit with the Bond Trustee all proceeds from the sale of the Series 2017 Bonds (including accrued interest on the Series 2017 Bonds from their date to the date of their delivery). The Bond Trustee, out of the proceeds of the Series 2017 Bonds, shall:

(a) Deposit to the Expense Fund the amount specified in the Bond Indenture which will be used to pay the fees and expenses incurred in connection with the issuance of the Series 2017 Bonds;

(b) Transfer the amount specified in the Bond Indenture to the Escrow Trustee to be held pursuant to the Escrow Deposit Agreement advance refund the Prior Bonds; and

(c) Deposit to the Project Fund the amount specified in the Bond Indenture which will be disbursed pursuant to the requirements of the Bond Indenture or pursuant to a letter of instructions from the Issuer approved by the Corporation.

Simultaneously with the delivery of the Series 2017 Bonds:

(a) the Bond Trustee, as trustee under the Indenture of Trust (Bond Indenture) securing the Prior Bonds (the "Prior Bond Indenture"), shall transfer the sum of amounts specified in the Bond Indenture from the debt service reserve fund and the bond fund held under the Prior Bond Indenture, and

(b) the Corporation shall transfer the amount specified in the Bond Indenture representing the proceeds of a taxable loan,

to the Escrow Trustee to be deposited to the credit of the Escrow Fund created under the Escrow Deposit Agreement to advance refund the Prior Bonds.

Investment of Funds

Moneys in the Interest Account, the Principal Account, the Capitalized Interest Account, the Project Fund, the Bond Redemption Fund, and the Expense Fund shall be invested in Qualified Investments pursuant to the Sublease. The Bond Trustee shall not be liable or responsible for any loss resulting from any such investment. Any such investments shall be held by or under the control of the Bond Trustee and shall mature at such times as it is anticipated that moneys from the particular Fund or Account will be required for the purposes of the Bond Indenture. The Bond Trustee is authorized to trade with itself in the purchase and sale of securities for such investment. The Bond Trustee shall sell at what it reasonably believes to be the best price obtainable or present for redemption any obligations so purchased whenever it shall be necessary so to do in order to provide money to make any payment or transfer of money from any fund or account as provided in the Bond Indenture.

For the purpose of determining the amount from time to time on deposit in any of said Funds or Accounts, such investment shall be valued at the market value thereof. Such valuation shall occur at least annually, commencing December 1, 2018. The method of valuation shall be reasonably determined by the Bond Trustee.

All income from the investment of moneys in the Principal Account, the Interest Account, the Capitalized Interest Account, the Project Fund, the Bond Redemption Fund, and the Expense Fund shall be deposited into the respective Fund or Account from which such investment was made.

The Issuer shall not cause the Bond Trustee to make any investment or determination or do any other act or thing during the period that any Series 2017 Bonds are outstanding under the Bond Indenture which would cause the Series 2017 Bonds to become or be classified as "arbitrage bonds" within Sections 103(b)(2) and 148 of the Code. It is further understood and agreed that the Bond Trustee shall not be required at any time to make any such investment or to do any such act.

In the absence of written direction delivered to the Bond Trustee from the Corporation, the Bond Trustee shall invest any funds in Qualified Investments described in clause (h) of the definition.

Events of Default

Each of the following events is declared an "event of default" under the Bond Indenture:

(a) payment of any installment of interest on any of the Series 2017 Bonds shall not be made when the same is due and payable; or

(b) payment of the principal of, or the redemption premium, if any on any of the Series 2017 Bonds shall not be made when the same is due and payable, either at maturity or by redemption or otherwise; or

(c) the Issuer shall for any reason be rendered incapable of fulfilling its obligations under the Bond Indenture or under the Sublease; or

(d) any event of default as defined in the Sublease shall occur and be continuing; or

(e) the Master Trustee shall declare under the Master Indenture that the principal of all Notes is immediately due and payable; or

(f) the Issuer shall default in the due and punctual performance of any other of the covenants, conditions, agreements and provisions contained in the Series 2017 Bonds or in the Bond Indenture or any agreement supplemental thereof on the part of the Issuer to be performed and such default shall continue for thirty (30) days after written notice specifying such default and requiring the same to be remedied shall have been given to the Issuer and the Corporation by the Bond Trustee, which shall only give such notice at the written request of the owners of not less than twenty-five percent (25%) in aggregate principal amount of the Series 2017 Bonds then Outstanding; provided, however, if said default be such that it cannot be corrected within the applicable period, it

shall not constitute an event of default if corrective action is instituted by the Issuer within the applicable period and diligently pursued until the default is corrected.

Acceleration

Upon the happening of any event of default, and the continuance of the same for the period, if any, the Bond Trustee may, without any action on the part of the owners of the Series 2017 Bonds, and shall (i) in the event the principal of the Notes has been declared immediately due and payable, or (ii) upon the written request of the owners of not less than twenty-five percent (25%) in aggregate principal amount of the Series 2017 Bonds then Outstanding, exclusive of Series 2017 Bonds then owned by the Issuer or the members of the Obligated Group, and upon being indemnified to its satisfaction, by notice in writing delivered to the Issuer and the Corporation, declare the entire principal amount of the Series 2017 Bonds then Outstanding and the interest accrued thereon immediately due and payable, and the said entire principal and accrued interest shall thereupon become and be immediately due and payable.

The provisions of the preceding paragraph, however, are subject to the condition that if, after the principal of, premium, if any, and accrued interest on, the Series 2017 Bonds and the principal of the Notes have been declared immediately due and payable, the declaration of acceleration of the Notes shall be annulled in accordance with the provisions of the Master Indenture, the declaration of acceleration of the Series 2017 Bonds shall be automatically annulled and the Bond Trustee shall promptly give written notice of such annulment to the Issuer, the Corporation and Bondholders in the same manner specified in the Bond Indenture for a notice of redemption. The provisions of the preceding paragraph are subject to the further condition that after the principal of, premium, if any, and accrued interest on, the Series 2017 Bonds have been declared immediately due and payable, the owners of a majority in aggregate principal amount of the Series 2017 Bonds then outstanding shall have the right, by written notice to the Bond Trustee, the Issuer and the Corporation to annul such declaration of acceleration of the Series 2017A Note pursuant to the Master Indenture. No such annulment shall extend to or affect any subsequent event of default or impair any right or remedy consequent thereon.

Remedies; Rights of Owners of the Series 2017 Bonds

Upon the occurrence of an event of default the Bond Trustee may, with the consent of the Master Trustee, also pursue any available remedy at law or in equity to enforce the payment of the principal of and interest on the Series 2017 Bonds then Outstanding or to enforce any obligations of the Issuer under the Bond Indenture.

If any event of default shall have occurred, and if requested so to do in writing by the owners of not less than twenty-five percent (25%) in aggregate principal amount of Series 2017 Bonds then outstanding, and having been indemnified as provided in the Bond Indenture, the Bond Trustee shall be obligated to exercise such one or more of the rights and powers conferred by the Bond Indenture as the Bond Trustee, being advised by counsel, shall deem most expedient in the interests of the Bondholders.

No remedy by the terms of the Bond Indenture conferred upon or reserved to the Bond Trustee (or to the owners of the Series 2017 Bonds) is intended to be exclusive of any other remedy, but each and every such remedy shall be cumulative and shall be in addition to any other remedy given to the Bond Trustee or to the owners of the Series 2017 Bonds under the Bond Indenture or now or hereafter existing at law or in equity or by statute.

No delay or omission to exercise any right or power accruing upon any event of default shall impair any such right or power or shall be construed to be a waiver of any event of default or acquiescence therein; and every such right and power may be exercised from time to time and as often as may be deemed expedient.

No waiver of any event of default pursuant to the Bond Indenture, whether by the Bond Trustee or by the owners of the Series 2017 Bonds, shall extend to or shall affect any subsequent event of default or shall impair any rights or remedies consequent thereon.

In the event that the Master Trustee has accelerated the Notes and is pursuing its available remedies under the Master Indenture, the Bond Trustee, without waiving any event of default under the Bond Indenture, shall not pursue its available remedies under the Bond Indenture or the Sublease in such manner as to hinder or frustrate the pursuit by the Master Trustee of its remedies under the Master Indenture; provided that the Bond Trustee may take any action permitted of a Noteholder under the Master Indenture.

Application of Moneys

All moneys received by the Bond Trustee pursuant to any right given or action taken, including any moneys contained in any funds and accounts created under the Bond Indenture, shall, after payment of the cost and expenses of the proceedings resulting in the collection of such moneys and of the fees, expenses, liabilities and advances incurred or made by the Bond Trustee, including reasonable legal fees and expenses, be held in trust for the benefit of the owners of the Series 2017 Bonds by the Bond Trustee and shall be applied as described in the Bond Indenture.

Waivers of Events of Default

The Bond Trustee may in its discretion waive any event of default and its consequences and rescind any declaration of maturity of principal of and interest on the Series 2017 Bonds, and shall do so upon the written request of the owners of a majority in aggregate principal amount of all Series 2017 Bonds then outstanding; provided, however, that there shall not be waived (a) any event of default in the payment of the principal of any outstanding Series 2017 Bonds at the date of maturity specified therein, or upon proceedings for mandatory redemption pursuant to the Bond Indenture or any mandatory sinking fund payments required by any supplemental indenture or (b) any default in the payment when due of the interest or premium on any such Series 2017 Bonds unless prior to such waiver or rescission, all arrears of interest, or all arrears of payments of principal, with interest at the rate borne by the Series 2017 Bonds on all arrears of payments of principal until paid, as the case may be, and all expenses (including any attorneys' fees and expenses) of the Bond Trustee in connection with such default, shall have been paid or provided for, and in case of any such waiver or rescission, or in case any proceeding

taken by the Bond Trustee on account of any such default shall have been discontinued or abandoned or determined adversely, then and in every such case the Issuer, the Bond Trustee and the Bondholders shall be restored to their former positions and rights, respectively, but no such waiver or rescission shall extend to any subsequent or other default, or impair any right consequent thereon.

Supplemental Indentures Not Requiring Consent of Owners of Series 2017 Bonds

The Issuer and the Bond Trustee may, without the consent of, or notice to, any of the owners of the Series 2017 Bonds enter into an indenture or indentures supplemental to the Bond Indenture, as shall not be inconsistent with the terms and provisions of the Bond Indenture, for any one or more of the following purposes:

(a) To cure any ambiguity, inconsistency or formal defect or omission in the Bond Indenture;

(b) To grant to or confer upon the Bond Trustee for the benefit of the owners of the Series 2017 Bonds any additional rights, remedies, powers or authority that may lawfully be granted to or conferred upon such owners or the Bond Trustee;

(c) To subject to the Bond Indenture additional revenues, properties or collateral;

(d) To add to the covenants and agreements of the Issuer contained in the Bond Indenture other covenants and agreements thereafter to be observed for protection of the Bondholders, or, if in the judgment of the Bond Trustee such is not to the prejudice of the Bond Trustee or the Bondholders, to surrender or limit any right, power or authority reserved to or conferred upon the Issuer in the Bond Indenture, including, without limitation, the limitation of rights of redemption;

(e) To evidence any succession to the Issuer and the assumption by such successor of the covenants and agreements of the Issuer contained in the Bond Indenture, the Sublease or any subsequent lease, sublease or other instruments providing for the operation of the Existing Facilities, and the Series 2017 Bonds;

(f) In connection with the issuance of any Related Bonds or other Indebtedness which is secured by a Note, in accordance with the provisions of the Master Indenture;

(g) To modify, amend or supplement the Bond Indenture or any indenture supplemental thereto in such manner as shall not, in the opinion of the Bond Trustee, be prejudicial to the interest of the owners of the Series 2017 Bonds, so as to permit the qualification thereof under the Trust Indenture Act of 1939 or any similar federal statute hereafter in effect or under any state blue sky law;

(h) To conform the Bond Indenture to any changes in the Corporation Documents permitted by the Bond Indenture;

(i) To provide for the issuance of coupon Series 2017 Bonds if in the written opinion of an attorney or a firm of attorneys of nationally recognized standing in matters of the tax-exempt status of municipal obligations the interest on such coupon Series 2017 Bonds would be exempt from federal income taxes;

(j) To permit the use of a book entry system to identify the owner of any interest in an obligation issued by the Issuer under the Bond Indenture, whether that obligation was formerly, or could be, evidenced by a physical security;

(k) To permit the Bond Trustee to comply with any duties imposed upon it by law;

(l) To specify further the duties and responsibilities of the Bond Trustee;

(m) To make any other change which is not prejudicial to the Bond Trustee or the Bondholders, in the judgment of the Bond Trustee; and.

(n) To make any other change which, in the judgment of an Independent Consultant, a copy of whose report shall be sent to the Bond Trustee, (1) is in the best interest of the Obligated Group and (2) does not materially adversely affect the Bondholders taken as a group; provided that no such change shall be made if within sixty (60) days of its receipt of such Independent Consultant's report, the Bond Trustee shall have obtained a report from another Independent Consultant indicating that in its opinion either clause (1) or (2) of this subparagraph (n) is not satisfied; provided further, that the Bond Trustee shall be under no duty to retain another such Independent Consultant.

(o) In connection with the substitution of a new note for the Series 2017A Note pursuant to the Master Indenture.

In connection with the execution and delivery of any supplemental indenture pursuant to subparagraph (f) above, the Bond Trustee, at the direction of the Corporation or the Issuer, shall take whatever actions are necessary to provide that such additional Related Bonds are equally and ratably secured with the Series 2017 Bonds.

Supplemental Indentures Requiring Consent of Owners of Series 2017 Bonds

Exclusive of supplemental indentures not requiring the consent of owners of Series 2017 Bonds, the owners of not less than a majority in aggregate principal amount of the Series 2017 Bonds then outstanding shall have the right, from time to time, anything contained in the Bond Indenture to the contrary notwithstanding, to consent to and approve the execution by the Issuer and the Bond Trustee of such other indenture or indentures supplemental thereto as shall be deemed necessary and desirable by the Issuer for the purpose of modifying, altering, amending, adding to or rescinding, in any particular, any of the terms or provisions contained in the Bond Indenture or in any supplemental indenture; provided, however, that nothing shall permit or be construed as permitting (a) an extension of the stated maturity or reduction in the principal amount of, or reduction in the rate or extension of the time of paying of interest on, or reduction

of any premium payable on the redemption of, any Series 2017 Bonds, without the consent of the owner of such Series 2017 Bonds, or (b) a reduction in the amount or extension of the time of any sinking fund payment required under the Bond Indenture, or (c) the creation of any lien prior to or on a parity with the lien of the Bond Indenture, without the consent of the owners of all the Series 2017 Bonds at the time Outstanding, or (d) a reduction in the aforesaid aggregate principal amount of Series 2017 Bonds the owners of which are required to consent to any such supplemental indenture, without the consent of the owners of all the Series 2017 Bonds at the time outstanding which would be affected by the action to be taken, or (e) the modification of the rights, duties or immunities of the Bond Trustee, without the written consent of the Bond Trustee.

Amendments to Corporation Documents Not Requiring Consent of Bondholders

The Issuer and the Corporation with the consent of the Bond Trustee may, without the consent of or notice to the owners of Series 2017 Bonds enter into any amendment, change or modification of the Corporation Documents as may be permitted or required (i) by the provisions of the Corporation Documents, (ii) for the purpose of curing any ambiguity, inconsistency or formal defect or omission therein, (iii) in order to provide for the issuance of any Additional Bonds, including, without limitation, the addition of the State or any political subdivision thereof as a lessee under the Lease and as a lessor under the Sublease, (iv) in connection with adding or releasing real property to the Corporation Documents as permitted therein or in connection with the granting of easements as permitted by the Sublease, (v) any amendments, modifications or changes which would be permitted by the Bond Indenture or (vi) in connection with any other change therein which, in the judgment of the Bond Trustee, is not to the prejudice of the Bond Trustee or the owners of the Series 2017 Bonds.

Amendments to Corporation Documents Requiring Consent of Bondholders

Except for the amendments, changes or modifications not requiring the consent of Bondholders, neither the Issuer nor the Bond Trustee shall consent to any other amendment, change or modification of the Corporation Documents without the written approval or consent of the Obligated Group Representative and the owners of the amount of Series 2017 Bonds Outstanding required by the Bond Indenture which approval or consent shall be given and procured as provided therein.

No Amendment to Corporation Documents May Alter Series 2017A Note

Under no circumstances shall any amendment to the Corporation Documents alter the Series 2017A Note or the payments of principal and interest thereon, without the consent of the owners of all the Series 2017 Bonds at the time outstanding.

Discharge of Lien

If the Issuer or the Corporation, as the case may be, shall pay or cause to be paid the principal of, premium, if any, and interest on the Series 2017 Bonds at the times and in the manner stipulated therein, and shall have made arrangements satisfactory to the Bond Trustee for the payment of all fees and expenses of the Bond Trustee and each paying agent, then these

presents and the estate and rights granted by the Bond Indenture shall, at the direction of the Corporation, cease, determine and be void, and thereupon the Bond Trustee shall cancel and discharge the lien of the Bond Indenture and execute and deliver to the Issuer such instruments in writing as shall be requisite to satisfy the lien thereof, and assign and deliver to the Issuer any property at the time its subject to the lien of the Bond Indenture which may then be in its possession, except amounts required to be paid to the Corporation under the Sublease and except funds held by the Bond Trustee for the payment of principal of, premium, if any, and interest on the Series 2017 Bonds.

All Outstanding Series 2017 Bonds and all interest due thereon, or a portion of the Outstanding Series 2017 Bonds and all interest due thereon, shall prior to the maturity thereof be deemed to have been paid within the meaning and with the effect expressed in the immediately preceding paragraph if, under circumstances which do not render interest on the Series 2017 Bonds subject to federal income taxation, (a) there shall have been deposited with the Bond Trustee either moneys, in an amount which shall be sufficient, or Defeasance Obligations the principal of and the interest or other income on which when due will provide moneys which, together with moneys, if any, deposited with the Bond Trustee at the same time, shall be sufficient to pay when due the principal of, premium, if any, and interest due and to become due on said Series 2017 Bonds on and prior to the maturity date thereof, (b) there shall be delivered to the Bond Trustee the report of an independent certified public accountant or nationally recognized bond counsel to the effect that the moneys or Defeasance Obligations will be sufficient to pay, as the same becomes due at maturity or upon redemption, the principal of and interest and premium, if any, on the Series 2017 Bonds and an opinion of nationally recognized bond counsel to the effect that the Series 2017 Bonds have been paid within the meaning of the Bond Indenture, and (c) the Issuer shall have given the Bond Trustee in form satisfactory to it irrevocable instructions to send via Electronic Means or mail, postage prepaid, a notice to the owners of such Series 2017 Bonds that the deposit required by (a) above has been made with the Bond Trustee and that said Series 2017 Bonds are deemed to have been paid and stating the date upon which moneys are to be available for the payment of the principal on said Series 2017 Bonds, provided, however, that the lien of the Bond Indenture shall not be discharged unless and until all Outstanding Bonds and all interest due thereon are deemed to have been paid within the meaning of the Bond Indenture. Except as provided in the following paragraph, neither direct or guaranteed obligations of the United States of America nor moneys deposited with the Bond Trustee nor principal or interest payments on any such securities shall be withdrawn or used for any purpose other than, and shall be held in trust for, the payment of the principal of, premium, if any, and interest on the Series 2017 Bonds for which such deposit was made.

At the written request of the Corporation and with the consent of the Issuer, which consent shall not be unreasonably withheld, and upon compliance with the conditions stated in the Bond Indenture, the Bond Trustee shall have the power to sell, transfer or otherwise dispose of or request the redemption of Defeasance Obligations acquired under the Bond Indenture and to substitute other Defeasance Obligations of such maturities and interest payment dates and bearing interest as will, without further investment or reinvestment of either the principal amount thereof or the interest earnings thereon, be sufficient to pay the principal of and interest and premium, if any, on the Series 2017 Bonds when due. The foregoing transaction may be effected only if (i) an independent certified public accountant or nationally recognized bond counsel shall certify that after such transaction the principal amount of and interest income from the

Defeasance Obligations to be substituted will be sufficient to pay, as the same becomes due at maturity or upon redemption, the principal of and interest and premium, if any, on the Series 2017 Bonds and (ii) the Bond Trustee shall receive an unqualified opinion of nationally recognized bond counsel to the effect that such disposition and substitution or purchase would not cause any of the Series 2017 Bonds to become an "arbitrage bond" within the meaning of Sections 103(b)(2) and 148 of the Code.

SUMMARY OF THE TAX REGULATORY AGREEMENT

The Tax Regulatory Agreement contains covenants and provisions relating to compliance with provisions of the Code governing the exclusion of interest on the Series 2017 Bonds from the gross income of the recipients thereof for federal income tax purposes, including covenants and provisions relating to (i) ownership of the Existing Facilities by a governmental entity or an organization described in Section 501(c)(3) of the Code; (ii) the weighted average maturity of the Series 2017 Bonds as compared to the reasonably expected economic life of the Project and the facilities financed from the proceeds of the Prior Bonds; (iii) use of the proceeds of the Series 2017 Bonds in a manner which would cause the Series 2017 Bonds to be "arbitrage bonds"; (iv) compliance with the arbitrage rebate requirements of the Code; (v) compliance with the public approval requirements of the Code; (vi) limitation on the use of proceeds of the Series 2017 Bonds to pay costs of issuance; and (vii) compliance with the information reporting requirements of the Code.

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APPENDIX D

FORM OF BOND COUNSEL OPINION

June 22, 2017

City of Chillicothe, Ohio
Chillicothe, Ohio

Cain Brothers & Company, LLC
New York, New York

The Huntington National Bank, as Trustee
Cincinnati, Ohio

Ladies and Gentlemen:

We have examined the transcript of proceedings, including the Lease, Sublease, Master Indenture, Master Note and Bond Indenture, all as defined herein, relating to the issue of $145,570,000 Hospital Facilities Revenue Refunding and Improvement Bonds, Series 2017 (Adena Health System Obligated Group Project), dated the date of initial delivery (the "Series 2017 Bonds") of the City of Chillicothe, Ohio (the "Issuer"). The Series 2017 Bonds are initially issued as fully registered bonds of the denomination of $5,000 each, or any integral multiple thereof.

The Series 2017 Bonds mature, bear interest and are redeemable all as provided in the Indenture of Trust (Bond Indenture) dated as of June 1, 2017 (the "Bond Indenture") between the Issuer and The Huntington National Bank, as trustee (the "Bond Trustee").

The Series 2017 Bonds have been issued, together with other available moneys, to (1) finance the acquisition, construction, renovation and equipping of the Project, as defined in the Bond Indenture, (2) advance refund the outstanding principal amount of the $142,970,000 County of Ross, Ohio Hospital Facilities Revenue Refunding Bonds, Series 2008 (Adena Health System) (the "Prior Bonds"), and (3) pay certain costs in connection with issuance of the Series 2017 Bonds and the refunding of the Prior Bonds.

The Issuer has entered into an Agreement of Lease, dated as of June 1, 2017 (the "Lease") with Adena Health System (the "Corporation"), an Ohio nonprofit corporation. Under the provisions of the Lease, the Issuer has leased the Existing Facilities (as defined in the Bond Indenture) from the Corporation. The Existing Facilities have then been subleased from the Issuer to the Corporation pursuant to a Sublease, dated as of June 1, 2017 (the "Sublease"), between the Corporation and the Issuer. The Sublease provides for the payment by the Corporation of Basic Rent, as defined therein, in amounts sufficient to pay the principal of and the interest on the Series 2017 Bonds.

The Corporation and Adena Medical Group, LLC, an Ohio limited liability company, have entered into the Amended and Restated Master Trust Indenture dated as of June 1, 2017 (the "Master Indenture") with The Huntington National Bank, as trustee (the "Master Trustee"), pursuant to which the

Corporation has issued its Series 2017A Note (the "Master Note") to the Bond Trustee, which Master Note provides for payments sufficient in time and amount to assure the full and prompt payment of the Series 2017 Bonds and the interest thereon, whether payable at maturity, redemption prior to maturity or acceleration.

The Bond Indenture provides for the creation of a special fund designated the Bond Fund (herein called the "Bond Fund"), which special fund is pledged to and charged with the payment of the principal of and interest and premium, if any, on all Series 2017 Bonds.

The Series 2017 Bonds are issued under the authority of the general laws of the State of Ohio, particularly Chapter 140 of the Ohio Revised Code, and by virtue of an Ordinance of the City Council of Issuer in relation thereto.

We have also examined a copy of the signed and authenticated bond numbered R-1 of the Series 2017 Bonds.

From such examination we are of the opinion that:

1. The laws under which the Series 2017 Bonds are issued are constitutional and the proceedings regular and in due form.

2. The Issuer is validly existing under the laws of the State of Ohio with full power and authority to issue the Series 2017 Bonds.

3. The Bond Indenture, the Lease and the Sublease are valid and binding obligations of the Issuer enforceable in accordance with the terms and tenor thereof, except to the extent that the enforceability (but not the validity) thereof may be limited by bankruptcy, insolvency or other laws affecting enforcement of creditors' rights generally.

4. The Issuer has full and lawful authority to provide, lease, sublease and cause to be operated and maintained the Existing Facilities as provided in the Lease, the Sublease and the Bond Indenture. All right, title and interest of the Issuer in and to the Lease and Sublease has been validly assigned to the Bond Trustee.

5. The Series 2017 Bonds are valid and legally binding limited revenue obligations of the Issuer payable in accordance with their terms solely from the Trust Estate (as defined in the Bond Indenture) and other amounts derived from its ownership, sale or leasing of the Existing Facilities (except to the extent paid out of moneys attributable to the Series 2017 Bond proceeds or the income from the temporary investment thereof) and constitute a valid claim of the respective holders thereof only against the Bond Fund and other moneys held by the Bond Trustee and the revenues and other amounts derived from the leasing or sale of the Existing Facilities.

6. The Series 2017 Bonds are not general obligations, debt or bonded indebtedness of the Issuer or of the State of Ohio or any political subdivision thereof, and the holders or owners thereof do not have the right to have excises or taxes levied by the Issuer or the State of Ohio or any political subdivision thereof for the payment of the principal of and interest and premium, if any, on the Series 2017 Bonds. The right to payment of such principal, interest and premium, if any, is limited to the revenues pledged therefor in the Bond Indenture and to other moneys payable under the Master Note.

7. The Series 2017 Bonds, the Master Note, the Lease and the Sublease are exempt from registration pursuant to the Securities Act of 1933, as amended, and the Bond Indenture and Master

Indenture are exempt from qualification as indentures pursuant to the Trust Indenture Act of 1939, as amended.

8. The interest on the Series 2017 Bonds is exempt from the income base used in calculating the corporate franchise tax levied by Chapter 5733 of the Ohio Revised Code and from the Ohio personal income tax levied by Chapter 5747 of the Ohio Revised Code. Pursuant to Section 140.08 of the Ohio Revised Code, the Series 2017 Bonds, the transfer thereof, and the income therefrom, including any profit made on the sale thereof, are exempt from taxation within the State of Ohio.

9. Under laws, regulations, rulings and judicial decisions in effect as of the date hereof, interest on the Series 2017 Bonds is excludible from gross income for Federal income tax purposes, pursuant to the Internal Revenue Code of 1986, as amended (the "Code"). Furthermore, interest on the Series 2017 Bonds will not be treated as a specific item of tax preference, under Section 57(a)(5) of the Code, in computing the alternative minimum tax for individuals and corporations. The Series 2017 Bonds are "qualified 501(c)(3) bonds" within the meaning of the Code. In rendering the opinions in this paragraph, we have assumed continuing compliance with certain covenants made by the Issuer and the Corporation designed to meet the requirements of Section 103 of the Code. We express no other opinion as to the federal tax consequences of purchasing, holding or disposing of the Series 2017 Bonds.

Very truly yours,

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APPENDIX E

BOOK-ENTRY SYSTEM

Information concerning DTC and the book entry system has been obtained from DTC and is not guaranteed as to accuracy or completeness by, and is not to be construed as a representation by, the Issuer, the Underwriter, the Trustee, or any member of the Obligated Group.

The Series 2017 Bonds will be available only in book entry form in Authorized Denominations. DTC New York, New York, will act as securities depository for the Series 2017 Bonds. The Series 2017 Bonds will be issued as fully-registered securities 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 security certificate will be issued for each maturity of the Series 2017 Bonds, each in the aggregate principal amount of such maturity, and will be deposited with DTC.

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 has a Standard & Poor's rating of AA+. The DTC Rules applicable to its Participants are on file with the Securities and Exchange Commission. More information about DTC can be found at www.dtcc.com.

Purchases of the Series 2017 Bonds under the DTC system must be made by or through Direct Participants which will receive a credit for such Series 2017 Bonds on DTC's records. The ownership interest of each actual purchaser of each Series 2017 Bond ("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 2017 Bonds 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 interest in the Series 2017 Bonds, except in the event that use of the book-entry system for the Series 2017 Bonds is discontinued.

To facilitate subsequent transfers, all Series 2017 Bonds deposited by Direct Participants with DTC 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 Series 2017 Bonds with DTC and their

registration in the name of Cede & Co. or such other DTC nominee do not affect any change in beneficial ownership. DTC has no knowledge of the actual Beneficial Owners of the Series 2017 Bonds; DTC's records reflect only the identity of the Direct Participants to whose accounts such Series 2017 Bonds 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.

Conveyances 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 2017 Bonds may wish to take certain steps to augment the transmission to them of notices of significant events with respect to the Series 2017 Bonds, such as redemptions, tenders, defaults, and proposed amendments to the Series 2017 Bond documents. For example, Beneficial Owners of the Series 2017 Bonds may wish to ascertain that the nominee holding the Series 2017 Bonds 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 Trustee and request that copies of notices be provided directly to them.

Redemption notices will be sent to DTC. If less than all of the Series 2017 Bonds are being redeemed, DTC's practice is to determine by lot the amount of the interest of each Direct Participant in such series to be redeemed.

Neither DTC nor Cede & Co. (nor any other DTC nominee) will consent or vote with respect to Series 2017 Bonds unless authorized by a Direct Participant in accordance with DTC's MMI Procedures. Under its usual procedures, DTC mails an Omnibus Proxy to the Issuer 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 2017 Bonds are credited on the record date (identified in a listing attached to the Omnibus Proxy).

Principal and interest payments on the Series 2017 Bonds 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 Issuer or the Trustee, on a payment 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 securities 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 the Issuer, the Commission, the Trustee, the Corporation or the Hospital, subject to any statutory or regulatory requirements as may be in effect from time to time. Payment of principal and interest to Cede & Co. (or such other nominee as may be requested by an authorized representative of DTC) is the responsibility of the 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.

Discontinuance of DTC Services

DTC may discontinue providing its services as securities depository with respect to the Series 2017 Bonds at any time by giving notice to the Issuer and the Trustee. Under such circumstances, in the event that a successor securities depository is not obtained, bond certificates are required to be authenticated and delivered.

The Issuer may, as provided in the Bond Indenture, decide to discontinue use of the system of book-entry transfers through DTC or a successor securities depository. In that event, bond certificates will be authenticated and delivered for the Series 2017 Bonds.

Use of Certain Terms in Other Sections of the Official Statement

In reviewing this Official Statement it should be understood that while the Series 2017 Bonds are in the book-entry system, reference in other sections of this Official Statement to owners of such Series 2017 Bonds should be read to include any person for whom a Participant acquires an interest in Series 2017 Bonds, but (a) all rights of ownership, as described herein, must be exercised through DTC and the book-entry system and (b) notices that are to be given to registered owners by the Bond Trustee will be given only to DTC. DTC is required to forward (or cause to be forwarded) the notices to the Participants by its usual procedures so that such Participants may forward (or cause to be forwarded) such notices to the Beneficial Owners.

None of the Issuer, any member of the Obligated Group, the Underwriter or the Bond Trustee has any responsibility or obligation to any DTC Participant or any Beneficial Owner with respect to: (a) the accuracy of any records maintained by DTC or any Participant; (b) the payment by DTC or any Participant of any amount due to any Beneficial Owner in respect of the principal or purchase price of, or interest or any premium on the Series 2017 Bonds; (c) the delivery by DTC or any Participant to any Beneficial Owner of any notice (including a notice of redemption) or other communication which is required or permitted to be given to bondholders under the Bond Indenture; (d) the selection of the Beneficial Owners to receive payment in the event of a partial redemption of the Series 2017 Bonds; or (e) any consent given or other action taken by DTC as the registered owner of the Series 2017 Bonds.

The Issuer, each member of the Obligated Group, the Underwriter, and the Bond Trustee cannot and do not give any assurances that DTC or the Direct or Indirect Participants will distribute to the Beneficial Owners of the Series 2017 Bonds (a) payments of principal or prepayment price of or interest on the Series 2017 Bonds; (b) certificates representing an ownership interest or other confirmation of Beneficial Ownership interests in the Series 2017 Bonds; or (c) prepayment or other notices sent to DTC or Cede & Co., its nominee, as the Holder of the Series 2017 Bonds, or that they will do so on a timely basis or that Direct or Indirect Participants will serve and act in the manner described in this Official Statement. The current "Rules" applicable to DTC are on file with the Securities and Exchange Commission, and the current "Procedures" of DTC to be followed in dealing with Participants are on file with DTC.

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CITY OF CHILLICOTHE, OHIO • HOSPITAL FACILITIES REVENUE REFUNDING AND IMPROVEMENT BONDS, SERIES 2017 (ADENA HEALTH SYSTEM OBLIGATED GROUP PROJECT)

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