NEW ISSUE
BOOK-ENTRY ONLY

Ratings: Moody's: Aa3
S&P: AA-
See "RATINGS" herein.

In the opinion of Ice Miller LLP, Indianapolis, Indiana, Bond Counsel, under existing federal statutes, decisions, regulations and rulings, interest on the Bonds, as defined herein, is excludable from gross income for purposes of federal income taxation pursuant to Section 103 of the Internal Revenue Code of 1986, as amended, is not an item of tax preference for purposes of the federal alternative minimum tax imposed on individuals and corporations but, is taken into account in determining adjusted current earnings for the purpose of computing the alternative minimum tax imposed on certain corporations. Such exclusion is conditioned upon continuing compliance by the Authority, the Obligated Group and certain other affiliates with the Tax Covenants, all as defined herein. In the opinion of Bond Counsel, under existing laws, regulations, judicial decisions and rulings, interest on the Bonds is exempt from income taxation in the State of Indiana. See "TAX MATTERS" and APPENDIX D.

PARKVIEW HEALTH

$110,630,000
INDIANA FINANCE AUTHORITY
HOSPITAL REFUNDING REVENUE BONDS, SERIES 2017A
(PARKVIEW HEALTH)

Dated: Date of Delivery **Due: As Shown Herein**

The Indiana Finance Authority (the "*Authority*") is issuing its Hospital Refunding Revenue Bonds, Series 2017A (Parkview Health) in the aggregate principal amount of $110,630,000 (the "*Bonds*"). The proceeds of the Bonds will be used, together with funds of Parkview Health System, Inc. ("*Parkview Health*"), to: (i) advance refund a portion of the outstanding Indiana Finance Authority Hospital Revenue Bonds, Series 2009A (Parkview Health System Obligated Group) and (ii) pay costs of issuance of the Bonds.

The Bonds are special and limited obligations of the Authority, a public body politic and corporate not a state agency but an independent instrumentality exercising essential public functions under the laws of the State of Indiana, secured under the provisions of the Indenture and the Loan Agreement described herein, and will be payable from loan repayments made by Parkview Health under the Loan Agreement, payments made by Parkview Health and Parkview Hospital, Inc. (the "*Obligated Group*") on the Series 2017A Note (as defined herein), issued under the Master Indenture, as described herein and from certain funds held under the Indenture. Under the Master Indenture, the members of the Obligated Group jointly and severally are obligated to make payments on the Series 2017A Note in amounts sufficient to pay principal of and premium, if any, and interest on the Bonds when due.

The Bonds will be issued under and secured by the provisions of the Indenture. The Bonds will be issued in fully registered form in denominations of $5,000 or any integral multiple thereof and, when delivered, will be registered in the name of Cede & Co., as nominee of The Depository Trust Company, New York, New York ("*DTC*"). DTC will act as Securities Depository (as defined herein) for the Bonds and individual purchases of the Bonds will be made in book-entry form only, all as described herein. Principal of and premium, if any, and interest on the Bonds will be payable from the sources set forth herein by U.S. Bank National Association, as bond trustee (the "*Trustee*"), to the registered owners of the Bonds (as long as the book-entry system is in effect, Cede & Co.). Interest on the Bonds will be payable by the Trustee on each May 1 and November 1 commencing November 1, 2017. Subsequent disbursements of such principal and interest will be made to the individual purchasers of beneficial interests in the Bonds as described herein.

The Bonds are not subject to optional redemption. The Bonds are subject to extraordinary optional redemption prior to maturity as described herein.

THE BONDS ARE SPECIAL AND LIMITED OBLIGATIONS OF THE AUTHORITY AND WILL BE PAYABLE SOLELY FROM AND SECURED EXCLUSIVELY BY PAYMENTS, REVENUES AND OTHER AMOUNTS PLEDGED THERETO PURSUANT TO THE INDENTURE. THE BONDS DO NOT REPRESENT OR CONSTITUTE A DEBT OF THE AUTHORITY, THE STATE OF INDIANA OR ANY POLITICAL SUBDIVISION THEREOF WITHIN THE MEANING OF THE PROVISIONS OF THE CONSTITUTION OR STATUTES OF THE STATE OF INDIANA OR A PLEDGE OF THE FAITH AND CREDIT OF THE AUTHORITY, THE STATE OF INDIANA OR ANY POLITICAL SUBDIVISION THEREOF, AND THE BONDS DO NOT GRANT TO THE OWNERS OR HOLDERS THEREOF ANY RIGHT TO HAVE THE AUTHORITY, THE STATE OF INDIANA OR ANY POLITICAL SUBDIVISION THEREOF LEVY ANY TAXES OR APPROPRIATE FUNDS FOR THE PAYMENT OF THE PRINCIPAL THEREOF OR PREMIUM, IF ANY, OR INTEREST THEREON. THE AUTHORITY HAS NO TAXING POWER.

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.

The delivery of the Bonds when, as and if delivered and received by the Underwriter, is subject to prior sale and to the approval of legality by Ice Miller LLP, Indianapolis, Indiana, Bond Counsel, and the approval of certain matters for the Obligated Group by their counsel, Rothberg Logan & Warsco LLP, Fort Wayne, Indiana; for the Authority by Krieg DeVault LLP, Carmel, Indiana; and for the Underwriter by its counsel, Hawkins Delafield & Wood LLP, Ann Arbor, Michigan. It is expected that the Bonds in definitive form will be available for delivery through the facilities of DTC on or about August 10, 2017.

J.P. Morgan

Dated: July 18, 2017

Parkview Regional Medical Center Campus

$110,630,000
INDIANA FINANCE AUTHORITY
HOSPITAL REFUNDING REVENUE BONDS, SERIES 2017A
(PARKVIEW HEALTH)

MATURITY SCHEDULE

$110,630,000 Serial Bonds

Maturity (November 1)	Principal Amount	Interest Rate	Price	CUSIP†
2018	$6,540,000	5.00%	104.869	45471APP1
2019	6,740,000	5.00	108.454	45471APQ9
2020	8,150,000	5.00	111.714	45471APR7
2021	8,915,000	5.00	114.495	45471APS5
2022	10,205,000	5.00	116.920	45471APT3
2023	10,535,000	5.00	118.891	45471APU0
2024	11,070,000	5.00	120.458	45471APV8
2025	14,260,000	5.00	121.461	45471APW6
2026	14,515,000	5.00	122.045	45471APX4
2027	7,650,000	5.00	122.937	45471APY2
2028	4,900,000	5.00	123.121	45471APZ9
2029	4,850,000	5.00	122.405	45471AQA3
2030	2,300,000	5.00	122.186	45471AQB1

† Copyright 2017, American Bankers Association. CUSIP is a registered trademark of the American Bankers Association. CUSIP data herein is provided to the CUSIP Service Bureau, managed on behalf of the American Bankers Association by S&P Global. This data is not intended to create a database and does not serve in any way as a substitute for the CUSIP Services Bureau. CUSIP numbers have been assigned by an independent company not affiliated with the Authority, the Underwriter, or the Obligated Group and are included solely for the convenience of the registered owners of the applicable Bonds. None of the Authority, the Underwriter or the Obligated Group is responsible for the selection or uses of those CUSIP numbers, and no representation is made as to their correctness on the applicable Bonds or as included herein. The CUSIP number for a specific maturity is subject to being changed after the issuance of the Bonds as a result of various subsequent actions including, but not limited to, a refunding in whole or in part or as a result of the pronouncement of secondary market portfolio insurance or other similar enhancement by investors that is applicable to all or a portion of the Bonds.

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REGARDING USE OF THIS OFFICIAL STATEMENT

No dealer, broker, sales representative or other person has been authorized by the Obligated Group, the Authority, or the Underwriter to give information or to make any representations with respect to the Bonds, other than those contained in this Official Statement, if given or made, such other information or representation must not be relied upon as having been authorized by any of the foregoing.

The information and expressions of opinion herein are subject to change without notice, and neither the delivery of this Official Statement nor any sale made hereunder shall under any circumstances create any implication that there has been no change in the affairs of the Authority or the Obligated Group since the date hereof (or since the date of any other information dated other than the date hereof). The Authority has consented to the use and distribution of this Official Statement. The information set forth herein relating to the Authority under the headings "INTRODUCTION - The Authority," "THE AUTHORITY" and "ABSENCE OF MATERIAL LITIGATION - Authority" has been obtained from the Authority. The Authority assumes no obligation related to any other information set forth herein. The information in the caption "BOOK-ENTRY SYSTEM" has been furnished by DTC. All other information set forth herein has been furnished by the Obligated Group, unless otherwise indicated.

The Underwriter has provided the following sentence for inclusion in this Official Statement: *The Underwriter has reviewed the information in this Official Statement in accordance with and as 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 CUSIP numbers included in this Official Statement are for the convenience of the holders and potential holders of the Bonds. No assurance can be given that the CUSIP numbers for the Bonds will remain the same after the date of issuance and delivery of the Bonds. CUSIP is a registered trademark of the American Bankers Association. CUSIP data herein is provided to the CUSIP Service Bureau, managed on behalf of the American Bankers Association by S&P Global. This data is not intended to create a database and does not serve in any way as a substitute for the CUSIP Services Bureau. The CUSIP numbers shown on the maturity schedule immediately following the cover page hereof have been assigned to the issue by an organization not affiliated with the Authority, the Underwriter or the Obligated Group and are included for convenience only. Neither the Authority, the Underwriter nor the Obligated Group is responsible for the selection of the CUSIP numbers, nor is any representation made as to their correctness on the Bonds or as indicated herein.

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

In connection with the offering of the Bonds, the Underwriter may over allot or effect transactions which stabilize or maintain the market price of the Bonds at a level above that which might otherwise prevail in the open market. Such stabilizing, if commenced, may be discontinued at any time.

In making an investment decision, investors must rely upon their own examination of the terms of the offering, including the merits and risks involved.

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS IN THIS OFFICIAL STATEMENT

Certain statements included or incorporated by reference in this Official Statement constitute projections or estimates of future events, generally known as forward-looking statements. These statements are generally identifiable by the terminology used such as "plan," "expect," "estimate," "budget" or other similar words. These forward-looking statements include, but are not limited to, the information under the caption "BONDHOLDERS' RISKS" in the forepart of this Official Statement and the information in APPENDIX A to this Official Statement. All forward-looking statements contained in this Official Statement have been provided solely by the Obligated Group.

The achievement of certain results or other expectations contained in such forward-looking statements involves 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 these forward-looking statements. The Obligated Group does not plan to issue any updates or revisions to those forward-looking statements if or when changes in its expectations, or events, conditions or circumstances on which such statements are based occur.

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OFFICIAL STATEMENT

$110,630,000

Indiana Finance Authority
Hospital Refunding Revenue Bonds, Series 2017A
(Parkview Health)

INTRODUCTION

The following introduction is subject in all respects to more complete information set forth in this Official Statement, including the cover page and Appendices hereto (the "Official Statement"). The description 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 and are qualified in their entirety by reference to each document. All capitalized terms used in this Official Statement and not otherwise defined herein shall have the same meanings as in the Indenture (as defined herein) or the Master Indenture (as defined herein). See APPENDIX C – "SUMMARY OF MASTER DOCUMENTS AND DEFINITIONS – Definitions of Certain Terms" hereto.

The information contained in this Official Statement has been compiled by the Obligated Group from official and other sources deemed by the Obligated Group to be reliable, and while not guaranteed as to completeness or accuracy, is believed by the Obligated Group to be correct as of this date. Only the information set forth herein under the captions "THE AUTHORITY" and "ABSENCE OF MATERIAL LITIGATION – Authority" has been obtained from the Authority. The Authority assumes no obligation related to any other information set forth herein.

General

This Official Statement is provided to furnish information in connection with the sale and delivery of the $110,630,000 aggregate principal amount of Indiana Finance Authority Hospital Refunding Revenue Bonds, Series 2017A (Parkview Health) (the "*Bonds*"), issued by the Indiana Finance Authority (the "*Authority*"). The Bonds will be issued pursuant to and secured by a Trust Indenture, dated as of August 1, 2017 (the "*Indenture*") between the Authority and U.S. Bank National Association, as bond trustee (the "*Trustee*"). The proceeds of the Bonds will be loaned to Parkview Health System, Inc. ("*Parkview Health"* or the *"Borrower*") pursuant to a Loan Agreement dated as of August 1, 2017 (the "*Loan Agreement*"), between the Authority and the Borrower.

Purpose of the Bonds

Parkview Health will use the proceeds of the Bonds, together with funds of Parkview Health, to (i) advance refund a portion of the outstanding Indiana Finance Authority Hospital Revenue Bonds, Series 2009A (Parkview Health System Obligated Group) (the "*Series 2009A Bonds*") in the amount of $121,395,000 (the portion of such bonds being refunded with proceeds of the Bonds is referred to herein as the "*Bonds To Be Refunded*") and (ii) pay certain costs of issuance of the Bonds. *See* "ESTIMATED SOURCES AND USES OF FUNDS" herein.

The Authority

The Authority is a body politic and corporate, not a state agency, but an independent instrumentality exercising essential public functions, of the State of Indiana (the "*State*"), duly organized and validly existing under the Indiana Finance Authority Law, Indiana Code §§ 4-4-10.9 and 11 and Indiana Code § 5-1-16, each as supplemented and amended (together, the "*IFA Act*"). Except as specifically stated herein, the Authority has not participated in the preparation or review of this Official Statement. Except for information concerning the Authority under the captions "THE AUTHORITY," and "ABSENCE OF MATERIAL LITIGATION - Authority," none of the information in this Official Statement has been supplied or verified by

the Authority and the Authority makes no representation or warranty, express or implied, as to the accuracy or completeness of such information. *See* "THE AUTHORITY" herein.

THE BONDS ARE SPECIAL AND LIMITED OBLIGATIONS OF THE AUTHORITY AND WILL BE PAYABLE SOLELY FROM AND SECURED EXCLUSIVELY BY PAYMENTS, REVENUES AND OTHER AMOUNTS PLEDGED THERETO PURSUANT TO THE INDENTURE. THE BONDS DO NOT REPRESENT OR CONSTITUTE A DEBT OF THE AUTHORITY, THE STATE OR ANY POLITICAL SUBDIVISION THEREOF WITHIN THE MEANING OF THE PROVISIONS OF THE CONSTITUTION OR STATUTES OF THE STATE OR A PLEDGE OF THE FAITH AND CREDIT OF THE AUTHORITY, THE STATE OR ANY POLITICAL SUBDIVISION THEREOF, AND THE BONDS DO NOT GRANT TO THE OWNERS OR HOLDERS THEREOF ANY RIGHT TO HAVE THE AUTHORITY, THE STATE OR ANY POLITICAL SUBDIVISION THEREOF LEVY ANY TAXES OR APPROPRIATE FUNDS FOR THE PAYMENT OF THE PRINCIPAL THEREOF OR PREMIUM, IF ANY, OR INTEREST THEREON. THE AUTHORITY HAS NO TAXING POWER.

Parkview Health System

The System. Formed in 1995, Parkview Health is a community based Indiana nonprofit corporation, located in Fort Wayne, Indiana. Parkview Health serves as the "parent" of various organizations that are directly or indirectly controlled by or under common control with Parkview Health (collectively, the "*Affiliated Entities*" and each an "*Affiliated Entity*"). Parkview Health and the Affiliated Entities comprise the Parkview Health system (the "*System*") which operates a physician-led, regionally integrated health care delivery system. The System provides a full array of services including acute, non-acute, and tertiary care services on an inpatient, outpatient and emergency basis; managed care services; diagnostic and therapeutic services; continuing care services including home health care, hospice, skilled nursing, and in-patient rehab; behavioral health care; primary and specialty physician care, a clinically integrated network, and research to residents to patients in 15 counties in northeast Indiana and northwest Ohio. In Fort Wayne and northeast Indiana, the System operates six acute care facilities, a behavioral health hospital, a tertiary care center and through a joint venture, an orthopedic specialty hospital, for a combined total of 906 licensed beds. The System has a medical staff of approximately 911 members. Parkview Hospital, Inc. ("*Parkview Hospital*") is the largest Affiliated Entity.

Parkview Health, Parkview Hospital, and certain of its Affiliated Entities, including the current Designated Affiliates (as defined below), are exempt from federal taxation under section 501(a) of the Internal Revenue Code of 1986 (the "*Code*"), as organizations described in section 501(c)(3) of the Code.

See APPENDIX A hereto for a detailed discussion of Parkview Health, Parkview Hospital, and the System.

The Obligated Group, the Credit Group and the Master Indenture

The Obligated Group. Parkview Health, Parkview Hospital and U.S. Bank National Association, N.A., as successor master trustee (the "*Master Trustee*") are parties to that certain Amended and Restated Master Trust Indenture dated as of November 1, 1998, as supplemented and amended to date (as supplemented and amended, the "*Original Master Indenture*" and, as supplemented and amended by the hereinafter defined Series 2017A Supplemental Indenture and when, as and if effective, as described herein, Supplemental No. 8, the "*Master Indenture*"). The Master Indenture authorizes Parkview Health, Parkview Hospital and any other entity that may become a party to the Master Indenture (collectively, the "*Obligated Group,"* the *"Obligated Group Members"* or the "*Members of the Obligated Group*" and each an "*Obligated Group Member*" or a "*Member*"), to issue Master Notes to evidence or secure Indebtedness. While each Obligated Group Member is the principal obligor on any Master Note issued on its behalf under the Master Indenture, all Members of the Obligated Group are jointly and severally liable for the repayment of all Master Notes issued under the Master Indenture. Parkview Health serves as representative for the Members of the Obligated Group for the purposes of the Master Indenture (in such capacity, the "*Obligated Group Representative*"). At present, Parkview Health and Parkview Hospital are the only Members of the Obligated Group under the Master Indenture. *See*

APPENDIX C – "SUMMARY OF MASTER DOCUMENTS AND DEFINITIONS – Summary of Certain Provisions of the Master Indenture – Entrance into the Obligated Group" and "– Cessation of Status as a Member of the Obligated Group" hereto.

The Credit Group. The Master Indenture also creates a Credit Group consisting of Members of the Obligated Group and certain entities designated from time to time by the Obligated Group Representative as "Designated Affiliates" under and in accordance with the Master Indenture. Designated Affiliates are not Members of the Obligated Group and are not liable for payments on the Master Notes**.** Designated Affiliates are obligated to transfer moneys to the Obligated Group Representative if necessary to make payments on outstanding Master Notes. The Obligated Group Representative is required to maintain control of each Designated Affiliate through governance and organizational relationships to the extent required, or contractual arrangements that it deems sufficient, to cause the Designated Affiliate to comply with the terms and conditions of the Master Indenture applicable to Designated Affiliates. At present, Community Hospital of LaGrange County, Inc. d/b/a Parkview LaGrange Hospital ("*Parkview LaGrange*") and Parkview Wabash Hospital, Inc. ("*Parkview Wabash*") are the only Designated Affiliates. *See* APPENDIX C – "SUMMARY OF MASTER DOCUMENTS AND DEFINITIONS – Summary of Certain Provisions of the Master Indenture – The Master Notes; Payment of the Master Notes; Designated Affiliates" hereto.

Amendment to the Master Indenture. The Corporation has proposed to amend the Original Master Indenture pursuant to the Supplemental and Amendatory Indenture No. 8, dated as of August 1, 2017 (the "*Supplemental No. 8*"), between Parkview Health and the Master Trustee. Pursuant to Supplemental No. 8, the audited financial statements for the System will be used for purposes of determining compliance with certain financial covenants and ratios required under the Master Indenture. Among other things, Supplemental No. 8 will add definitions of "*System Affiliate*" and "*System*", amend certain definitions, provide for the audited financial statements of the System to be used for purposes of financial reporting, provide for certain amendments relating to generally accepted accounting principles, and remove the requirement to provide an annual insurance certificate. The amendments to the Master Indenture are referred to herein as the "*Master Indenture Amendments*." The Master Indenture Amendments will become effective upon the receipt by the Master Trustee of consent of the holders of not less than 51% in aggregate principal amount of Master Notes Outstanding. *See* "SECURITY FOR THE BONDS – The Master Indenture – Amendment to the Master Indenture" and APPENDIX C – "SUMMARY OF MASTER DOCUMENTS AND DEFINITIONS – Summary of Certain Provisions of Supplemental No. 8" for further information on the Master Indenture Amendments.

The purchasers of the Bonds and the Bond Trustee shall be deemed to have consented to the Master Indenture Amendments upon their purchase of the Bonds and the Bond Trustee's acceptance of the Series 2017A Note, respectively.

Security for the Bonds

The Bonds are secured by and payable solely from the Trust Estate, which consists primarily of payments required to be made by Parkview Health under the Loan Agreement, payments to be made on the Series 2017A Note, and certain funds held under the Indenture. Pursuant to the terms of the Loan Agreement, Parkview Health will issue and deliver to the Trustee, on behalf of the Authority, the Series 2017A Master Note, dated the date of delivery of the Bonds (the "*Series 2017A Note*"). The Series 2017A Note will be issued pursuant to the Master Indenture and the Series 2017A Supplemental Master Indenture dated as of August 1, 2017 (the "*Series 2017A Supplemental Indenture*"), between Parkview Health and the Master Trustee. Pursuant to the Master Indenture, the Obligated Group Members agree to make payments on the Series 2017A Note in amounts sufficient to pay, principal of and premium, if any, and interest on the Bonds when due. The Series 2017A Note will be a general, unsecured, joint and several obligation of the Members of the Obligated Group.

No Designated Affiliate is or will be obligated to make payments on the Series 2017A Note. The Obligated Group Representative is obligated, however, to cause its Designated Affiliates to pay, loan or otherwise transfer to the Obligated Group Representative the moneys, as are necessary, to pay the principal of, premium, if any, and interest on all outstanding Master Notes issued under the Master Indenture, including the

Series 2017A Note. *See* "SECURITY FOR THE BONDS – The Master Indenture – Designated Affiliates" herein.

The Obligated Group has granted, and each entity that becomes a Member of the Obligated Group will be required to grant, a security interest pursuant to the Master Indenture in its Pledged Revenues for the purpose of securing, on a parity basis, the payment of all Master Notes issued from time to time under the Master Indenture. *See* "SECURITY FOR THE BONDS" herein and APPENDIX C "SUMMARY OF MASTER DOCUMENTS AND DEFINITIONS – Summary of Certain Provisions of the Master Indenture" hereto.

Under certain circumstances, the Series 2017A Note may be exchanged, without the consent of any of the Holders of the Bonds, for an obligation of a different obligated group or credit group that would include among its members the Members of the Obligated Group. Under certain circumstances, this could lead to the substitution of different security in the form of an obligation backed by an obligated group or credit group that is financially and operationally different from the then existing Obligated Group or Credit Group. That new obligated group or credit group could have substantial debt outstanding that would rank on a parity basis with the obligation substituted for the Series 2017A Note. *See* "SECURITY FOR THE BONDS – The Indenture – Replacement of the Series 2017A Note with an Obligation Issued Under a Separate Master Indenture."

Outstanding Master Notes

The Series 2017A Note will be equally and ratably secured with Master Notes issued under the Master Indenture. Additional Master Notes issued in the future will be equally and ratably secured with each other Master Note issued under the Master Indenture, including the Series 2017A Note. *See* "SECURITY FOR THE BONDS – The Master Indenture – Outstanding Master Notes" herein.

Covenants Related to Other Series of Bonds

The provisions of certain Related Supplemental Indentures or the financing documents to which they relate contain covenants and restrictions (the "*Bank/Insurer Covenants*") for the exclusive benefit of the respective providers of credit enhancement (each a "*Credit Enhancer*" and collectively, the "*Credit Enhancers*"), commercial bank purchasers (each a "*Direct Purchaser*" and collectively, the "*Direct Purchasers*"), interest rate swap agreement counterparties (each a "*Swap Provider*" and collectively, the "*Swap Providers*") and the bond insurer (the "*Bond Insurer*") that are more restrictive than the Master Indenture covenants described herein. These Bank/Insurer Covenants may be waived, modified or amended by the applicable Credit Enhancer, Direct Purchaser, Swap Provider or Bond Insurer in their sole discretion and without notice to or consent by the bond trustee of any outstanding bonds, the Trustee, the Master Trustee, the holders of outstanding bonds, including the Bonds, the holders of any Master Notes or any other Person. Violation of any of such covenants may result in an Event of Default under the Master Indenture which could result in acceleration of all of the Master Notes, including the Series 2017A Note. *See* "SECURITY FOR THE BONDS – The Master Indenture" herein.

Additional Indebtedness

Parkview Health, Parkview Hospital and any future Members of the Obligated Group, upon compliance with the terms and conditions, and for the purposes described in the Master Indenture, may incur Additional Indebtedness. Such Additional Indebtedness may be secured or unsecured, and may or may not be issued in the form of Master Notes under the Master Indenture. *See* APPENDIX C – "SUMMARY OF MASTER DOCUMENTS AND DEFINITIONS – Summary of Certain Provisions of the Master Indenture – Permitted Additional Indebtedness" hereto.

The Bonds

The Bonds will be registered in the name of Cede & Co., as nominee for The Depository Trust Company, New York, New York ("*DTC*"). Purchases of beneficial interests in the Bonds may be made in book-entry form only in denominations of $5,000 or any integral multiple thereof. Purchasers of beneficial

interests in the Bonds ("*Beneficial Owners*") will not receive physical delivery of certificates representing their interest in the Bonds. The Bonds will bear interest from the date of their delivery, payable on May 1 and November 1, commencing on November 1, 2017, at the interest rates per annum and will mature in the corresponding amounts set forth in the maturity schedule immediately following the cover page of this Official Statement.

Principal of and premium, if any, and interest on the Bonds will be paid by the Trustee, as paying agent under the Indenture (or by any successor paying agent), directly to DTC, so long as DTC or its nominee is the registered owner of the Bonds. The final disbursement of such payments to Beneficial Owners will be the responsibility of the DTC Participants and Indirect Participants, as more fully described herein. *See* "BOOK-ENTRY SYSTEM" herein. In the event that the Bonds are no longer held in book-entry form, principal of and premium, if any, and interest on the Bonds will be payable at the corporate trust operations office of the Trustee.

The Bonds are not subject to optional redemption. The Bonds are subject to extraordinary optional redemption prior to maturity as described herein. *See* "THE BONDS – Redemption" herein.

Bondholders' Risks

Certain risk factors associated with the purchase of the Bonds are described under the caption "BONDHOLDERS' RISKS" herein.

Availability of Documents

This Official Statement contains descriptions of, among other matters, the Bonds, the Series 2017A Note, the Indenture, the Loan Agreement, the Master Indenture, the Series 2017A Supplemental Indenture, Supplemental No. 8, and the System. Such descriptions and information do not purport to be comprehensive or definitive. All references herein to the Indenture, the Loan Agreement, the Master Indenture, the Series 2017A Supplemental Indenture, and Supplemental No. 8 are qualified in their entirety by reference to such documents, and references herein to the Bonds and the Series 2017A Note are qualified in their entirety by reference to the forms thereof included in the Indenture and the Series 2017A Supplemental Indenture, respectively. After delivery of the Bonds, copies of the Indenture, the Loan Agreement, the Master Indenture, the Series 2017A Supplemental Indenture, Supplemental No. 8 and other documents described herein will be available for inspection at the principal corporate trust operations office of the Trustee.

THE AUTHORITY

The Authority was created pursuant to the IFA Act as a body politic and corporate, not a state agency, but an independent instrumentality exercising essential public functions. In 2007, the Authority became the statutory successor to the Indiana Health and Educational Facility Financing Authority, which had been the statutory successor to the Indiana Health Facility Financing Authority. As successor, the Authority has power to issue bonds pursuant to the provisions of Indiana Code § 5-1-16, as amended and supplemented (the "*Healthcare Finance Act*" together with the IFA Act, the "*Act*"). Under the Healthcare Finance Act, the Authority is authorized to make loans to "participating providers" as defined in the Healthcare Finance Act in order to provide funds to finance, refinance and provide reimbursement for all or a portion of any and all costs authorized under the Healthcare Finance Act and related to the acquisition, lease, construction, repair, restoration, reconditioning, refinancing, installation or housing of "health facility property" as defined in the Healthcare Finance Act.

The Authority has undertaken and will continue to undertake other types of financing for the purposes authorized by the Healthcare Finance Act, the Act and certain other statutes.

No covenant or agreement contained in the Indenture, the Loan Agreement or the Bonds shall be deemed to be a covenant or agreement of any member, officer, director, agent, attorney or employee of the Authority, nor shall any member, officer, director, agent, attorney or employee of the Authority be liable personally on the Bonds or any other of the aforementioned documents.

THE BONDS ARE SPECIAL AND LIMITED OBLIGATIONS OF THE AUTHORITY AND THE PRINCIPAL OF, PREMIUM, IF ANY, AND INTEREST ON THE BONDS WILL BE PAYABLE SOLELY FROM AND SECURED EXCLUSIVELY BY PAYMENTS, REVENUES AND OTHER AMOUNTS PLEDGED THERETO PURSUANT TO THE INDENTURE. THE BONDS DO NOT REPRESENT OR CONSTITUTE A DEBT OF THE AUTHORITY, THE STATE OR ANY POLITICAL SUBDIVISION THEREOF WITHIN THE MEANING OF THE PROVISIONS OF THE CONSTITUTION OR STATUTES OF THE STATE OR PLEDGE OF THE FAITH AND CREDIT OF THE AUTHORITY, THE STATE OR ANY POLITICAL SUBDIVISION THEREOF, AND THE BONDS DO NOT GRANT TO THE OWNERS OR HOLDERS THEREOF ANY RIGHT TO HAVE THE AUTHORITY, THE STATE OR ANY POLITICAL SUBDIVISION THEREOF LEVY ANY TAXES OR APPROPRIATE FUNDS FOR THE PAYMENT OF THE PRINCIPAL THEREOF OR PREMIUM, IF ANY, OR INTEREST THEREON. THE AUTHORITY HAS NO TAXING POWER.

PLAN OF FINANCE

General

Parkview Health will use the proceeds of the Bonds, together with funds of Parkview Health, to (i) advance refund the Bonds To Be Refunded and (ii) pay certain costs of issuance of the Bonds.

The Refunding

In order to accomplish the advance refunding of and to secure the payment of principal and interest becoming due on the Bonds To Be Refunded on or prior to May 1, 2019, a portion of the proceeds of the Bonds will be used to purchase direct obligations of the U.S. (the "*Defeasance Obligations*") which will be deposited with and held in a trust fund (the "*Escrow Fund*") by U.S. Bank National Association, under and pursuant to the Escrow Deposit Agreement dated as of August 1, 2017 (the "*Escrow Deposit Agreement*"), among Parkview Health, U.S. Bank National Association, as escrow trustee, and U.S. Bank National Association, as the prior Series 2009A Bonds trustee. The Defeasance Obligations and any uninvested cash on deposit in the Escrow Fund will be in a principal amount which, together with interest to be earned thereon, without consideration of any reinvestment thereof, will be sufficient to pay the principal of and interest on all of the Bonds To Be Refunded to be redeemed until and including their aforementioned redemption date. Upon deposit of such funds and compliance with the provisions of the bond indenture for the Series 2009A Bonds, the Bonds To Be Refunded will be secured solely by the Escrow Fund.

Additionally, in connection with the advance refunding, a portion of the debt service reserve fund relating to the Series 2009A Bonds, in the amount of approximately $16,800,000, will be released to Parkview Health.

THE BONDS

The following is a summary of certain provisions of the Bonds. Reference is made to the Bonds and to the Indenture for a more detailed description of such provisions. The discussion herein is qualified by such reference. *See* APPENDIX C hereto for a more detailed description of the provisions of the Bonds and the Indenture. Any reference herein to the Bonds or to the Indenture or other documents shall be deemed to mean the Bonds, the Indenture or such documents, unless the context or use clearly indicates otherwise.

General

The Bonds will bear interest at the rates per annum and will mature in the corresponding amounts set forth in the maturity schedule immediately following the cover page of this Official Statement. Interest on the Bonds will accrue from the date of their delivery, and such interest is payable on May 1 and November 1 of each year, commencing on November 1, 2017 (each, an "*Interest Payment Date*"), to registered owners of the Bonds as of the first day of the month of the Interest Payment Date. Calculations of interest on the Bonds will be computed on the basis of a 360 day year consisting of twelve 30 day months.

The Bonds will be issued in fully registered form only in denominations of $5,000 or any integral multiple thereof ("*Authorized Denominations*"). For so long as the Bonds are registered in the name of DTC or its nominee, payments of principal of and premium, if any, and interest on the Bonds will be paid by the Trustee (or any successor paying agent) only to DTC or its nominee. Neither the Authority nor the Trustee will have any responsibility for any Beneficial Owner's receipt from DTC or its nominee, or from any DTC Participant or Indirect Participant, of any payment of principal of or premium, if any, or interest on any Bonds. *See* "BOOK-ENTRY SYSTEM".

Redemption

Optional Redemption. The Bonds are not subject to optional redemption.

Extraordinary Optional Redemption. The Bonds are subject to extraordinary optional redemption (in an amount not to exceed the available net proceeds of an insurance or condemnation award) by the Authority at the direction of the Obligated Group Representative in whole or in part at any time (upon the simultaneous prepayment of a like principal amount of the Series 2017A Note), in any order of maturity selected by the Obligated Group Representative (or if the Obligated Group Representative fails to designate such maturities, in inverse order of maturity) and by lot within a single maturity, at a redemption price equal to the principal amount of the Bonds to be redeemed, plus accrued and unpaid interest to the redemption date, without premium, in the event any facilities of the Members of the Obligated Group financed or refinanced with the proceeds of the Bonds shall have been damaged, destroyed or condemned, provided that the net proceeds of such insurance or condemnation award shall exceed $3,000,000 and that the applicable Member of the Obligated Group shall have determined not to use such net proceeds to rebuild, replace or repair such facilities.

Selection of Bonds for Redemption. Upon any redemption of Bonds in part, there will be no partial redemption of less than an Authorized Denomination. If less than all of the outstanding Bonds of a maturity are called for redemption under any provision of the Indenture permitting partial redemption, the particular Bonds within such maturity to be redeemed will be selected by the Trustee by lot in such manner as the Trustee in its discretion may deem fair and appropriate consistent with the requirements of the Indenture.

Notice of Redemption. Notice of any redemption of Bonds, either in whole or in part, will be sent by the Trustee by first class mail, postage prepaid, not less than twenty (20) days nor more than sixty (60) days prior to the proposed redemption date, to all holders of the Bonds to be redeemed at their addresses as they appear on the registration books of the Trustee as of the close of business on the Business Day preceding the mailing. Each notice will (i) identify the Bonds to be redeemed (including the complete name of the Bonds, the interest rate, the dated date, the maturity date, the CUSIP number and the certificate number), the redemption date, the redemption price, and the place or places where amounts due upon such redemption will be payable (which will be the principal corporate trust operations office of the Trustee), and, if less than all of the Bonds are to be redeemed, the respective principal amounts of the Bonds to be redeemed, (ii) state that the Bonds called for redemption must be surrendered to collect the redemption price, (iii) state any condition to such redemption and (iv) state that on the redemption date, the redemption price will be due and payable upon the Bonds called for redemption and the Bonds to be redeemed will cease to bear interest. A failure to give such notice to any holder or any defect in such notice, however, shall not affect the validity of the proceedings for the redemption of any of the other Bonds. Any notice mailed as provided in the Indenture will be conclusively presumed to have been given whether or not actually received by any holder.

Securities Depository

Unless a successor Securities Depository (as defined herein) is designated pursuant to the Indenture, DTC will act as the Securities Depository for the Bonds. On the date of original issuance of the Bonds, one fully registered Bond for each maturity will be issued in the name of Cede & Co., as nominee of DTC, in the aggregate principal amount of each maturity of Bonds. So long as Cede & Co. is the registered owner of the Bonds as nominee of DTC, references herein to the owners or registered owners of the Bonds will mean Cede & Co. and will not mean the Beneficial Owners (as hereinafter defined) of the Bonds. The Securities Depository or its nominee will be the owner of record of all issued and outstanding Bonds, and the Beneficial Owners may not obtain physical possession of the certificates representing the Bonds unless the Securities

Depository resigns or is removed at the election of the Authority, at the direction of Parkview Health in accordance with the Indenture and no successor Securities Depository is appointed. In such event the Beneficial Owners may obtain physical possession of certificates representing the Bonds that they beneficially own.

So long as DTC is the Securities Depository for the Bonds, payments of the principal of, purchase price of, premium, if any, on and interest on the Bonds will be made directly by the Trustee to DTC or its nominee. Disbursement of such payments to the DTC Participants is the responsibility of DTC, and disbursement of such payments to the Beneficial Owners of the Bonds is the responsibility of the DTC Participants and Indirect Participants.

For further information regarding DTC and the book-entry only system, *see* "BOOK-ENTRY SYSTEM" herein.

The Beneficial Owners of the Bonds have no right to a Securities Depository. DTC or any successor Securities Depository may resign as Security Depository for the Bonds by giving notice to the Trustee and discharging its responsibilities under applicable law. If DTC is removed or a successor Depository is appointed, the Beneficial Owners of the Bonds shall obtain such Bonds in certificated form. The Authority, at the direction of Parkview Health shall (i) appoint a Securities Depository qualified to act as such under Section 17(a) of the Securities Exchange Act of 1934, notify the prior Securities Depository of the appointment of such successor Securities Depository and transfer certificated Bonds to such successor Securities Depository, or (ii) notify the Securities Depository of the availability through the Securities Depository of certificated Bonds and transfer certificated Bonds to Securities Depository participants having Bonds credited to their accounts at the Securities Depository. In such event, the Bonds shall no longer be restricted to being registered in the name of the Securities Depository but may be registered in the name of the successor Securities Depository or its nominee or in such names as the Bondholders transferring or receiving the certificated Bonds shall designate in accordance with the Indenture.

In the event that no successor Securities Depository is appointed, such certificated Bonds shall be issued in fully registered form and shall be issued in Authorized Denominations.

BOOK-ENTRY SYSTEM

The information provided in this caption has been provided by DTC. No representation is made by the Authority, the Trustee, the Master Trustee, the Obligated Group or the Underwriter as to the accuracy or adequacy of such information provided by DTC or as to the absence of material adverse changes in such information subsequent to the date hereof.

DTC will act as the depository for the Bonds. The Bonds will be issued as fully-registered securities registered in the name of Cede & Co. (DTC's partnership nominee) or such other name as may be requested by an authorized representative of DTC. The ownership of one fully-registered bond for each maturity of the Bonds, each in the aggregate principal amount of such maturity, will be registered in the name of Cede & Co.

DTC, the world's largest 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 ("*SEC*"). More information about DTC can be found at www.dtcc.com.

Purchases of Bonds under the DTC system must be made by or through Direct Participants, which will receive a credit for the Bonds on DTC's records. The ownership interest of each actual purchaser of each 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 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 interests in Bonds, except in the event that use of the book entry system for the Bonds is discontinued.

To facilitate subsequent transfers, 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 Bonds with DTC and their registration in the name of Cede & Co. or such other DTC nominee do not effect any change in beneficial ownership. DTC has no knowledge of the actual Beneficial Owners of the Bonds; DTC's records reflect only the identity of the Direct Participants to whose accounts such 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.

Conveyance of notices and other communications by DTC to Direct Participants, by Direct Participants to Indirect Participants, and by Direct Participants and Indirect Participants to Beneficial Owners will be governed by arrangements among them, subject to any statutory or regulatory requirements as may be in effect from time to time. Beneficial Owners of the Bonds may wish to take certain steps to augment the transmission to them of notices of significant events with respect to the Bonds, such as redemptions, tenders, defaults, and proposed amendments to the Bond documents. For example, Beneficial Owners of Bonds may wish to ascertain that the nominee holding the 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 registrar and request that copies of notices be provided directly to them.

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

Neither DTC nor Cede & Co. (nor any other DTC nominee) will consent or vote with respect to the 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 Authority or to the Obligated Group Representative, as the case may be, as soon as possible after the Record Date. The Omnibus Proxy assigns Cede & Co.'s consenting or voting rights to those DTC Participants to whose accounts the Bonds are credited on the Record Date (identified in a listing attached to the "*Omnibus Proxy*").

Payments of principal, interest, and redemption prices respectively, on the 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 Trustee or the Obligated Group Representative, as the case may be, on a payable date in accordance with their respective holdings shown on DTC's records. Payments by DTC Participants to Beneficial Owners will be governed by standing instructions and customary practices, as in 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, the Trustee, or the Obligated Group Representative, subject to any statutory or regulatory requirements as may be in effect from time to time.

Payment of principal, interest, and redemption prices to Cede & Co. (or such other nominee as may be requested by an authorized representative of DTC) is the responsibility of the Trustee or Obligated Group Representative, as the case may be. Disbursement of such payments to Direct Participants will be the responsibility of DTC, and disbursement of such payments to the Beneficial Owners will be the responsibility of Direct and Indirect Participants.

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

THE INFORMATION PROVIDED ABOVE HAS BEEN PROVIDED BY DTC. NO REPRESENTATION IS MADE BY THE AUTHORITY, THE OBLIGATED GROUP OR THE UNDERWRITER AS TO THE ACCURACY OR ADEQUACY OF SUCH INFORMATION PROVIDED BY DTC OR AS TO THE ABSENCE OF MATERIAL ADVERSE CHANGES IN SUCH INFORMATION SUBSEQUENT TO THE DATE HEREOF.

For so long as the Bonds are registered in the name of DTC or its nominee, Cede & Co., the Authority, the Obligated Group and the Trustee will recognize only DTC or its nominee, Cede & Co., as the registered owner of the Bonds for all purposes, including payments, notices and voting.

The Trustee at the direction and expense of the Obligated Group Representative, with respect to the Bonds may decide to discontinue use of the system of book entry transfers through DTC (or a successor securities depository). Once the Trustee or the Obligated Group Representative, as the case may be, has requested that holders withdraw securities from DTC, DTC will notify its Participants of such request and such Participants may utilize DTC's withdrawal process to withdraw their Bonds from DTC. In the event a Participant utilizes DTC's withdrawal process, Bond certificates will be printed and delivered.

Under the Indenture, payments made by the Trustee to DTC or its nominee will satisfy the Authority's obligations under the Indenture and Parkview Health's obligations under the Loan Agreement, to the extent of the payments so made.

Neither the Authority, the Underwriter, the Obligated Group, the Master Trustee nor the Trustee will have any responsibility or obligation with respect to (i) the accuracy of the records of DTC, its nominee or any DTC Participant or Indirect Participant with respect to any beneficial ownership interest in any Bond, (ii) the delivery to any DTC Participant or Indirect Participant or any other Person, other than an owner, as shown in the bond register, of any notice with respect to any Bond including, without limitation, any notice of redemption, tender, purchase or any event which would or could give rise to a tender or purchase right or option with respect to any Bond, (iii) the payment of any DTC Participant or Indirect Participant or any other Person, other than an owner, as shown in the bond register, of any amount with respect to the principal of, premium, if any, or interest on, or the purchase price of, any Bond or (iv) any consent given by DTC as registered owner.

Prior to any discontinuation of the book-entry only system described above, the Authority and the Obligated Group, as applicable, and the Trustee may treat DTC as, and deem DTC to be, the absolute owner of the Bonds for all purposes whatsoever, including, without limitation, (i) the payment of principal of, premium, if any, and interest on the Bonds, (ii) giving notices of redemption and other matters with respect to the Bonds, (iii) registering transfers with respect to the Bonds and (iv) the selection of Bonds for redemption.

Registration, Transfer and Exchange Provisions if Book-Entry System is Discontinued

The Beneficial Owners of the Bonds have no right to a Securities Depository for the Bonds. The following describes the provisions for registration, transfer and exchange of the Bonds if the book-entry system is discontinued.

The Trustee will maintain the bond register in which the registration of the related Bonds and the registration of transfers and exchanges of the related Bonds entitled to be transferred or exchanged will be recorded. The person in whose name a Bond is registered in the bond register will be deemed the absolute owner thereof for all purposes.

Any registered owner of a Bond or its duly authorized attorney may transfer title to such registered owner's Bond in the bond register upon surrender thereof at the corporate trust operations office of the Trustee, together with a written instrument of transfer (in substantially the form of assignment printed on the Bond or in such other form as shall be satisfactory to the Trustee) executed by the registered owner or its duly authorized attorney. The Bonds may be exchanged at the corporate trust operations office of the Trustee for a new Bond or Bonds of the same maturity and aggregate principal amount, but in different authorized denominations, as the Bonds being exchanged, upon surrender thereof at the corporate trust operations office of the Trustee. Upon surrender for transfer or exchange of any Bond, the Authority shall execute and the Trustee shall authenticate and deliver in the name of the transferee or transferees or the registered owner thereof, as applicable, a new Bond or Bonds of the same maturity and aggregate principal amount as the Bond surrendered.

The Trustee may charge each holder of a Bond requesting a transfer or exchange any tax, fee or other governmental charge required to be paid with respect to such transfer or exchange. The Trustee is not required to transfer or exchange any Bonds after notice of redemption of such Bond or portion thereof has been given as herein described or during the period from a Record Date to the succeeding Interest Payment Date.

SECURITY FOR THE BONDS

Limited Obligations of Authority

The Bonds will be special and limited obligations of the Authority, secured by and payable solely from the Trust Estate, which consists primarily of payments required to be made by Parkview Health under the Loan Agreement, payments to be made on the Series 2017A Note, and certain funds held under the Indenture.

THE BONDS ARE SPECIAL AND LIMITED OBLIGATIONS OF THE AUTHORITY AND WILL BE PAYABLE SOLELY FROM AND SECURED EXCLUSIVELY BY PAYMENTS, REVENUES AND OTHER AMOUNTS PLEDGED THERETO PURSUANT TO THE INDENTURE. THE BONDS DO NOT REPRESENT OR CONSTITUTE A DEBT OF THE AUTHORITY, THE STATE OR ANY POLITICAL SUBDIVISION THEREOF WITHIN THE MEANING OF THE PROVISIONS OF THE CONSTITUTION OR STATUTES OF THE STATE OR A PLEDGE OF THE FAITH AND CREDIT OF THE AUTHORITY, THE STATE OR ANY POLITICAL SUBDIVISION THEREOF, AND THE BONDS DO NOT GRANT TO THE OWNERS OR HOLDERS THEREOF ANY RIGHT TO HAVE THE AUTHORITY, THE STATE OR ANY POLITICAL SUBDIVISION THEREOF LEVY ANY TAXES OR APPROPRIATE FUNDS FOR THE PAYMENT OF THE PRINCIPAL THEREOF OR PREMIUM, IF ANY, OR INTEREST THEREON. THE AUTHORITY HAS NO TAXING POWER.

The Loan Agreement

Pursuant to the Loan Agreement, Parkview Health agrees to make payments to the Authority in such amounts and at such times as are sufficient to pay in full, when due, the principal of and premium, if any, and interest on the Bonds.

The Series 2017A Note

Pursuant to the terms of the Loan Agreement, Parkview Health will issue and deliver to the Trustee, on behalf of the Authority, the Series 2017A Note, dated the date of delivery of the Bonds. The Series 2017A Note will be issued pursuant to the Master Indenture and the Series 2017A Supplemental Indenture. Pursuant to the Master Indenture, the Obligated Group Members agree to make payments on the Series 2017A Note in

amounts sufficient to pay, principal of and premium, if any, and interest on the Bonds when due. The Series 2017A Note will be a general, unsecured, joint and several obligation of the Members of the Obligated Group.

All payments of principal, premium, if any, and interest by the Obligated Group on the Series 2017A Note will be made to the Trustee, and each payment will be made on or before the date when the corresponding payment is required to be made on the related Bonds. The principal, premium, if any, and interest payments on the Series 2017A Note corresponds in amount to the principal, premium, if any, and interest payments on the Bonds. The Series 2017A Note will at all times be in fully registered form and will be non-transferable except as required to effect assignment to any successor trustee. The Series 2017A Note, and all other Master Notes previously issued or to be issued under the Master Indenture, will be equally and ratably secured under the Master Indenture by the covenants and agreements therein and by the collateral, if any, provided for therein. Under certain circumstances, the Series 2017A Note may be exchanged, without the consent of any of the holders of the Bonds, for an obligation of a different obligated group or credit group that would include among its members the Members of the Obligated Group. *See* "SECURITY FOR THE BONDS – The Indenture – Replacement of the Series 2017A Note with an Obligation Issued Under a Separate Master Indenture".

The Master Indenture

Collective Obligations of the Obligated Group. The Master Indenture permits Parkview Health and other Members of the Obligated Group to issue additional Master Notes and to secure all Master Notes on a parity thereunder. **Parkview Health and Parkview Hospital are currently the only Members of the Obligated Group.** Additional Master Notes may be issued to evidence or secure Additional Indebtedness. *See* "─ Outstanding Master Notes" herein for a description of Master Notes, in addition to the Series 2017A Note, that are currently anticipated to be outstanding following the issuance of the Bonds and application of the proceeds thereof. Members of the Obligated Group may be added to and withdraw from the Obligated Group, in accordance with the provisions of the Master Indenture. *See* APPENDIX C – "SUMMARY OF MASTER DOCUMENTS AND DEFINITIONS – Summary of Certain Provisions of the Master Indenture – Entrance into the Obligated Group" and "– Cessation of Status as a Member of the Obligated Group".

Designated Affiliates. The Master Indenture permits the Obligated Group Representative to designate certain entities as "Designated Affiliates" under and in accordance with the Master Indenture. Designated Affiliates are not Members of the Obligated Group and are not liable for payments on the Master Notes**.** Designated Affiliates are obligated to transfer moneys to the Obligated Group Representative if necessary to make payments on outstanding Master Notes. The Obligated Group Representative is required to maintain control of each Designated Affiliate through governance and organizational relationships to the extent required, or contractual arrangements that it deems sufficient, to cause the Designated Affiliate to comply with the terms and conditions of the Master Indenture applicable to Designated Affiliates. **Parkview LaGrange and Parkview Wabash are currently the only Designated Affiliates.**

No assurance can be given that the Obligated Group Representative will, in all circumstances, be able to exercise such control (including, without limitation, the ability of the Obligated Group Representative to cause its Designated Affiliates to transfer funds to make payments on the Master Notes).

Additional entities may be designated as Designated Affiliates by the Obligated Group Representative from time to time, and such designation may be rescinded by the Obligated Group Representative from time to time, provided no Event of Default exists. Although the Master Indenture requires the Obligated Group Representative to include the Designated Affiliates in covenant calculations required under the Master Indenture, the Master Indenture imposes no limitations on the ability of the Obligated Group Representative to rescind the designation of an entity as a Designated Affiliate.

For additional information regarding the Credit Group, as currently configured, and provisions concerning additions to and withdrawals from the Credit Group, see APPENDIX A – "INFORMATION CONCERNING PARKVIEW HEALTH SYSTEM, INC. AND ITS AFFILIATES" and APPENDIX C – "SUMMARY OF MASTER DOCUMENTS AND DEFINITIONS – Summary of Certain Provisions of the

Master Indenture – The Master Notes; Payment of the Master Notes; Designated Affiliates," "– Entrance into the Obligated Group" and "– Cessation of Status as a Member of the Obligated Group".

Grant of Security Interest in Pledged Revenues. Each Master Note, including the Series 2017A Note, is secured by a security interest (which security interest has been assigned to the Master Trustee) in all Pledged Revenues now owned or hereafter acquired by the Obligated Group Members. "Pledged Revenues" consists generally of: all gross revenues, rents, profits, receipts, benefits, royalties, money and income of any Obligated Group Member arising from services provided by Obligated Group Members or arising in any manner with respect to, incident to or on account of the Obligated Group Members operations, including, without limitation, (i) the Obligated Group Members' rights under agreements with insurance companies, Medicare, Medicaid, governmental units and prepaid health organizations, including rights to Medicare and Medicaid loss recapture under applicable regulations and (ii) gifts, grants, bequests, donations, contributions and pledges to any Obligated Group Members and (iii) insurance proceeds or any award, or payment in lieu of an award, resulting from condemnation proceedings and all rights to receive the foregoing, whether now owned or hereafter acquired by any Obligated Group Member and regardless of whether generated in the form of accounts, accounts receivable, contract rights, chattel paper, documents, general intangibles, instruments, investment property, proceeds of insurance and all proceeds of the foregoing, whether cash or noncash. Gifts, grants, bequests, donations, contributions and pledges to any Obligated Group Member designated at the time of making by the donor or grantor as being for certain specific purposes, and the income and gains derived therefrom, to the extent required by such designation, are excluded from Pledged Revenues. System Affiliates which are not Members of the Obligated Group are not subject to this covenant under the Master Indenture regarding Pledged Revenues.

Except as otherwise described herein, the Series 2017A Note is not secured by a pledge, grant or mortgage of, or interest in, any other property of any Member of the Obligated Group or any Designated Affiliate. *See* "BONDHOLDERS' RISKS – Matters Relating to Enforceability of the Master Indenture" for a description of, among other matters, possible instances in which the security interest may not have priority or may not be enforceable.

Covenant Not to Create Additional Liens. The current Obligated Group Members and any future Obligated Group Members have agreed in the Master Indenture, that they will keep, and the Obligated Group Representative agreed that it will cause its Designated Affiliates to keep, its Property free and clear all Liens which are not Permitted Encumbrances. *See* APPENDIX C – "SUMMARY OF MASTER DOCUMENTS AND DEFINITIONS – Summary of Certain Provisions of the Master Indenture – Liens on Property".

Merger, Consolidation, Sale or Conveyance. The current Obligated Group Members and any future Obligated Group Member have agreed in the Master Indenture not to merge into, or consolidate with, one or more corporations which are not Obligated Group Members, or allow one or more of such corporations to merge into it, or sell or convey all or substantially all of its Property to any Person who is not an Obligated Group Member except as provided in the Master Indenture. *See* APPENDIX C – "SUMMARY OF MASTER DOCUMENTS AND DEFINITIONS – Summary of Certain Provisions of the Master Indenture – Merger, Consolidation, Sale or Conveyance".

Debt Service Coverage Ratio. The current Obligated Group Members and any future Obligated Group Member have agreed in the Master Indenture to maintain a Historical Debt Service Coverage Ratio of 1.10 to 1 or higher, the sole remedy for which is the requirement that the Obligated Group retain a consultant as provided for under the Master Indenture. *See* APPENDIX C – "SUMMARY OF MASTER DOCUMENTS AND DEFINITIONS – Summary of Certain Provisions of the Master Indenture – Calculation of Debt Service and Debt Service Coverage".

Outstanding Master Notes. The Obligated Group has previously issued Master Notes under the Master Indenture to secure revenue bonds previously issued for the benefit of the Obligated Group. The Obligated Group has also issued Master Notes to banks providing liquidity or credit facilities certain of these revenue bonds in order to evidence and secure the Obligated Group's obligations under the agreements entered into with those banks to obtain the liquidity or credit facilities. *See* APPENDIX A – "INFORMATION

CONCERNING PARKVIEW HEALTH SYSTEM, INC. AND ITS AFFILIATES – Financial Information – Outstanding Indebtedness" hereto for additional information on the long-term debt of the Obligated Group.

Additionally, the Obligated Group has issued Master Notes under the Master Indenture to Swap Providers to evidence and secure the Obligated Group's obligations under those interest rate swap agreements. For more information regarding these interest rate swap agreements, see "BONDHOLDER'S RISKS – Market Risks – Interest Rate Swap Risk" and APPENDIX A – "INFORMATION CONCERNING PARKVIEW HEALTH SYSTEM, INC. AND ITS AFFILIATES – Financial Information – Outstanding Indebtedness" hereto.

Covenants Related to Other Series of Bonds. The provisions of certain Related Supplemental Indentures or the financing documents to which they relate contain covenants for the exclusive benefit of the respective Credit Enhancers, Direct Purchasers, Swap Providers, and the Bond Insurer that are more restrictive than the Master Indenture covenants described herein. Such covenants may be amended or waived by the related credit enhancer at its sole discretion without the consent of bondholders. Failure to satisfy such covenants could lead to an acceleration of the indebtedness secured by such covenants or even an event of default under the Master Indenture.

Amendment to the Master Indenture. The Corporation has proposed to amend the Original Master Indenture pursuant to the Supplemental No. 8. Pursuant to Supplemental No. 8, the audited financial statements for the System will be used for purposes of determining compliance with certain financial covenants and ratios required under the Master Indenture. Among other things, Supplemental No. 8 will add definitions of "*System Affiliate*" and "*System*", amend certain definitions, provide for the audited financial statements of the System to be used for purposes of financial reporting, provide for certain amendments relating to generally accepted accounting principles, and remove the requirement to provide an annual insurance certificate. *See* "SECURITY FOR THE BONDS – The Master Indenture – Amendment to the Master Indenture" and APPENDIX C – "SUMMARY OF MASTER DOCUMENTS AND DEFINITIONS – Summary of Certain Provisions of Supplemental No. 8" for further information on the Master Indenture Amendments.

The Master Indenture Amendments will become effective upon the receipt by the Master Trustee of consent of the holders of not less than 51% in aggregate principal amount of Master Notes Outstanding. Where the Master Indenture requires the consent of the holders of the Master Notes for the amendment of the Master Indenture, the respective bond trustee is deemed such Master Note holder unless otherwise provided in the Master Indenture or a Related Supplemental Indenture. Under Related Supplemental Indentures, the Bond Insurer, the Swap Providers and the Credit Enhancers are treated as the holders of the Master Notes. Additionally, certain tax-exempt bonds were purchased directly by Direct Purchasers, which are the holders of Master Notes. *See* APPENDIX C – "SUMMARY OF MASTER DOCUMENTS AND DEFINITIONS – Summary of Certain Provisions of the Master Indenture – Credit Enhancement Providers Deemed Bondholders for Purposes of Consents and Supplements."

The purchasers of the Bonds and the Bond Trustee shall be deemed to have consented to the Master Indenture Amendments upon their purchase of the Bonds and the Bond Trustee's acceptance of the Series 2017A Note, respectively.

The Master Indenture may be further amended without the consent of or notice to the holders of Master Notes under certain circumstances. *See* APPENDIX C – "SUMMARY OF MASTER DOCUMENTS AND DEFINITIONS – Summary of Certain Provisions of the Master Indenture – Supplemental Master Indentures".

Additional Master Indenture Covenants. For additional covenants, warranties and representations of the Obligated Group under the Master Indenture and for conditions to the issuance of Additional Indebtedness by the Obligated Group, see APPENDIX C – "SUMMARY OF MASTER DOCUMENTS AND DEFINITIONS – Summary of Certain Provisions of the Master Indenture".

The Indenture

Assignment by Authority to the Trustee. Pursuant to the Indenture, the Authority will assign to the Trustee, as security for the payment of the Bonds, the following:

(1) all rights and interest of the Authority under the Loan Agreement (except the Authority's rights to indemnification and payment of its expenses and certain expenses of collection in the event of default), including the right to receive payments from Parkview Health; and

(2) all moneys and securities on deposit from time to time in the fund established under the provisions of the Indenture, permitting the application thereof for the purposes and on the terms and conditions set forth in the Indenture.

Replacement of the Series 2017A Note with an Obligation Issued Under a Separate Master Indenture. The Indenture provides that the Series 2017A Note will be surrendered by the Trustee and delivered to the Master Trustee for cancellation upon satisfaction of certain requirements that include receipt by such Trustee and the Authority of (i) a request from the Obligated Group Representative requesting such surrender and delivery and stating that Members of the Obligated Group have become members of an obligated group under a replacement master indenture (other than the Master Indenture) and that a replacement note is being issued to such Trustee under such replacement master indenture (the "*Replacement Master Indenture*"); (ii) a properly executed replacement obligation issued under the Replacement Master Indenture with the same tenor and effect as the Series 2017A Master Note delivered for cancellation; (iii) written confirmation from each rating service then rating the Bonds that the replacement of the Series 2017A Note will not, by itself, result in a reduction in the then-current ratings on the Bonds; and (iv) certain opinions of counsel described in the Indenture. *See* APPENDIX C – "SUMMARY OF MASTER DOCUMENTS AND DEFINITIONS – Summary of Certain Provisions of the Indenture – Replacement of the Series 2017A Note with Obligation Issued Under Replacement Master Indenture."

ESTIMATED SOURCES AND USES OF FUNDS

The proceeds to be received from the sale of the Bonds and other anticipated funds are expected to be applied as shown below:

Estimated Sources of Funds:	
Aggregate Principal Amount of the Bonds	$110,630,000
Plus Original Issue Premium	19,861,406
Parkview Health Contribution	2,439,956
Total Sources	$132,931,362
Estimated Uses of Funds:	
Refunding of the Bonds To Be Refunded	$131,647,749
Costs of Issuance[(1)]	1,283,613
Total Uses	$132,931,362

(1) Includes Underwriter's discount, legal fees, issuer fees, accounting fees, rating agency fees, printing costs and other miscellaneous expenses relating to the issuance of the Bonds and the refunding of the Bonds To Be Refunded.

DEBT SERVICE REQUIREMENTS

The following table sets forth for each fiscal year ending December 31 the amounts required to be made available for the payment of debt service on the Bonds and other outstanding Master Indenture indebtedness (excluding the Bonds To Be Refunded) at maturity or by mandatory sinking fund redemption. All amounts below are rounded to the nearest whole dollar amount.

Series 2017A Bonds

Year Ending December 31	Principal	Interest	Other Debt Service[(1)]	Total Debt Service[(2)]
2017	$ -	$1,244,588	$37,821,539	$39,066,126
2018	6,540,000	5,531,500	26,254,449	38,325,949
2019	6,740,000	5,204,500	28,273,201	40,217,701
2020	8,150,000	4,867,500	27,863,458	40,880,958
2021	8,915,000	4,460,000	29,050,388	42,425,388
2022	10,205,000	4,014,250	28,958,417	43,177,667
2023	10,535,000	3,504,000	29,157,565	43,196,565
2024	11,070,000	2,977,250	29,521,553	43,568,803
2025	14,260,000	2,423,750	27,144,023	43,827,773
2026	14,515,000	1,710,750	27,602,078	43,827,828
2027	7,650,000	985,000	28,383,572	37,018,572
2028	4,900,000	602,500	30,349,590	35,852,090
2029	4,850,000	357,500	26,604,552	31,812,052
2030	2,300,000	115,000	25,594,499	28,009,499
2031	-	-	31,921,923	31,921,923
2032	-	-	37,405,701	37,405,701
2033	-	-	37,145,651	37,145,651
2034	-	-	36,874,640	36,874,640
2035	-	-	36,592,191	36,592,191
2036	-	-	36,302,194	36,302,194
2037	-	-	36,003,707	36,003,707
2038	-	-	35,690,703	35,690,703
2039	-	-	35,075,414	35,075,414
2040	-	-	5,999,256	5,999,256
2041	-	-	5,998,496	5,998,496
2042	-	-	4,498,296	4,498,296
2043	-	-	4,498,296	4,498,296
2044	-	-	4,498,296	4,498,296
2045	-	-	4,498,296	4,498,296
2046	-	-	4,498,296	4,498,296
2047	-	-	4,498,296	4,498,296
2048	-	-	4,498,296	4,498,296
2049	-	-	4,498,296	4,498,296
2050	-	-	4,498,296	4,498,296
2051	-	-	4,498,296	4,498,296
2052	-	-	4,498,296	4,498,296
2053	-	-	4,001,816	4,001,816
2054	-	-	3,009,969	3,009,969
2055	-	-	3,009,969	3,009,969
2056	-	-	2,005,979	2,005,979
TOTAL	$110,630,000	$37,998,088	$799,097,747	$947,725,834

(1) Interest on variable rate debt bears interest at assumed swap rates. The maximum annual debt service shown in this schedule may differ from the Maximum Annual Debt Service Requirement, as defined under the Master Indenture, and as shown in APPENDIX A under the caption "FINANCIAL INFORMATION – Ratios – Debt Ratios". No assurance can be given that such rate will be achieved or maintained over the life of such debt.

(2) Totals may vary due to rounding.

BONDHOLDERS' RISKS

The purchase of the Bonds involves investment risks that are discussed throughout this Official Statement. Prospective purchasers of the Bonds should evaluate all the information presented in this Official Statement. This section on Bondholders' Risks focuses primarily on the general risks associated with hospital or health system operations, whereas APPENDIX A describes Parkview Health and its Affiliated Entities specifically. These should be read together.

The operations and financial condition of the System could be affected adversely by, among other things, legislation, regulatory actions, economic conditions, increased competition from other health care providers, changes in the demand for health care services, demographic changes, malpractice claims, other litigation, nurse staffing and medical malpractice insurance costs. No assurance can be given as to the nature of such factors or the potential effects thereof upon the System. This discussion is not intended to be comprehensive or definitive, but rather to summarize certain matters that could affect payment of the Bonds. Investors should recognize that the discussion below does not cover all such risks, that payment provisions for, and regulations and restrictions on, hospitals and health care providers change frequently and that additional material payment limitations and restrictions may be created, implemented or expanded while the Bonds are Outstanding.

General

Except as noted under the caption "SECURITY FOR THE BONDS," the Bonds are payable solely from payments made under the Loan Agreement and funds provided under the Series 2017A Note and the Indenture. No representation or assurance is given or can be made that revenues will be realized by Parkview Health, or any member of the Obligated Group, in amounts sufficient to pay debt service on Bonds.

The System 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 are subject to actions by, among others, the Centers for Medicare & Medicaid Services of the U.S. Department of Health and Human Services, The Joint Commission, the National Labor Relations Board and other federal, state and local government agencies. The future financial condition of the System could be adversely affected by, among other things, changes in the method and amount of payments to the System by governmental and nongovernmental payors, the financial viability of these payors, increased competition from other health care entities, the costs associated with responding to governmental audits, inquiries and investigations, 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, changes in the structure of how health care is delivered and paid for (e.g., accountable care organizations and other health reform payment mechanisms), future changes in the economy, demographic changes, availability of physicians, nurses and other health care professionals, and malpractice claims and other litigation. These factors and others may adversely affect payment by Parkview Health under the Loan Agreement and, consequently, on the Bonds. In addition, the tax-exempt status of Parkview Health, Parkview Hospital and other Affiliated Entities could be adversely affected by, among other things, an adverse determination by a governmental entity or non-compliance with governmental regulations or legislative changes which could adversely affect the Bonds, including the tax-exempt status of the Bonds.

Health Care Reform

The discussion herein describes risks associated with certain existing federal and state laws, regulations, rules, and governmental administrative policies and determinations to which the System and the health care industry are subject. While these are regularly subject to change, many of the existing provisions were enacted by or promulgated pursuant to the Affordable Care Act, to which opposition has been expressed by President Trump and the Secretary of DHHS, as well as the majority leaders of each chamber of Congress and members of their caucuses. It is not possible to predict with any certainty whether or when the Affordable Care Act or any specific provision or implementing measure will be repealed, withdrawn or modified in any significant respect, but a unified administration and majority in both chambers of Congress could enact legislation, withdraw, modify or promulgate rules, regulations and policies, or make determinations affecting

the health care industry and the System, any of which individually or collectively could have a material adverse effect on the operations, financial condition and financial performance of the System.

President Trump and certain Congressional leaders have included a repeal of all or a portion of the Affordable Care Act in early 2017 statements concerning their respective legislative agendas, and Congress has already taken steps to repeal and replace the Affordable Care Act. The repeal effort, to date, has focused on individual and employer mandates, exchanges, insurance industry regulations, Medicaid expansion, and the taxes to pay for these elements of the Affordable Care Act. The timing of such repeal and whether it would be in whole or in part is unclear. It is also unclear when or if a replacement plan would be implemented. A repeal could result in additional pressure on Medicaid and Medicare funding and could have the effect of reducing the availability of health insurance to individuals who were previously insured, resulting in greater numbers of uninsured individuals, and could otherwise materially adversely affect the System.

In May 2017, the U.S. House of Representatives adopted legislation to replace the Affordable Care Act., the American Health Care Act of 2017 ("*AHCA*") (H.R. 1628), which partially repeals the Affordable Care Act and makes significant changes to the Medicaid program. On June 22, 2017, the U.S. Senate Budget Committee released draft legislation known as the Better Care Reconciliation Act of 2017 ("*BCRA*"). BCRA is different than AHCA but also partially repeals the Affordable Care Act and makes significant changes to the Medicaid program. With this pending legislation, there is uncertainty regarding whether, when, and how the Affordable Care Act will be changed, what alternative provisions, if any, will be proposed or enacted, the timing of enactment and implementation of alternative provisions, and the impact of alternative provisions on providers as well as other health care industry participants. Congress or executive agencies could eliminate or alter provisions beneficial to the System while leaving in place provisions reducing reimbursement for health care providers, including the System. Government efforts to repeal or modify the Accordable Care Act may have an adverse effect on the System's business, result of operations, cash flow, capital resources, and liquidity.

Also, there can be no assurances that any current health care laws and regulations, in addition to the Affordable Care Act, will remain in their current form. There can be no assurances that any potential changes to the laws and regulations governing health care would not have a material adverse financial or operational impact on the System.

Therefore, the following discussion should be read with the understanding that significant changes could occur in 2017 and beyond in many of the statutory and regulatory matters discussed.

Affordable Care Act

As a result of the Affordable Care Act, substantial changes have occurred and are anticipated to occur in the United States health care system. The Affordable Care Act is impacting the delivery of health care services, the financing of health care costs, reimbursement of health care providers and the legal obligations of health insurers, providers, employers and consumers. Because of the complexity of the Affordable Care Act generally, additional legislation may be considered and enacted over time. The Affordable Care Act has also required, and continues to require, the promulgation of substantial regulations with 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 are expected to impose new and additional contractual terms and conditions. Thus, the health care industry will continue to be subjected to significant new statutory and regulatory requirements and contractual terms and conditions and, consequently to structural and operational changes and challenges for an extended period of time.

Management has analyzed the Affordable Care Act and regulations, and will continue to do so, in conjunction with trade associations and internal government relations staff, in order to assess the effects of the legislation and evolving regulations on current and projected operations, financial performance and financial condition. However, management cannot predict with any reasonable degree of certainty or reliability any interim or ultimate effects of the legislation. Moreover, the full ramifications of the Affordable Care Act may also become apparent only over time and through later regulatory and judicial interpretations. Portions of the Affordable Care Act have already been limited and nullified as a result of legislative amendments and judicial

interpretations and future actions may further change its impact. The uncertainties regarding the implementation of the Affordable Care Act create unpredictability for the strategic and business planning efforts of health care providers, which in itself constitutes a risk.

The changes in the health care industry brought about by the Affordable Care Act may have both positive and negative effects, directly and indirectly, on the nation's hospitals and other health care providers, including the System. For example, the projected increase in the numbers of individuals with health care insurance occurring as a consequence of Medicaid expansion, creation of health insurance exchanges, subsidies for insurance purchase and the penalty on certain individuals who do not purchase insurance could result in lower levels of bad debt and increased utilization or profitable shifts in utilization patterns for hospitals. However, the extent to which Medicaid expansion, which is now optional on a state by state basis, is either not pursued or results in a shifting of significant numbers of commercially-insured individuals to Medicaid, or health insurance options on exchanges are limited or unaffordable, as well as the cost containment measures and pilot programs that the Affordable Care Act requires, may offset these benefits. A negative impact to the hospital industry overall will likely result from scheduled cumulative reductions in Medicare payments; such reductions are substantial. The legislation's cost-cutting provisions to the Medicare program include reduction in Medicare market basket updates to hospital reimbursement rates under the inpatient prospective payment system ("*IPPS*"), additional reductions to or elimination of Medicare reimbursement for certain patient readmissions and hospital-acquired conditions, as well as anticipated reductions in rates paid to Medicare managed care plans that may ultimately be passed on to providers. Industry experts also expect that government cost reduction actions may be followed by private insurers and payors because approximately 43.5% of the gross patient services revenues of the System, for its fiscal year ended December 31, 2016 were from Medicare spending (including original fee for service Medicare and both fee-for service and capitated managed care arrangements), the reductions may have a material impact, and could offset any positive effects of the Affordable Care Act. *See also* "Medicare and Medicaid Programs – The Medicare Program" below.

Health care providers could be further subjected to decreased reimbursement as a result of implementation of recommendations of the Independent Payment Advisory Board ("*IPAB*"). In the event that the projected Medicare per capita growth rate exceeds a target growth rate in any year, the IPAB is directed to make recommendations for cost reduction, and those recommended reductions will be automatically implemented unless Congress adopts alternative legislation that meets equivalent savings targets. Hospitals are largely exempted from recommendations from the IPAB until 2020. The IPAB was to begin submitting its annual recommendations no later than January 15, 2014. However, no members of the IPAB have yet been appointed. Additionally, the Chief Actuary of CMS has concluded that the projected Medicare per capita growth rate has not yet exceeded the target growth rate and there will be no need for IPAB activity at least through 2017. Nevertheless, there have been unsuccessful Congressional efforts to repeal the IPAB to date.

Beginning in 2014, the Affordable Care Act created state "health insurance exchanges" in which health insurance can be purchased by certain groups and segments of the population, expanded the availability of subsidies and tax credits for premium payments by some consumers and employers, and required that certain terms and conditions be included by commercial insurers in contracts with providers. In addition, the Affordable Care Act imposed many new obligations on states related to health insurance. It is unclear how the increased federal oversight of state health care may affect future state oversight or affect the System. The health insurance exchanges may have a positive impact for hospitals by increasing the availability of health insurance to individuals who were previously uninsured. Conversely, employers or individuals may shift their purchase of health insurance to new plans offered through the exchanges, which may or may not reimburse providers at rates equivalent to rates the providers currently receive. The exchanges could alter the health insurance markets in ways that cannot be predicted, and exchanges might, directly or indirectly, take on a rate-setting function that could negatively impact providers. Because the exchanges are still relatively new, the effects of these changes upon the financial condition of any third party payor that offers health insurance, rates paid by third-party payors to providers and, thus, the revenues of the System, and upon the operations, results of operations and financial condition of the System cannot be predicted.

The Affordable Care Act has expanded the base of consumers for health care services through various provisions such as: (i) the creation of active markets (referred to as exchanges or marketplaces) in which

individuals and small employers can purchase health care insurance for themselves and their families or their employees and dependents, (ii) the provision of subsidies for premium costs to individuals and families based upon their income relative to federal poverty levels, (iii) the mandate that individual consumers obtain and certain employers provide a minimum level of health care insurance, and penalizing or taxing on consumers and employers that do not comply with these mandates, (iv) the expansion of private commercial insurance coverage generally through such reforms as prohibitions on denials of coverage for pre-existing conditions and elimination of lifetime or annual cost caps, and (v) the expansion of existing public programs, including Medicaid, for individuals and families.

The Congressional Budget Office ("*CBO*") expects the number of insured consumers under age 65 to increase to 246 million in federal fiscal year 2017. To the extent all or any of these provisions produce the expected result, an increase in utilization of health care services by those who are currently avoiding or rationing their health care can be expected and bad debt expenses may be reduced. Associated with increased utilization will be increased variable and fixed costs of providing health care services, which may or may not be offset by increased revenues. Any benefit of an expanded Medicaid patient base will not be realized for health care providers operating in states that have chosen not to expand Medicaid.

In addition, some provisions of the Affordable Care Act may or may not adversely affect the System. The demographics of the markets in which the System provides services, the mix of services that the System provides to its community and other factors that are unique to the System will affect individual outcomes. At this time, management cannot predict the aggregate effect of the Affordable Care Act upon the System.

- *Market Basket Reductions*. Commencing upon enactment of the Affordable Care Act and through September 30, 2019, the annual Medicare market basket updates for hospitals have been, and will be, reduced. The market basket adjustments for inpatient hospital care have averaged approximately 2% to 4% annually in recent years. The Affordable Care Act calls for reductions in the annual market basket updates ranging from 0.10% to 0.75% each year through federal fiscal year 2019. The market basket reduction for fiscal year 2017 is -0.75%. In addition, the market basket updates are subject to productivity adjustment. The productivity adjustment for fiscal year 2017 is -0.3%. The reductions in market basket updates and the productivity adjustments will have a disproportionately negative effect upon those providers that are more dependent upon Medicare than other providers. These reductions and the productivity adjustments have had, and will continue to have, a disproportionately negative effect upon those providers (including certain Affiliated Entities) that are relatively more dependent upon Medicare than other providers. In addition, the reductions in market basket updates were effective prior to the periods during which insurance coverage and the insured consumer base began to expand, which may have an interim negative effect on revenues. The combination of reductions to the market basket updates and the imposition of the productivity adjustments may result in reductions in Medicare payment per discharge on a year-to-year basis.

- *Value-Based Purchasing*. Beginning in federal fiscal year 2013, Medicare inpatient payments to hospitals are determined, in part, based on a program under which value-based incentive payments are made in a fiscal year to hospitals that meet certain performance standards during that fiscal year. The program is funded through the reduction of hospital inpatient care payment by 1% in federal fiscal year 2013, progressing to 2% by federal fiscal year 2017. This reduction may be offset by incentive payments that commenced in federal fiscal year 2013 for hospitals that meet or exceed quality standards. In each federal fiscal year, the total amount collected from these reductions will be pooled and used to fund payments to reward hospitals that meet certain quality performance standards established by DHHS.

- *Disproportionate Share Payments*. The Affordable Care Act provided that, beginning in federal fiscal year 2014, hospitals receiving supplemental disproportionate share hospital ("*DSH*") payments from Medicare (*i.e.*, those hospitals that care for a disproportionate share of low-income Medicare beneficiaries and Medicaid enrollees) will see their DSH payments reduced significantly. This reduction potentially will be offset by new, additional payments based on the volume of uninsured and uncompensated care provided by each such hospital, and is anticipated to be offset by a higher proportion of covered patients as other provisions of the Affordable Care Act go into effect. The

extent to which these reductions are offset depends considerably on whether the state in which the hospital is located has expanded Medicaid eligibility. Medicare DSH payments will continue to decrease as the number of uninsured also decreases.

On September 13, 2013, CMS issued a final rule confirming its methodology, which accounted for statewide reductions in uninsured and uncompensated care, and reduced Medicaid DSH allotments to each state. Under this final rule, the federal share of Medicaid DSH payments was reduced by $500 million in fiscal year 2014 and $600 million in fiscal year 2015. Such reductions have been delayed several times, most recently under the Medicare Access and CHIP Reauthorization Act of 2015 ("*MACRA*"), but are scheduled to take effect October 1, 2018, while extending cuts through fiscal year 2025.

- *Readmission Rate Penalty*. Beginning in federal fiscal year 2013, Medicare inpatient payments to those hospitals with excess readmissions compared to the national average for three patient conditions (acute myocardial infarction, pneumonia and heart failure) are reduced based on a risk-adjusted measure of the hospital's readmissions performance. The maximum penalty was 1% in fiscal year 2013, which increased to 3% in fiscal year 2015. In fiscal year 2015, the patient conditions assessed for this penalty was expanded to include acute exacerbation of chronic obstructive pulmonary disease, elective total hip arthroplasty, and total knee arthroplasty. Effective fiscal year 2017, CMS expanded the program to include patients admitted for coronary artery bypass graft surgery.

- *Hospital-Acquired Conditions Penalty*. Effective October 1, 2014, CMS began reducing Medicare payments by 1% for all diagnosis related groups ("*DRGs*") to hospitals that are in the top quartile nationally for their rate of hospital-acquired conditions. Effective July 1, 2011, federal payments to states for Medicaid services related to preventable health conditions were prohibited.

- *Medicare Advantage*. Hospitals also receive payments from health plans under the Medicare Advantage Program. The Affordable Care Act includes significant changes to federal payments to Medicare Advantage plans resulting in a transition to benchmark payments tied to the level of fee-for-service spending in the applicable county. Decreased federal payments to the Medicare Advantage plans whether through adjustments to benchmark payments or other federal policy changes could in turn affect the scope of coverage of these plans or cause plan sponsors to negotiate lower payments to providers.

- Effective October 1, 2011, 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 the DHHS. Commencing January 1, 2015, health care insurers participating in the health insurance exchanges are allowed to contract only with hospitals that 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 Affordable Care Act is intended to enhance 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 Affordable Care 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 Affordable Care Act creates a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models and to implement various demonstration programs and pilot projects to test, evaluate, encourage and expand new payment structures and methodologies to reduce health care expenditures while maintaining or improving quality of care. Demonstration efforts include, bundled payments under Medicare and Medicaid, and comparative effectiveness research

programs that compare the clinical effectiveness of medical treatments and develop recommendations concerning practice guidelines and coverage determinations. Other provisions encourage the creation of new health care delivery models, such as accountable care organizations (described below) or combinations of provider organizations, that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. The Center for Medicare and Medicaid Innovation has begun to testing new payment and service delivery models by instituting mandatory pilot programs. For example, the Comprehensive Care for Joint Replacement ("*CJR*") Model is currently in effect. Other proposed mandatory models include the Part B Drug model, extending the CJR model to include hip fracture, and cardiac episode payment models for acute myocardial infarction hospitalization and coronary artery bypass graft surgery. The outcomes of these projects and programs, including their effect on payments to providers and financial performance, cannot be predicted.

- Healthcare.gov, the health care exchange website created by the federal government under the provisions of the Affordable Care Act, launched on October 1, 2013. The website is designed to allow residents of states, which opted not to create their own state exchanges or to enter into a partnership with the federal government, to purchase health insurance or qualify for Medicaid coverage. The website faced serious technical problems on its launch and for a period thereafter, making it difficult for individuals to purchase health insurance. Under the Affordable Care Act, uninsured Americans must either purchase insurance through the health care exchanges or other venues, or, if no exemption is available and obtained, face a financial penalty. In addition, beginning in 2020, an excise tax on certain high-cost employment based health plans will be imposed. This tax, created under the Affordable Care Act, was originally scheduled to take effect in 2018 but its implementation was delayed by subsequent legislation. The published legislative proposals to repeal or replace the Affordable Care Act have to date focused largely on reorganizing the health exchange system created under the Affordable Care Act and reorganizing the individual, corporate and public funding obligations associated with health coverage enrollment.

- The Affordable Care Act establishes a Medicare Shared Savings Program ("*MSSP*") that seeks to promote accountability and coordination of care through the creation of Accountable Care Organizations ("*ACOs*"). The program allows 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 are eligible to share in a portion of the amounts saved by the Medicare program. DHHS 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.

In June 2016, CMS published a final rule adopting proposed modifications to ACO benchmark methodology. While these revised benchmark rebasing calculations may be particularly attractive for high performing ACOs, the delayed onset of these revised benchmark calculations (e.g., the revised methodology would not apply for the earliest ACOs until the start of their third participation agreement in 2019) leaves the ACO landscape somewhat uncertain. Also, the Federal Trade Commission ("*FTC*") and Department of Justice ("*DOJ*") issued a joint statement of antitrust enforcement policy in October 2011 as applied to ACOs; CMS and the OIG issued a final rule in October 2015 on certain waivers of the Anti-Kickback Law, Stark Law and the Civil Monetary Penalty Law ("*CMPL*") for ACOs; and the IRS issued a notice and fact sheet in October 2011 addressing the impact on tax-exempt organizations participating in ACOs; however, there may remain regulatory risks for participating hospitals, as well as financial and operational risks. Participants in ACOs will have to marshal a large upfront financial investment to form unique and untested ACO structures, which may or may not succeed in gaining qualification. For those that do qualify, it is uncertain whether the savings will be adequate to recoup the initial investment.

The Obama administration delayed the effective date of certain aspects of the Affordable Care Act, such as the requirement that employers with more than 50 employees provide health insurance to their workers or pay a penalty, of which the deadline was delayed to 2015 for employers with 100 or more full-time employees and 2016 for employers with 50 to 99 full-time employees. Further, in response to difficulties faced

by individuals who received cancellation notices regarding plans that did not meet the coverage requirements for the Affordable Care Act, the administration has granted those individuals an exemption from the Affordable Care Act's individual mandate, which requires individuals to have health insurance coverage or face a penalty beginning in 2014. Those individuals may now obtain catastrophic coverage, which is basic coverage generally available to those under 30 or who meet a hardship exemption; the administration announced that it is granting a "hardship exemption" to individuals whose plans were cancelled and might be having difficulty finding affordable exchange coverage. Similarly, delaying the Affordable Care Act adjusted community rating provisions for grandfathered small group plans temporarily stabilizes renewal rates for many small employers with young, healthy employees in many markets. But when this delay expires, many of these small employers will receive significant rate increases as they are moved toward an average "community" rate.

The Affordable Care Act establishes the criteria for the new Qualified Health Plans ("*QHPs*") that may participate in the state run exchanges. A QHP must meet certain minimum essential coverage requirements. Minimum essential coverage requirements may be offered at one of four levels of coverage: bronze, silver, gold or platinum. Each QHP must agree to offer at least one plan at the silver or gold level. The Affordable Care Act sets forth the minimum coverage offered under each plan level and limits the variations in premiums that may be charged for exchange coverage on the basis of age and tobacco use. A QHP must also be certified by each exchange through which the plan is offered, must be licensed in each state where it offers insurance, and the QHP must limit cost sharing with the insured. Under the Affordable Care Act, individuals with family income under 400% of the Federal Poverty Level are eligible for subsidized premiums, deductibles and co-pays for coverage purchased on the exchange. Initially, only individuals and small employers will be able to access coverage through the exchanges. By 2017, large employers will also be able to use the exchanges to provide employer-based coverage to their employees. Although existing health insurance plans may continue to offer coverage in the individual and employer group markets, coverage will not satisfy an individual's mandate unless the plan meets the Affordable Care Act's qualified health plan requirements. At this time, it is not possible to project what impact the exchanges will have on competition in the insurance markets, the cost of coverage for employers, reimbursement rates for hospitals and physicians or the number of uninsured patients that the System will still need to treat. As noted above, the first legislative proposals to repeal or replace the Affordable Care Act feature changes to the finances associated with obtaining coverage. To the extent that any implemented legislative changes discourage individuals from participation in coverage, such legislation could have a material adverse effect on the System.

High deductible health plans have become more common in recent years, and the Affordable Care Act is expected to encourage the increase in high deductible health plans as the health care exchanges include a variety of plans, several of which offer lower monthly premiums in return for higher deductibles. High deductible health plans may contribute to lower inpatient volumes as patients may forgo or choose less expensive medical treatment to avoid having to pay costs under the deductible. There is also a potential concern that some patients with high deductible health plans will not be able to pay their share of medical bills under the deductible. Employers have implemented a variety of strategies to offset high deductibles under these plans, including offering supplemental voluntary insurance products, such as per diem hospitalization, critical illness or cancer insurance policies and/or enabling employees to contribute to health savings accounts.

The Affordable Care Act will likely affect some health care organizations differently from others, depending, in part, on how each organization adapts to the legislation's emphasis on directing more federal health care dollars to integrated provider organizations and providers with demonstrable achievements in quality care. The Affordable Care Act proposes a value-based purchasing system for hospitals under which a percentage of payments will be contingent on satisfaction of specified performance measures related to common and high-cost medical conditions, such as cardiac, surgical and pneumonia care. The Affordable Care Act establishes a mechanism by which the government develops and tests various demonstration programs and pilot projects and other voluntary and mandatory programs to evaluate and encourage new provider delivery models and payment structures, including ACOs and bundled provider payments. On January 26, 2015, DHHS announced a timetable for transitioning Medicare payments from the traditional fee-for-service model to a value-based payment system. This schedule calls for tying 30% of traditional Medicare fee-for-service payments to quality or value through alternative payment models, such as ACOs or bundled payment arrangements, by the end of 2016, increasing to 50% by 2018. In addition, DHHS set a goal of tying 85% of all traditional Medicare fee-for-service payments to quality or value by 2016, increasing to 90% by 2018. In 2015,

CMS announced that it would implement a mandatory bundled payment demonstration for certain joint replacement procedures. In March 2016, DHHS announced that it had already achieved its 2016 objectives. The outcomes of these projects and programs, including the likelihood of being made permanent or expanded or their effect on health care organizations' revenues or financial performance, cannot be predicted. On July 25, 2016, CMS proposed new models in line with its goal of shifting Medicare payments from quantity to quality. CMS's July 2016 proposed rule outlined three new policies: (1) a new bundled payment model for cardiac care; (2) an extension of the existing bundled payment model for hip replacements to other hip surgeries; and (3) a new model to increase cardiac rehabilitation.

The Affordable Care Act is projected to expand access to Medicaid and the scope of services covered thereunder. With respect to access, Medicaid is expected to cover all individuals with incomes of less than 138% of the federal poverty level. The new law also allows states to expand Medicaid eligibility to non-elderly, non-pregnant individuals who are not otherwise eligible for Medicare, if they have incomes of less than 138% of the federal poverty level. To assist states with the cost of covering such newly eligible individuals, the federal government will pay 100% of the new cost for a limited number of years. Thereafter, the cost share is expected to decrease to 90%. However, as stated above, the U.S. Supreme Court's decision in *NFIB v. Sebelius* (2012) made the decision to expand Medicaid an option for each state. In the event a state chooses not to participate in the expanded Medicaid program, the net effect of the reforms in the Affordable Care Act could be significantly reduced. Additionally, Medicaid reimbursement rates differ by state and the effect of expanded Medicaid enrollment must be determined on a state-by-state basis.

The Affordable Care Act contains amendments to existing criminal, civil and administrative anti-fraud statutes and increases in funding for enforcement and efforts to recoup prior federal health care payments to providers. Under the Affordable Care Act, a broad range of providers, suppliers and physicians are required to adopt a compliance and ethics program. While the government has already increased its enforcement efforts, failure to implement certain core compliance program features provides new opportunities for regulatory and enforcement scrutiny, as well as potential liability if an organization fails to prevent or identify improper federal health care program claims and payments. *See also* " – Regulatory Environment" below.

With respect to charity care, the Affordable Care Act contains many features from previous tax-exempt reform proposals, including a set of sweeping changes applicable to charitable hospitals exempt under Section 501(c)(3) of the Code. The Affordable Care Act: (i) imposes new requirements for 501(c)(3) hospitals and an excise tax for failures to meet certain of those requirements; (ii) requires mandatory IRS review of the hospitals' entitlement to exemption; (iii) sets forth new reporting requirements, including information related to community health needs assessments and audited financial statements; (iv) requires hospitals to adopt and publicize a financial assistance policy that includes various specific provisions, limit charges to patients who qualify for financial assistance to the lowest amount charged to insured patients, and control the billing and collection processes to ensure that no extraordinary collection actions are taken against a patient before reasonable efforts are made to determine whether such patient qualifies for financial assistance; and (v) imposes further reporting requirements on the Secretary of the Treasury regarding charity care levels. Failure to satisfy these conditions may result in the imposition of fines and the loss of tax-exempt status.

Efforts to repeal or substantially modify provisions of the Affordable Care Act are from time to time pending in Congress. In November 2015, the Bipartisan Budget Act of 2015 (the "*BBA*") repealed a provision of the Affordable Care Act which would require employers that offer one or more health benefits plans and have more than 200 full-time employees to automatically enroll new full-time employees in a health plan. The ultimate outcomes of legislative attempts to repeal or amend the Affordable Care Act and legal challenges to the Affordable Care Act are unknown. Results of recent Congressional elections and of the Presidential election in 2016 could create a political environment in which substantial portions of the Affordable Care Act are repealed or revised. In addition to the prospect for legislative repeal or revision, a hostile administration could impose substantial change upon the Affordable Care Act through administrative action, including revised regulation and other Executive Branch action and inaction.

Impact of Disruptions in the Credit Markets and General Economic Factors

The disruption of the credit and financial markets in the last several years led to volatility in the securities markets, significant losses in investment portfolios, increased business failures and consumer and business bankruptcies, and was a major cause of the economic recession in 2008/2009. As a direct consequence, the financial condition of the System and its operating results were adversely affected.

In response to that disruption, the Dodd-Frank Wall Street Reform and Consumer Protection Act (the "*Financial Reform Act*") was enacted on July 21, 2010. The Financial Reform Act includes broad changes to the existing financial regulatory structure, including the creation of new federal agencies to identify and respond to risks to the financial stability of the United States. Additional legislation is pending or under active consideration by Congress and regulatory action is being considered by various federal agencies and the Federal Reserve Board and foreign governments, which are intended to increase the regulation of domestic and global credit markets. The effects of the Financial Reform Act and of these legislative, regulatory and other governmental actions, if implemented, are unclear.

The health care sector, including the System, was adversely affected by these developments. The consequences of these developments generally included, among other things, realized and unrealized investment portfolio losses, increased borrowing costs and periodic disruption of access to the capital markets. The economic recession adversely affected, and is continuing to adversely affect, the operations of the System. During 2008 and 2009, unemployment rates increased, but have stabilized in market areas in which the System owns and operates health care facilities. This has resulted in increases in self-pay admissions, increased levels of bad debt and uncompensated care, reduced demand for elective procedures, and reduced availability and affordability of health insurance. In response to these operational pressures, the System implemented loss reducing and revenue improving measures that have reduced costs, improved revenue cycle results and broadened service capabilities.

On February 17, 2009, President Obama signed into law the American Recovery and Reinvestment Act of 2009 ("*ARRA*"). ARRA includes several provisions that were intended to provide financial relief to the health care sector, including an increase through December 31, 2010 in federal payments to states to fund the Medicaid program, a requirement that states promptly reimburse health care providers and a subsidy to the recently unemployed for health insurance premium costs. 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 electronic health records. Pursuant to ARRA, commencing in 2015, Medicare eligible providers that do not demonstrate "meaningful use" of electronic health records have received a downward adjustment in their Medicare reimbursement.

Market Risks

Interest Rate Swap Risk

In the normal course of business, Parkview Health, after receiving the appropriate approval of its Board of Directors, periodically enters into interest rate swap agreements to hedge interest rate risk. Changes in market value of such agreements could negatively or positively impact the System's operating results and financial condition, and such impact could be material. Any of Parkview Health's swap agreements may be subject to early termination upon the occurrence of certain specified events. If either Parkview Health or the counterparty terminates such an agreement when the agreement has a negative value to Parkview Health, Parkview Health could be obligated to make a termination payment to the counterparty in the amount of such negative value, and such payment could be substantial and potentially materially adverse to the System's financial condition. In the event of an early termination of any swap agreement, there can be no assurance that (i) Parkview Health will receive any termination payment payable to it by the counterparty, (ii) Parkview Health will have sufficient amounts to pay a termination payment payable by it to a counterparty, and (iii) Parkview Health will be able to obtain a replacement swap agreement with comparable terms. Certain of Parkview Health's existing swap agreements are subject to periodic "mark-to-market" valuations and may, at any time, have a negative value (which could be substantial) to Parkview Health.

Certain of Parkview Health's existing swap agreements require Parkview Health to secure its obligations in certain circumstances, which circumstances include, without limitation, a downgrade of long-term debt issued by the Obligated Group. The Obligated Group's ability to place a lien on its collateral is limited by the Master Indenture. *See* APPENDIX C – "SUMMARY OF MASTER DOCUMENTS AND DEFINITIONS – Summary of Certain Provisions of the Master Indenture – Liens on Property". If Parkview Health is unable to secure its obligations under a swap agreement with sufficient collateral, the swap counterparty will have the right to terminate the swap agreement and Parkview Health could be required to make a termination payment to the counterparty, the amount of which could be substantial. Under the terms of those swap agreements no collateral was required to be posted at December 31, 2016 and 2015.

See APPENDIX A – "INFORMATION CONCERNING PARKVIEW HEALTH SYSTEM, INC. AND ITS AFFILIATES – Financial Information – Outstanding Indebtedness" hereto and Note 10 to the audited consolidated financial statements of Parkview Health and subsidiaries in APPENDIX B hereto for additional information on interest rate swaps of Parkview Health.

Risks Related to Auction Rate Securities and Variable Rate Indebtedness

Beginning in February 2008, the Obligated Group's Series 2001 Bonds, which were issued as auction rate securities, have failed to attract sufficient bids to be re-marketed. As a result of the failed auctions, the interest being paid on such bonds is based upon a formula contained in the bond documents. The interest rate formula is based upon the seven day AA Composite Commercial Paper rate times a factor. This factor can vary from 125% to 225%, depending upon the credit rating of the bond insurer or the Obligated Group, whichever is higher.

Certain of the Obligated Group's outstanding indebtedness has been issued as variable rate demand obligations, the interest rate on which varies from time to time. Such variable rate indebtedness may be converted to fixed rates. This protection against rising interest rates is limited, however, because the Obligated Group would be required to continue to pay interest at the applicable variable rate until it is permitted to either convert the obligation to a fixed rate pursuant to the terms of the related bond indenture or to refund same. In addition, certain of the Obligated Group's variable rate indebtedness is subject to credit facility renewal risk.

See APPENDIX A – "INFORMATION CONCERNING PARKVIEW HEALTH SYSTEM, INC. AND ITS AFFILIATES – Financial Information – Outstanding Indebtedness" hereto and Note 9 to the audited consolidated financial statements of Parkview Health and subsidiaries in APPENDIX B hereto for additional information on the outstanding indebtedness of the Obligated Group.

Market for Bonds

The Underwriter has advised Parkview Health that it intends to make a market in the Bonds; however, the Underwriter is not obligated to make such market, and no assurance can be given that a secondary market therefor will develop. Consequently, investors may not be able to resell the Bonds purchased should they need or wish to do so for emergency or other purposes.

Federal Debt Limit Increase

Through federal legislation, the federal government has created a debt "ceiling" or limit on the amount of debt that may be issued by the United States Treasury. In the past several years, political disputes have arisen within the federal government in connection with discussions concerning the authorization for an increase in the federal debt ceiling. Any failure by Congress to increase the federal debt limit may impact the federal government's ability to incur additional debt, pay its existing debt instruments and to satisfy its obligations relating to Medicare and Medicaid programs. Management of Parkview Health is unable to determine at this time impact any future failure to increase the federal debt limit may have on its operations and financial condition of the System, although such impact may be material. Additionally, the market price or marketability of the Bonds may be materially adversely impacted by any failure to increase the federal debt limit.

Federal Budget Cuts

The Budget Control Act of 2011 (the "*BCA*") mandates significant reductions and spending caps on the federal budget for fiscal years 2012-2021, including a two percent reduction on all Medicare payments during this period. Subsequent legislation enacted by Congress extended these reductions through 2025. There is a substantial risk that Congress could act to extend or increase these across-the-board reductions.

Because Congress may make changes to the budget in the future, it is impossible to predict the impact any spending cuts may have upon the System. 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. If and to the extent Medicare and/or Medicaid spending is reduced under either scenario, this may have a material adverse effect upon the financial condition of the System. Ultimately, these reductions or alternatives could have a disproportionate impact on hospital providers and could have an adverse effect on the financial condition of the System, which could be material.

Tax Reform

Tax reform may be introduced with such reform likely focused on lowering corporate and individual tax rates, while eliminating certain tax preferences and other tax expenditures, including the authority to issue tax-exempt bonds for certain purposes. Any future tax reform could have a material impact on the System's operations, financial condition and financial performance. Additionally, the market price or marketability of the Bonds in the secondary market may be materially adversely effected by such tax reform.

Nonprofit Health Care Environment

Each of the Obligated Group Members is a not for profit corporation, exempt from federal income taxation as an organization described in Section 501(c)(3) of the Code. Therefore, each Obligated Group Member is subject to federal, state and local laws, regulations, rulings and court decisions relating to its organization and operation, including its operation for charitable purposes. At the same time, the Obligated Group as a whole conducts large-scale complex business transactions and is a major employer in its geographic areas. 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 organization.

The operations and practices of nonprofit, tax-exempt hospitals are routinely challenged or criticized for inconsistency or inadequate compliance with the regulatory requirements for, and societal expectations of, nonprofit 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. A common theme of these challenges is that nonprofit hospitals may not confer community benefits that equal the benefits received from tax-exempt status. Areas which have come under examination have included pricing practices, cost shifting charity care expenditures to commercial payors, billing and collection practices, charitable care methods of providing and reporting community benefit, executive compensation, exemption of property from real property taxation, 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, and in a variety of forums, including legislation, regulations, hearings, audits and litigation. These challenges or examinations include the following, among others:

Nonprofit Hospitals' 501(c)(3) Status

The Affordable Care Act added to the Code a new Section 501(r) which applies to charitable hospitals or other charitable organizations whose principal purpose is to provide hospital care. Section 501(r) adds four requirements, in addition to those required under Section 501(c)(3) of the Code, which must be satisfied in order for such organizations to continue to be treated as exempt organizations under Section 501(c)(3) of the Code. First, a "community needs assessment" must be conducted every three

years and an "implementation strategy" must be adopted to meet the needs identified in the assessment. Second, written policies regarding financial assistance and emergency medical care must be established, including policies relating to the basis for calculating patient charges and actions to be taken in the event of nonpayment. Third, limits must be established for emergency or other medically necessary care charges to patients eligible for financial assistance. Fourth, certain billing and collection requirements must be met, including a prohibition on "extraordinary collection actions" unless a "reasonable effort" has been made to determine whether the patient is eligible for financial assistance. *See* also "Federal Health Care Reform and Other Governmental Initiatives" above.

IRS Community Benefit and Section 501(r) Initiatives

The IRS continues to direct attention toward the community benefit practices of tax-exempt hospitals, particularly following the Affordable Care Act's significant changes to the tax exemption standards for hospitals. Section 501(r) of the Code, adopted under the Affordable Care Act, includes four primary adjustments to the federal income tax exemption requirements for nonprofit hospitals. In addition to complying with the requirements of Section 501(c)(3) and the community benefit standards described in Rev. Rul. 69-545, 1969-2 CB 117, tax-exempt hospitals now must also: (i) conduct community health needs assessments once every three years (or else pay a $50,000 excise tax) and adopt an implementation strategy to meet the identified community needs; (ii) communicate their financial assistance policies, including a policy to provide emergency medical treatment without discrimination, to the communities they serve; (iii) limit charges for patients eligible for financial assistance to no more than the amounts generally billed to individuals who have insurance covering such care and refrain from using "gross charges" when billing such individuals; and (iv) comply with certain billing and collection standards, to include refraining from taking extraordinary collection actions without first making reasonable efforts to determine whether the individual is eligible for assistance under the hospital's financial assistance policy. Final regulations have been issued under Section 501(r) implementing these requirements, and these regulations are complex and administratively burdensome. Also, under the Affordable Care Act, the IRS must review the community benefit activities of each tax-exempt hospital at least once every three years. In February 2009, the IRS issued its Hospital Compliance Project Final Report (the "*IRS Final Report*") that determined that the reporting of community benefit by nonprofit hospitals varied widely, both as to types of programs and expenditures classified as community benefit and the measurement of community benefits. As a result, the IRS issued the revised Form 990 that includes Schedule H, effective for tax years beginning after March 23, 2010, which is designed to provide uniformity regarding types of programs and expenditures reported as community benefit by nonprofit hospitals. As the IRS collects and reviews information from hospitals about the level and types of community benefit provided, the IRS may issue a more stringent interpretation of community benefit. Findings from Schedule H reports may also revive proposals in Congressional committees which, from time to time, have been made to codify additional requirements for hospitals' tax exempt status, including requirements to provide minimum levels of charity care.

Congressional Hearings

Senate and House committees have conducted several nationwide investigations of hospital billing and collection practices and prices charged to uninsured patients and have considered reforms to the nonprofit sector, including proposed reform in the area of tax-exempt health care organizations, as part of health care reform generally. In addition, the House Ways and Means Committee and Senate Finance Committee continue to evaluate comprehensive tax reform. The Ways and Means Committee has formed eleven tax reform working groups including one focused on the Charitable/Exempt Organizations sector. Comprehensive tax reform could impact tax exemption for all organizations, not only health care organizations which are tax-exempt under Section 501(c)(3) of the Code. *See* "IRS Examination of Compensation Practices," "IRS Community Benefit and Section 501(r) Initiatives" above and "Challenges to Real Property Tax Exemption" below under the caption "Nonprofit Health Care Environment."

Bond Examinations

IRS officials have indicated that more resources will be invested in audits of tax-exempt bonds in the charitable organization sector with specific review of private use. A schedule to the revised Form 990 return (Schedule K), is intended to address what the IRS believes is significant noncompliance with recordkeeping and record retention requirements. Schedule K also requires tax-exempt organizations to report on the investment and use of bond proceeds to address IRS concerns regarding compliance with arbitrage rebate requirements and the compliant use of bond-financed facilities.

IRS Examination of Compensation Practices

For nearly the past decade, the IRS has been concerned about executive compensation practices of tax-exempt hospitals. In 2004, the IRS began a new program to measure compliance by tax-exempt organizations with requirements that they do not pay excessive compensation. The IRS Final Report examined tax-exempt organizations' practices and procedures with regard to compensation and benefits paid to their officers and other defined "insiders." The IRS Final Report indicated that the IRS (1) will continue to heavily scrutinize executive compensation arrangements, practices and procedures, and (2) in certain circumstances, may conduct further investigations or impose fines on tax-exempt organizations.

IRS Scrutiny of Employee Classification

The IRS is aggressively pursuing businesses, including nonprofit tax-exempt organizations, that misclassify their employees as independent contractors. A number of employers incorrectly treat their workers (or a class or group of workers) as independent contractors or other nonemployees to reduce their employment tax withholding burden. An IRS audit of employee classification can result in employment tax liability for the employers, as well as interest and penalties on the amounts owed. Whether a worker is performing services as an employee or as an independent contractor depends on facts and circumstances and generally is determined under various common law tests, like whether the service recipient has the right to direct and control the worker regarding how he or she performs the services. The IRS is offering a Voluntary Classification Settlement program that provides partial relief from federal employment taxes owed for employers that agree to prospectively treat workers as employees and not independent contractors.

Revisions to Form 990, Schedule H

The revised Form 990's Schedule H, which hospitals and health systems must use to report their community benefit activities, has been revised to require details on how a hospital determines eligibility for free or discounted care (if the federal poverty guidelines are not used). Consistent with Section 501(r) of the Code, Schedule H now requires hospitals to describe billing and collection practices permitted under the hospital facility's policies, as well as information about the hospital's emergency medical care policy. Hospitals must complete all of Schedule H for the 2016 tax year, including lines that relate to community health needs assessments.

Litigation Relating to Billing and Collection Practices

Lawsuits have been filed in federal and state courts alleging, among other things, that hospitals have failed to fulfill their obligations to provide charity care to uninsured patients and have overcharged uninsured patients. Many of these cases have since been dismissed by the courts. A number of cases are still pending in various courts around the country with inconsistent results. While it is not possible to make general predictions, some hospitals and health systems have entered into substantial settlements.

Class Actions

Nonprofit hospitals and health systems have also long been subject to a wide variety of other litigation risks, including liability for care outcomes, employer liability, property and premises liability, and peer review litigation with physicians, among others. In recent years, consumer class action litigation has emerged as a potentially significant source of litigation liability for nonprofit hospitals and health systems. These class action suits have most recently focused on hospital billing and collections practices and breaches of privacy, and they may be used for a variety of currently unanticipated causes of action. Since the subject matter of class action suits may involve uninsured risks, and since such actions often involve alleged large classes of plaintiffs, they may have material adverse consequences on nonprofit hospitals and health systems in the future.

Attorneys General and Other State Oversight or Audits

State nonprofit public benefit corporations, including certain Affiliated Entities, are subject to oversight and examination by the Attorney Generals of various states to ensure their charitable purposes are being carried out, that their fundraising and investment activities comply with state law and that the terms of charitable gifts are followed. In addition, state legislatures may direct state executive bodies to monitor or audit levels of charity care being provided in nonprofit hospitals.

Financial Assistance and Charity Care

Some state laws require hospitals to maintain written policies about discount payment and charity care and/or to follow specific billing and collection procedures. Each hospital within the System has adopted and maintains such policies.

Challenges to Real Property Tax Exemptions

The real property tax exemptions afforded to certain nonprofit health care providers by state and local taxing authorities are being scrutinized, and in some cases have been challenged in court, on the grounds that the health care providers were not engaged in charitable activities. Court challenges have been based on a variety of grounds, including allegations of aggressive billing and collection practices, excessive financial margins and operations that closely resemble for-profit businesses. Several of these disputes have been determined in favor of the taxing authorities or have resulted in settlements. In addition, some states have proposed overhauling their property tax exemption laws.

The foregoing are some examples of the challenges and examinations facing nonprofit health care organizations. They are indicative of a greater scrutiny of the billing, collection and other business practices of these organizations, and may indicate an increasingly more difficult operating environment for health care organizations, including the System. The challenges and examinations, and any resulting legislation, regulations, judgments, or penalties, could have a material adverse effect on the System.

Patient Services Revenues – Third-Party Payment Programs

Most of the net patient service revenues of the Credit Group are derived from third-party payors that 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 program and private health plans and insurers, health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs") and other managed care payors. Many of these third-party payors make payments to the System at rates other than the direct charges of the Credit Group, which rates may be determined other than on the basis of the actual costs incurred in providing services and items to patients. Accordingly, there can be no assurance that payments made under these programs will be adequate to cover the System's actual costs of furnishing health care services and items. In addition, the financial performance of the System could be adversely affected by the insolvency of, or other delay in receipt of payments from, third-party payors, which provide coverage for services to their patients.

Medicare and Medicaid Programs

The Medicare Program

Medicare is the federal health insurance system under which hospitals and other providers are paid for services provided to eligible elderly and disabled persons. Medicare provides certain health care benefits to beneficiaries who are 65 years of age or older, blind, disabled or qualify for the End Stage Renal Disease Program. Medicare Part A covers inpatient hospital services, skilled nursing care, hospice and some home health care, and Medicare Part B covers physician services, outpatient hospital services, diagnostic tests, outpatient therapy and some supplies. Medicare is administered by CMS, which delegates to the states the process for certifying hospitals to which CMS will make payment. In order to achieve and maintain Medicare certification, hospitals must meet CMS's "Conditions of Participation" on an ongoing basis, as determined by the hospital's state survey agency and/or CMS, and comply with the standards of The Joint Commission or other CMS-approved accrediting organization. The requirements for Medicare certification are subject to change, and, therefore, it may be necessary for hospitals to effect changes from time to time in their facilities, equipment, operations, personnel, billing, policies and services to ensure continued compliance.

As the U.S. population ages, more people will become eligible for the Medicare program. Current projections indicate that demographic changes and continuation of current cost trends will exert significant and negative forces on the overall federal budget. The Medicare program reimburses most hospitals based on a fixed schedule of rates based on categories of treatments or conditions. These rates change over time and there is no assurance that these rates will cover the actual costs of providing services to Medicare patients. Further, it is anticipated there will be reductions in rates paid to Medicare managed care plans that may ultimately be passed on to providers.

Payment for Inpatient Hospital Services. A substantial portion of the Medicare revenues of the System is anticipated to be derived from payments made for services rendered to Medicare beneficiaries under the Inpatient PPS. Under the IPPS, for each covered hospitalization Medicare pays a predetermined base operating payment and a separate predetermined base payment for capital-related costs. Each hospitalization of a Medicare beneficiary is classified into one of several hundred DRGs, which determines the IPPS base payment rate for the hospitalization. The IPPS payment rate is not correlated to the hospital's actual cost of treating a particular patient. It is a fixed sum, generally based on national DRG rates and a Hospital Wage Index intended to reflect geographic differences in the costs of labor. Several hospital characteristics are reflected in payment adjustments, including an indirect medical education adjustment, the disproportionate share adjustment to pay certain hospitals for a portion of the higher costs of treating a large proportion of poor patients and for indirect costs of operating in areas accessible to poor patients and outlier case adjustments (an additional payment for selected cases of unusually long stays or high costs).

In addition, DRG rates are subject to annual adjustment by CMS or Congress and are subject to federal budget considerations. The legislation that created the IPPS requires that payments under the IPPS be adjusted annually based on the national average cost of providing inpatient services (the "market basket"). For every year since 1983, Congress has modified the increases and given substantially less than the increase in the "market basket" index. There is no assurance that future updates in the IPPS payments will come any closer to keeping pace with the increases in the cost of providing hospital services. If a hospital incurs operating and capital costs in treating Medicare inpatients which exceed the DRG level of reimbursement, the hospital will experience a loss from providing these services.

In recent years, CMS has implemented a number of initiatives that may adversely affect Medicare payment to the System, including reduced payment for certain cases in which a beneficiary acquires a complication or condition while in the hospital; an overall reduction in payment to fund bonus payments to some hospital who satisfy CMS's "value-based purchasing" criteria; and reduced payments to hospitals whose readmission rate for patients with specified diagnoses exceeds the anticipated readmission rate.

There is no assurance that the System will be paid amounts that will reflect adequately its costs incurred in providing inpatient hospital services to Medicare beneficiaries, as well as any changes in the cost of providing health care or in the cost of health care technology being made available to Medicare beneficiaries.

The ultimate effect of the IPPS on the System will depend on its ability to control costs involved in providing inpatient hospital services.

Inpatient rehabilitation facilities and units ("*IRFs*") and inpatient psychiatric facilities and unit ("*IPFs*") have been excluded from the DRG-based PPS established for general inpatient acute care facilities. Both IPFs and IRFs are paid by Medicare under a separate generally higher-paying inpatient prospective payment system that is distinct from general IPPS. The Social Security Act authorizes the Secretary of DHHS to determine which facilities are classified as IRFs. Such facilities and units are required to draw at least 60% of their inpatients from 13 specific rehabilitation diagnoses identified by CMS, in order to qualify for payment as an IRF. Effective October 1, 2014, CMS reduced the number of diagnoses presumed to "count" toward meeting the 60% rule. There is no guarantee that the IRF payment will be adequate to cover the System's cost of furnishing care, or that a given IRF will continue to satisfy the 60% rule.

Recent Medicare Payment Advisory Commission ("*MedPAC*") guidance has recommended site-neutral payment policies for certain services provided in the IRF setting. These policies reflect MedPAC's position that Medicare should not pay more for care in one setting than in another if the care can safely and effectively be provided in a lower cost setting. Accordingly, MedPAC has proposed to reimburse certain IRF services at rates commensurate with payments made to skilled nursing facilities. To the extent adopted by CMS, these policies would have the potential to decrease Medicare revenues available to IRFs.

Effective October 1, 2013, CMS adopted a policy known as the Inpatient Hospital Prepayment Review "Probe & Educate" review process or the "Two-Midnight" rule. The "Two-Midnight" rule specifies that hospital stays spanning two or more midnights after the beneficiary is properly and formally admitted as an inpatient will be presumed to be "reasonable and necessary" for purposes of inpatient reimbursement. With some exceptions, stays not expected to extend past two midnights should not be admitted and instead should be billed as outpatient. Enforcement of the "Two-Midnight" rule was ultimately delayed until the end of 2015. Effective October 1, 2015, responsibility for initial review of inpatient admissions shifted from Medicare administrative contractors to quality improvement organizations ("*QIO*"), and recovery audit contractors will only conduct reviews for providers that have been referred by the related QIO. The Outpatient PPS Final Rule, issued in November 2015 and effective January 1, 2016, revised the Two-Midnight Rule to allow an exception for Medicare Part A payment on a case-by-case basis for inpatient admissions that do not satisfy the two-midnight benchmark if documentation in the medical records supports that the patient required inpatient care. CMS has announced that it will not continue to impose an inpatient payment cut to hospitals under the "Two-Midnight" rule starting in 2017 following ongoing industry criticism and a legal challenge. In the 2017 Medicare IPPS final rule released on August 2, 2016, CMS removed the inpatient payment cuts under the "Two-Midnight" rule for fiscal year 2017 and onward and provided a temporary increase of 0.6% payment in fiscal year 2017 to help offset the fiscal year 2014-2016 cuts under the "Two-Midnight" rule. The "Two-Midnight" rule has had and will likely continue to have an adverse financial impact for hospitals.

Payment for Hospital Outpatient Services. Hospitals are generally paid for outpatient services provided to Medicare beneficiaries under the OPPS, which is based on established categories of treatments or conditions known as ambulatory payment classifications ("*APC*"). The actual cost of care, including capital costs, may be more or less than the reimbursements. Generally, Medicare payment rates to hospitals for outpatient hospital services are adjusted annually based on estimated cost increases and other factors, including productivity and budget neutrality adjustments. These adjustments are typically positive, and often range from 0.5% to 2.5%. However, occasionally, because of statutory formulas and other legislative and administrative actions, these adjustments can be negative, and Medicare payments to hospitals can be reduced as a result. Moreover, Congress often takes action to specify payment update reductions, which can have the effect of constraining or reducing hospital payments. There is no guarantee that APC rates, as they change from time to time, will cover actual costs of providing services to Medicare patients.

Payment for Physician Services. On April 16, 2015, President Obama signed into law MACRA, legislation that when implemented in 2017, will substantially alter how physicians and other practitioners are paid by Medicare for services furnished to program beneficiaries. CMS previously relied on a formula known as the Sustainable Growth Rate ("*SGR*"), which imposed a limit on the growth of Medicare payments for physician services based on changes to the U.S. Gross Domestic Product over a ten-year period. MACRA

permanently replaced the SGR formula with statutorily prescribed physician payment updates and incentives based upon performance measures that began in January 2017. This legislation increases Medicare physician reimbursement by 0.5% annually until 2019 and then provides for no additional increases to base physician reimbursement through 2025.

MACRA moved Medicare physician reimbursement from a fee-for-service to a pay-for-performance model that will continue to control the growth of physician payments based on clinical outcomes and quality reporting. In addition to the base payment methodology, physicians can earn merit-based payments based on factors including compliance with meaningful use of certified electronic health records technology ("*CEHRT*") and demonstration of quality-based medicine.

Beginning January 1, 2019, and carrying through 2025, physician payment adjustments will occur through the Quality Payment Program's two reimbursement tracks – the Merit-based Incentive Payment System ("*MIPS*") or an Advanced Alternative Payment Model ("*APM*"). In calculating physician payment adjustments, MIPS streamlines existing quality and value programs, accounting for physician performance under the meaningful use of electronic health records incentive program, the value-based modifier, and physician quality reporting system. Payments to physicians participating in APMs similarly accounts for performance under such programs. Beginning January 1, 2026, and effective January 1 of each subsequent calendar year, physician payments will be increased 0.75% for physicians who adequately participate in APMs, and 0.25% for those in MIPS. Notably, CMS has designated calendar year 2017 as the "transition year" during which physician reporting obligations for participation in these programs are substantially reduced. The outcomes of these programs, including the likelihood of being revised or expanded or their effect on health care organizations revenues or financial performance cannot be predicted, and it remains unclear what effect this legislation will have on the System. For example, these programs may encourage more physicians to retire, not accept Medicare (or only accept Medicare Advantage). Alternatively, or in addition to other externalities of the implementation of these programs, increased focus and performance scoring on resource use may impact utilization of health care resources by the Obligated Group. Furthermore, implementation of a quality payment system will likely require regular reporting to CMS and greater internal resources to monitor performance and prevent payment reductions.

Off-Campus Provider-Based Departments. Beginning January 1, 2017, off-campus hospital outpatient departments established on or after November 2, 2015 will not be eligible for payment under the OPPS for non-emergency services. Instead, CMS has proposed that non-emergency services performed at these facilities will be paid under the physician fee schedule in fiscal year 2017, and at a to-be-determined rate in subsequent years. The new payment methodology for these locations and services will likely result in lower payments to hospitals than in previous years for providing the same services, if the services are provided in a new off-campus outpatient department or a new service added to an existing off-campus outpatient department. A hospital outpatient department is considered to be "off-campus" if it is located more than 250 yards from a main provider hospital or a remote location of a hospital. Administrative and judicial review are unavailable for determinations relating to applicable payment systems or determinations whether a provider department is considered an off-campus hospital outpatient department.

Other Medicare Service Payments. Medicare payment for skilled nursing services, psychiatric services, inpatient rehabilitation services, and home health services are based on regulatory formulas or pre-determined rates. There is no guarantee that these rates, as they may change from time to time, will be adequate to cover the actual cost of providing these services to Medicare patients.

Reimbursement of Hospital Capital Costs. Hospital capital costs apportioned to Medicare patient use (including depreciation and interest) are paid by Medicare on the basis of a standard federal rate (based upon average national costs of capital), subject to limited adjustments specific to the hospital. There can be no assurance that future capital-related payments will be sufficient to cover the actual capital-related costs of the System's facilities applicable to Medicare patient stays or will provide flexibility for hospitals to meet changing capital needs.

Medical Education Payments. Medicare currently pays for a portion of both direct and indirect graduate medical education costs. Payment for the direct costs of graduate 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 number of current year reimbursable resident positions. Payment for indirect graduate medical education costs 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 System for providing medical education will be sufficient to cover the costs associated with medical education programs.

Medicare Bad Debt Reimbursement. Under Medicare, the costs attributable to the deductible and coinsurance amounts which remain unpaid by the Medicare beneficiary can be added to the Medicare share of allowable costs as cost reports are filed. Hospitals generally receive interim pass-through payments during the cost report year which were determined by the Medicare Administrative Contractor ("*MAC*") from the prior cost report filing.

The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be uncollectible. In some cases, an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period. In these cases, the recoveries must be used to reduce the cost of beneficiary services for the period in which the collection is made. In determining reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs is reduced by 35% of the total amount. Amounts incurred by a hospital as reimbursement for bad debts are subject to audit and recoupment by the MAC. Bad debt reimbursement has been a focus of MAC audit/recoupment efforts in the past.

Recovery Audit Contractor Program. CMS has implemented a Recovery Audit Contractor ("*RAC*") program on a nationwide basis pursuant to which CMS contracts with private contractors to conduct pre- and post-payment reviews to detect and correct improper payments in the fee-for-service Medicare program. The Affordable Care Act expands the RAC program's scope to include managed Medicare plans and Medicaid claims. CMS also employs Medicaid Integrity Contractors ("*MICs*") to perform post-payment audits of Medicaid claims and identify improper payments. These programs tend to result in retroactively reduced payment and higher administration costs to hospitals.

The Medicaid Program

Medicaid is a program of medical assistance, funded jointly by the federal government and the states, for certain low income individuals and their dependents. Under Medicaid, the federal government provides limited funding to states that have medical assistance programs that meet federal standards. The Affordable Care Act provides significantly enhanced federal funding for states to expand their Medicaid program to virtually all non-elderly, non-disabled adults with incomes up to 138% of the federal poverty level. Attempts to balance or reduce the federal and state budgets, may negatively impact spending for Medicaid and other state health care programs spending.

Approximately 16.8% and 15.4% of the gross revenues of the System were derived from the Medicaid program (apart from payments received from the Medicaid provider tax discussed in APPENDIX A) for the fiscal years ended December 31, 2016 and December 31, 2015, respectively. Significant changes have been and may continue to be made in the Medicaid program which could have a material adverse impact on the financial condition of the System.

Medicaid (Title XIX of the federal Social Security Act) is a health insurance program for certain low-income and needy individuals that 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. In Indiana, Medicaid is administered by the Office of Medicaid Policy & Planning of the Indiana Family and Social Services Administration.

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. For example, the DRA included Medicaid cuts of approximately $4.8 billion over a five-year period.

The following paragraphs discuss certain Medicaid reimbursement rules for Indiana to which the System is subject.

Indiana Medicaid Program

A portion of the Medicaid program's costs in Indiana are paid by the State of Indiana, therefore, the absolute level of Medicaid revenues paid to the System, as well as the timeliness of their receipt, may be affected by the financial condition of the budgetary factors facing the State of Indiana. The State of Indiana could take actions to reduce Medicaid expenditures to accommodate any budgetary shortfalls, including without limitation, changes in the method of payment to hospitals, changes in eligibility requirements for Medicaid recipients and delays of payments due to hospitals. Any such action taken by the State of Indiana could have a material adverse effect upon the System operations and financial results.

Indiana has implemented the Healthy Indiana Plan 2.0 ("*HIP 2.0*") under a federal Section 1115 waiver. HIP 2.0 is available to Medicaid-eligible, non-disabled adult individuals ages 19 to 64 with incomes up to 133% of the federal poverty level ("*FPL*"). HIP 2.0 includes two different coverage programs – HIP Plus and HIP Basic – both of which meet the ACA's minimum coverage requirements. The HIP Plus Plan offers a more comprehensive benefits package and may be utilized by all beneficiaries above 100% FPL and is optional for HIP 2.0 members below 100% FPL. HIP 2.0 also includes another program, HIP Employer Benefit Link, which provides financial assistance to beneficiaries who purchase employer-sponsored health insurance. HIP 2.0 is intended to decrease State costs by utilizing two forms of cost sharing with members. The first is the use of POWER accounts that serve as a health savings account and into which participants are required to contribute in order to retain HIP Plus coverage, and the second is making co-payments mandatory for most services for HIP Basic participants. The HIP 2.0 program has decreased the number of individuals who were previously under- or uninsured in the State. The impact on the System of more individuals having health insurance coverage under the HIP 2.0 program is not known.

Inpatient Hospital Services. The Indiana Medicaid program makes payments to hospitals for inpatient services using a hybrid DRG system and level-of care ("*LOC*") system. The DRG component is a per-case reimbursement system based on diagnosis, age, gender and discharge status. The LOC component is applied to certain burn, psychiatric and rehabilitation cases in participating hospitals to account for variances in length of stay and costs associated with these types of cases. DRG payments are intended to cover all inpatient hospital costs, including the costs of inpatient routine care and most ancillary services. Previously, the Indiana Medicaid program reimbursed hospitals for inpatient services on the basis of the hospital's reasonable costs, as determined under Medicare cost reimbursement principles, and limited such reimbursement by allowing increases in the per discharge target rates based upon certain fiscal year inflationary adjustment percentages.

Outpatient Hospital Services. The Indiana Medicaid Program has an outpatient payment system that reimburses hospitals based upon established fee schedule allowances and rates for surgery groups. Hospitals are reimbursed the lesser of their submitted charges or the Medicaid-allowed amount for all outpatient hospital services. In addition, Outpatient services that occur within three days of an inpatient admission for the same diagnosis are rolled into the corresponding inpatient admission payment. Consequently, no assurance can be given that Medicaid payments received or to be received by the System will be sufficient to cover costs for inpatient and outpatient services or other expenses otherwise eligible for reimbursement.

Nursing Facility Services. The Indiana Medicaid program pays nursing facilities using a case-mix methodology system. The case-mix system of reimbursement is based on one rate, adjusted each quarter for changes in a patient's acuity level, for all Medicaid residents in a Medicaid-certified or dually licensed nursing facility. Under the case-mixed methodology system, a facility's per diem rate is the sum of several different components including direct care costs (including costs associated with nursing and nursing aides, medical

supplies, medical director services, medical records, nurse aide training and nursing and pharmacy consulting services); indirect care costs (including dietary, housekeeping, laundry, plant operations and social services costs); administrative costs (including costs associated with administrators, office supplies and utilization review); therapy costs; employee turnover; and special add-on costs, such as special units and ventilator unit add-ons, and a quality assessment add-on.

Medicaid Disproportionate Share Hospital Payments. Certain Indiana hospitals that serve a disproportionate share of Medicaid and low-income patients may be eligible to receive Medicaid DSH payments and may qualify for additional enhanced disproportionate share payments. The amount of these additional payments is determined by the level, extent and cost of uncompensated care provided to Medicaid and low-income patients. The System recorded approximately $1.0 million and $2.6 million as net patient service revenue for each of the years ended December 31, 2016 and December 31, 2015, respectively, relating to Medicaid DSH payments. There can be no assurance that the System will continue to receive Medicaid DSH payments in the future, or if Medicaid DSH payments that are received will be at the same or similar levels as they have been in the past. *See* Note 15 to the audited consolidated financial statements of Parkview Health and subsidiaries in APPENDIX B hereto for additional information relating to Medicaid DSH payments.

Commercial Insurance and Other Third-Party Plans

Many commercial insurance plans, including group plans, reimburse their customers or make direct payments to the System for charges at established rates. Generally, these plans pay semi-private room rates plus ancillary service charges, which are subject to various limitations and deductibles depending on the plan. Patients carrying such coverage are responsible to the hospital for any deficiency between the commercial insurance proceeds and total billed charges.

Managed Care and Integrated Delivery Systems

Many hospitals and health systems, including the System, are pursuing strategies with physicians in order to offer an integrated package of health care services, including physician hospital services, to patients, health care insurers, and managed care providers. These integration strategies take many forms, several of which are discussed below. Further, many of these integration strategies are capital intensive and may create certain business and legal liabilities for the System

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

The System has entered into contractual arrangements with PPOs, HMOs, and other similar managed care organizations ("*MCOs*"), pursuant to which it agrees to provide or arrange to provide certain health care services for these organizations' eligible enrollees. Revenues received under such contracts are expected to be sufficient to cover the variable cost of the services provided. There can, however, be no assurance that revenues received under such contracts will be sufficient to cover all costs of services provided. Failure of the revenues received under such contracts to cover all costs of services provided may have a material adverse effect on the operations or financial condition of the System. *See* APPENDIX A – "INFORMATION CONCERING PARKVIEW HEALTH SYSTEM, INC. AND ITS AFFILIATES – Financial Information – Third Party Payments" hereto.

Medicare law states that MCO and provider contracts may include a physician incentive plan only if (1) no specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual enrollee; and (2) the stop-loss protection, enrollee survey and disclosure requirements of this section are met. If an MCO and

provider enter into an agreement that does not meet these requirements, CMS may apply intermediate sanctions or the Office of Inspector General ("*OIG*") may apply civil money penalties.

MCOs in general reimburse participating providers on the basis of capitation for services rendered to enrollees. A capitated payment does not fluctuate with the frequency of patient visits. Rather, an MCO typically negotiates with the provider a flat fee per patient regardless of the extent of covered medical services required by that patient. Therefore, there is a risk that the provider may need to furnish the enrollee with additional services whose cost will not be covered by the capitated rate paid by the MCO. *See* "Capitated Payments" below for more information.

State Laws

States are increasingly regulating the delivery of health care services in response to the federal government's failure to adopt comprehensive health care reform measures. Much of this increased regulation has centered around 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. For example, a number of states have enacted laws mandating a minimum of 48-hour hospital stays for women after delivery; laws prohibiting "gag clauses" (contract provisions that prohibit providers from discussing various issues with their patients); laws defining "emergencies," which provide that a health care plan may not deny coverage for an emergency room visit if a layperson would perceive the situation as an emergency; and laws requiring direct access to obstetrician-gynecologists without the requirement of a referral from a primary care physician.

Due to this increased state oversight, the System could be subject to a variety of state health care laws and regulations, affecting both MCOs and health care providers. In addition, the System 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; fee-splitting; the "corporate practice of medicine"; selective contracting ("any willing provider" laws 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 areas.

Dependence Upon Third-Party Payors

The System's ability to develop and expand its services and, therefore, its profitability is dependent upon their ability to enter into contracts with third-party payors at competitive rates. There can be no assurance that they will be able to attract and maintain third-party payors in the future, and where it does, no assurance that it will be able to contract with such payors on advantageous terms. The inability of the System to contract with a sufficient number of such payors on advantageous terms would have a material adverse effect on the System's operations and financial results. Further, while the System expects to employ a system to control health care service utilization and increase quality, the System cannot predict changes in utilization patterns or on health care providers.

Physician Contracting and Relations

The System may wish to contract with physician organizations ("*POs*") (e.g., independent physician associations, physician-hospital organizations, etc.) to arrange for the provision of physician and ancillary services. Because POs are separate legal entities with their own goals, obligations to shareholders, financial status, and personnel, there are risks involved in contracting with the POs. As of December 31, 2016, approximately 400 physicians were employed by Parkview Health. *See* APPENDIX A – "INFORMATION CONCERNING PARKVIEW HEALTH SYSTEM, INC. AND ITS AFFILIATES – Regional Integrated Delivery System and Other Clinical Initiatives – Parkview Physicians Group" for additional information.

The success of the System will be partially dependent upon its ability to attract physicians to join the POs and to attract POs to participate in its network, and upon the physicians', including the employed physicians', abilities to perform their obligations and deliver high-quality patient care in a cost-effective

manner. There can be no assurance that the System will be able to attract and retain the requisite number of physicians, or that such physicians will deliver high-quality health care services. Without impaneling a sufficient number of providers and requisite specialties, the System could fail to be competitive, could fail to keep or attract payor contracts, or could be prohibited from operating until its panel provided adequate access to patients. Such occurrences could have a material adverse effect on the business or operations of the System.

Termination of Managed Care Contracts

The System has contracts with numerous non-governmental payors, two of which contributed in excess of 20% of gross patient service revenues of the System for the twelve-month period ended December 31, 2016. One of these two contracts is Signature Care, which represented approximately 6.3% of the System's gross patient service revenues for the fiscal year ended December 31, 2016. The other contract is with Blue Cross, which represented approximately 14.4% of the System's gross patient service revenues for the fiscal year ended December 31, 2016. The initial stated term of the System's contract with Blue Cross has expired but, under the terms of the contract, the parties' existing contractual relationship continues (except for automatic annual rate adjustments) unless and until it is renegotiated, which either party may request at any time. There are not currently any negotiations pending and neither party has requested renegotiation. Certain of these contracts can be terminated in the event of a material breach which has not been cured by the breaching party within 30 days' notice of such breach, or if a party loses its license to operate in the State of Indiana. These contracts provide for arbitration if disputes cannot be resolved. There is no assurance that these payor contracts will be renewed beyond their current terms, and such non-renewals could have an adverse effect on the financial performance of the System. *See* APPENDIX A – "INFORMATION CONCERING PARKVIEW HEALTH SYSTEM, INC. AND ITS AFFILIATES – Financial Information – Third Party Payments".

Regulation of the Health Care Industry

General

The health care industry is highly dependent on a number of factors that may limit the ability of the Obligated Group to meet its obligations under the Loan Agreement, the Master Indenture and the Series 2017A Note. Among other things, participants in the health care industry (such as the System) are subject to significant regulatory requirements of federal, state and local governmental agencies and independent professional organizations and accrediting bodies, technological advances and changes in treatment modes, various competitive factors and changes in third-party reimbursement programs. Discussed below are certain of these factors that could have a significant effect on the future operations and financial condition of the System.

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 the methods and requirements for submitting claims for services rendered to beneficiaries. Under these laws, hospitals and others can be penalized for a wide variety of conduct, including submitting claims for services that are not provided, billing in a manner that does not comply with government requirements or submitting inaccurate billing information, billing for services deemed to be medically unnecessary, or billings accompanied by an illegal inducement to utilize or refrain from utilizing a service or product.

Federal and state governments have a broad range of criminal, civil and administrative sanctions available to penalize and remediate health care fraud, including the exclusion of a hospital from participation in the Medicare/Medicaid programs, civil monetary penalties, executing corrective action plans, and suspension of Medicare/Medicaid payments. Fraud and abuse cases may be prosecuted by one or more governmental entities and/or private individuals, and more than one of the available sanctions may be, and often are, imposed for each violation. The Affordable Care Act authorizes the Secretary of DHHS to exclude a provider's participation in Medicare and Medicaid, as well as suspend payments to a provider pending an investigation or prosecution 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 providers, pharmaceutical providers, insurers, HMOs, PPOs, third party administrators, physicians, physician groups, and physician practice management companies. Fraud and abuse prosecutions can have a catastrophic effect on a provider and potentially a material adverse impact on the financial condition of other entities in the health care delivery system of which that entity is a part.

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, statutes prohibiting referrals for compensation (including the federal "*Anti-Kickback Law*") or fee-splitting, or the "Stark Law" (discussed below), which prohibits certain referrals by a physician to certain organizations in which the physician has a financial relationship, unless an exception applies. The civil and criminal monetary assessments and penalties arising out of such investigations and prosecutions may be substantial. In addition, the provider may be denied participation in the Medicare and/or Medicaid programs. If and to the extent the Affiliated Entities engaged in a prohibited activity and judicial or administrative proceedings concluded adversely to the System, the outcome could materially affect the System.

The System has internal policies and procedures and has developed and implemented a compliance program that management believes will effectively reduce exposure for violations of these laws. However, because the government's enforcement efforts presently are widespread within the industry and may vary from region to region, there can be no assurance that the compliance program will significantly reduce or eliminate the exposure of the System to civil or criminal sanctions or adverse administrative determinations.

False Claims Act

The federal False Claims Act ("*FCA*") makes it illegal to knowingly submit or present a false, fictitious or fraudulent claim for payment or approval for payment for which the federal government provides, or reimburses at least some portion of the requested money or property. Because the term "knowingly" is defined broadly under the law to include not only actual knowledge but also deliberate ignorance or reckless disregard of the facts, the FCA can be used to punish a wide range of conduct. The Affordable Care Act amends the FCA by expanding the number of activities that are subject to civil monetary penalties to include, among other things, failure to report and return known overpayments within statutory limits. FCA investigations and cases have become common in the health care field and may cover a range of activity from submission of intentionally inflated billings, to highly technical billing infractions, to allegations of inadequate care. Penalties under the FCA are severe and may include damages equal to three times the amount of the alleged false claims, as well as substantial civil monetary penalties. As a result, violation or alleged violation of the FCA frequently results in settlements that require multi-million dollar payments and costly corporate integrity agreements. The FCA provides for potentially severe penalties: treble damages, attorneys' fees and civil fines of $5,000 to $11,000 per claim. In June 2016, the DOJ issued a rule that more than doubles civil monetary penalties under the FCA. Effective August 1, 2016, these penalties are based on the Bureau of Labor Statistics' Consumer Price Index for October 2015 and increase to $10,781 (minimum) to $21,563 (maximum) per claim for violations occurring after November 2, 2015. The increased penalty range significantly increases the potential financial exposure resulting from an FCA violation.

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," can share in the damages recovered by the federal government or recover independently if the government does not participate. The FCA has become one of the federal government's primary weapons against health care fraud and suspected fraud. FCA violations or alleged violations could lead to settlements, fines, exclusion or reputation damage that could have a material adverse impact on a hospital and other health care providers. Some regulators and whistleblowers have asserted that claims submitted to governmental payors that do not comply fully with regulations or guidelines come within the scope of the FCA.

In June 2016, the United States Supreme Court announced its decision in *Universal Health Services, Inc. v. United States ex rel. Escobar*, No. 15-7 (I.S. June 16, 2016). Prior to Escobar, lower courts had split on the issue of whether the FCA extended to so-called "implied certification" of compliance with laws, and

whether such compliance was limited to express conditions of payment or extended to conditions of participation. The United States Supreme Court affirmed the theory of "implied certification" and rejected the distinction between conditions of payment and conditions of participation for these purposes, ruling that the relevant inquiry is whether the alleged noncompliance, if known to the government, would have in fact been material to the government's determination as to whether to pay the claim. There is considerable uncertainty as to the application of the Escobar holding, but depending on how it is interpreted by the lower courts, it could result in an expanded scope of potential FCA liability for noncompliance with applicable laws, regulations and subregulatory guidance.

Under the Affordable Care Act, the FCA has been expanded to include overpayments that are discovered by a health care provider and are not promptly refunded to the applicable federal health care program, even if the claims relating to the overpayment were initially submitted without any knowledge that they were false. The 2016 Medicare Overpayments Final Rule, which took effect on March 14, 2016, requires that providers report and return identified overpayments by the later of 60 days after identification, or the date the corresponding cost report is due, if applicable. If the overpayment is not so reported and returned, it becomes an "obligation" under the FCA. This expansion of the FCA exposes hospitals and other health care providers to liability under the FCA for a considerably broader range of claims than in the past. CMS clarified that the 60-day timeframe for report and return begins when either reasonable diligence is completed (including determination of the overpayment amount) or on the day the person received credible information of a potential overpayment (if the person failed to conduct reasonable diligence and the person in fact received an overpayment). Failure to report and return overpayments as described herein may result in false claims liability. That same final rule also established a six-year lookback period, meaning overpayments must be reported and returned only if a person identifies the overpayment within six years of the date the overpayment was received.

Management is not aware of any pending FCA lawsuits filed against it. Because such lawsuits are filed under seal, however, there can be no guarantee that one or more lawsuits has not been filed or will not be filed in the future.

Anti-Kickback Law

The federal "Anti-Kickback Law" is a criminal statute that prohibits anyone from soliciting, receiving, offering or paying any remuneration, directly or indirectly, overtly or covertly, in cash or in kind, in return for a referral of a patient (or to induce a referral) or the ordering or recommending of the purchase (or lease) of any item or service that is paid by any federal or state health care program. The Anti-Kickback Law applies to many common health care transactions between persons and entities with which a hospital does business, including hospital-physician joint ventures, medical director agreements, physician recruitment agreements, physician office leases and other transactions. The Affordable Care Act amended the Anti-Kickback Law to provide explicitly that a claim that includes items or services resulting from a violation of the Anti-Kickback Law constitutes a false or fraudulent claim for purposes of the FCA. Another amendment provides that an Anti-Kickback Law violation may be established without showing that an individual knew of the statute's proscriptions or acted with specific intent to violate the Anti-Kickback Law, but only that the conduct was generally wrongful.

Violations or alleged violations of the Anti-Kickback Law most often result in settlements that require multi-million dollar payments and onerous corporate integrity agreements. The Anti-Kickback Law can be prosecuted either criminally or civilly. A criminal violation may be prosecuted as a felony, subject to a fine of up to $250,000 for each act (which may be each item or each bill sent to a federal program), imprisonment and exclusion from the Medicare and Medicaid programs, any of which would have a significant detrimental effect on the financial stability of most hospitals. In addition, civil monetary penalties of $50,000 per item or service in noncompliance (which may be each item or each bill sent to a federal program) or an "assessment" of three times the amount collected may be collected. Increasingly, the federal government and qui tam relators are prosecuting violations of the Anti-Kickback Law under the FCA, based on the argument that claims resulting from an illegal kickback arrangement are also false claims for FCA purposes. *See* the discussion under the subheading " – False Claims Act" above. The IRS has taken the position that hospitals that are in violation of

the Anti-Kickback Law may also be subject to revocation of their tax-exempt status. *See* " – Tax-Exempt Status and Other Tax Matters" below.

Stark Referral Law

The Ethics in Patient Referrals Act of 1989 ("*Stark I*"), as amended in the Omnibus Budget Reconciliation Act of 1993 ("*Stark II*") (collectively, the "*Stark Law*"), prohibits the referral of Medicare patients for certain designated health services (including inpatient and outpatient hospital services, clinical laboratory services, and radiology and other imaging services) to entities with which the referring physician has a financial relationship unless that relationship fits within an exception to the Stark Law. It also prohibits a hospital furnishing the designated services from billing Medicare, or any other payor or individual for services performed pursuant to a prohibited referral. The government does not need to prove that the entity knew that the referral was prohibited to establish a Stark Law violation. If certain substantive and technical requirements of an applicable exception are not satisfied, many ordinary business arrangements between hospitals and physicians may fall within the gambit of the Stark Law, thus triggering the prohibition on referrals and billing. Most providers of designated health services with physician relationships have some exposure to liability under the Stark Law.

Penalties for violation of the Stark Law include denial of payment, recoupment, refunds of amounts paid in violation of the law, exclusion from the Medicare or Medicaid program, and substantial civil monetary penalties (up to $15,000 per service, $100,000 for each arrangement or scheme intended to circumvent or to violate the statute, or $10,000 per day for false reporting or failure to report certain information required under the law). Violation of the Stark Law may also provide the basis for a claim under the FCA (*see* discussion above).

Medicare may deny payment for all services performed based on a prohibited referral and a hospital that has billed for prohibited services is obligated to refund the amounts collected from the Medicare program or to make a self-disclosure to CMS under its Self-Referral Disclosure Protocol ("*SRDP*"). For example, if an office lease between a hospital and a large group of heart surgeons is found to violate the Stark Law, the hospital could be obligated to repay CMS for the payments received from Medicare for all of the heart surgeries performed by all of the physicians in the group for the duration of the lease; a potentially significant amount. As a result, even relatively minor, technical violations of the Stark Law may trigger substantial refund obligations. Moreover, if the violations of the Stark Law were knowing, the government may also seek substantial civil monetary penalties, and in some cases, a hospital may be excluded from the Medicare and Medicaid programs. Potential repayments to CMS, settlements, fines or exclusion for a Stark Law violation or alleged violation could have a material adverse impact on a hospital and other health care providers. Increasingly, the federal government is prosecuting Stark Law violations under the FCA, based on the argument that claims resulting from an illegal referral arrangement are also false claims for FCA purposes. *See* the discussion under the subheading "False Claims Act" above. The DOJ and others have asserted that Medicaid referrals in which an non-excepted financial arrangement exists under the Stark Law also create FCA exposure, and have had some success with these arguments outside the Ninth Circuit, where it has not yet been litigated.

CMS has established a voluntary self-disclosure program under which hospitals and other entities may report Stark Law violations and seek a reduction in potential refund obligations. The limited publicly available information with respect to the self-disclosure program suggests that most voluntary self-disclosure submissions remain under consideration by CMS for an extended period of time, and that it is difficult to predict how CMS will react to any specific voluntary self-disclosure. Parkview or its Affiliated Entities may make self-disclosures under this program as appropriate from time to time. Any submission pursuant to the self-disclosure program does not waive or limit the ability of the OIG or DOJ to seek or prosecute violations of the Anti-Kickback Law or impose civil monetary penalties.

The System has and may have in the future various relationships with physicians that may be characterized as financial arrangements under the Stark Law. The statutes and interpretive regulations contain numerous ambiguities and are subject to varying interpretations. Under these circumstances, it is not possible

to ascertain with certainty the effects that the Stark Law may have on the System's operations or financial results.

Civil Monetary Penalties Law

The federal Civil Monetary Penalties Law ("*CMPL*") provides for administrative sanctions against health care providers for a broad range of billing and other abuses. For example, penalties may be imposed for the knowing presentation of claims that are (i) incorrectly coded for payment, (ii) for services that are known to be medically unnecessary, (iii) for services furnished by an excluded party, or (iv) otherwise false. An entity that offers remuneration to an individual that the entity knows is likely to induce the individual to receive care from a particular provider may also be fined. Under the Affordable Care Act, Congress amended the CMPL to authorize civil monetary penalties for a number of additional activities, including (i) knowingly making or using a false record or statement material to a false or fraudulent claim for payment, (ii) failing to grant the OIG timely access for audits, investigations, or evaluations, and (iii) failing to report and return a known overpayment within statutory time limits. The CMPL authorizes imposition of civil monetary penalties ranging from $10,000 to $50,000 for each item or service improperly claimed and each instance of prohibited conduct. Health care providers may be found liable under the CMPL even when they did not have actual knowledge of the impropriety of the claim. It is sufficient that the provider "should have known" that the claim was false, and ignorance of the Medicare regulations is no defense.

Antitrust

Antitrust liability may arise in a wide variety of circumstances, including payor contracting, physician relations, joint ventures, merger, affiliation and acquisition activities, certain pricing or salary setting activities, physician relations and medical staff privilege disputes, as well as other areas of activity. Consolidation transactions among health care providers is an area in which investigation and enforcement activity by federal and state antitrust agencies is particularly frequent and vigorous. For example, the FTC filed complaints challenging three different hospital mergers in the last two months of 2015. The application of the federal and state antitrust laws to transactions and conduct in the health care industry is evolving as the industry adapts to accountability for the cost and quality of care. Currently, the most common areas of potential liability for health care providers are mergers and acquisitions, joint contracting with payors, and exclusionary conduct and contracts.

Violation of the antitrust laws could result in criminal and/or civil enforcement proceedings by federal and state agencies, as well as actions by private litigants. In certain actions, private litigants may be entitled to treble damages, and in others, governmental entities may be able to assess substantial monetary fines. Investigations and proceedings arising from the application of federal and state antitrust laws can require the dedication of substantial resources by affected providers and can delay or impede proposed transactions even if ultimately it is determined that no violation of applicable law would occur as a result of the proposed transaction.

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 does not believe that any potential review of its Medicare revenues would materially adversely affect its results of operations of the System.

HIPAA and Other Privacy Requirements

HIPAA adds additional criminal sanctions for health care fraud and applies to all health care benefit programs, whether public or private. HIPAA also provides for punishment of a health care provider for knowingly and willfully embezzling, stealing, converting or intentionally misapplying any money, funds, or other assets of a health care benefit program. A health care provider convicted of health care fraud could be subject to mandatory exclusion from Medicare.

HIPAA, along with new privacy rules arising under federal and various state statutes, addresses the confidentiality of individuals' personal information, including, but not limited to, demographic information, social security numbers, financial information and health information. For example, HIPAA prohibits the disclosure of protected health information unless expressly required or permitted under the provisions of the HIPAA statute and regulations or authorized by the patient. HIPAA's confidentiality provisions extend not only to patient medical records, but also to a wide variety of health care clinical and financial information. These patient privacy requirements often impose communication, operational, and accounting obligations that add costs and create potentially unanticipated sources of liability.

There are also other federal or state privacy laws that may have more restrictive privacy requirements than HIPAA. For example, the regulations under 42 C.F.R. Part 2 provide a heightened level of privacy of records associated with the provision of substance abuse counseling and treatment by covered alcohol and substance abuse treatment programs. These rules are significantly more restrictive than the privacy provisions set forth in HIPAA. States may also adopt privacy laws that are more restrictive than HIPAA. Together, all of these laws and regulations add compliance costs and create potentially unanticipated sources of legal liability for the System.

The HITECH Act

On January 25, 2013, DHHS issued comprehensive modifications to the existing HIPAA regulations to implement the requirements of the Health Information Technology for Economic and Clinical Health Act (the "*HITECH Act*"), commonly known as the "*HIPAA Omnibus Rule*." The HIPAA Omnibus Rule became effective on March 26, 2013, and covered entities were required to be in compliance by September 23, 2013 (though certain requirements have a longer timeframe). Key aspects of the HIPAA Omnibus Rule include, but are not limited to: (i) a new standard for what constitutes a breach of protected health information, (ii) establishing four levels of culpability with respect to civil monetary penalties assessed for HIPAA violations, (iii) direct liability of business associates for certain violations of HIPAA, (iv) modifications to the rules governing research, (v) stricter requirements regarding non-exempt marketing practices, (vi) modification and re-distribution of notices of privacy practices, and (vii) stricter requirements regarding the protection of genetic information. The obligations imposed by the HIPAA Omnibus Rule could have a material adverse effect on the financial condition of the System.

The HITECH Act's breach notification requirement (the "*Breach Notification Rule*"), in particular, may expose "*Covered Entities*" such as hospitals to heightened liability. The Breach Notification Rule created a uniform federal breach notification law that mirrors protections that many states have passed in recent years. The Breach Notification Rule requires the System to notify patients of any unauthorized access, acquisition, or disclosure of their unsecured protected health information unless it is demonstrated that there is a low probability that the protected health information was not compromised based on a four-factor test. In addition, all breaches must be reported to the Secretary of DHHS. If more than 500 individuals are affected by the breach, (i) the Covered Entity must also notify the media and (ii) the Secretary of DHHS will post a description of the breach on its website. These reporting obligations increase the risk of government enforcement as well as class action lawsuits, especially if large numbers of individuals are affected by a breach.

The HITECH Act revises the civil monetary penalties associated with violations of HIPAA as well as provides state attorneys general with authority to enforce the HIPAA privacy and security regulations in some cases through a damages assessment of $110 per violation or an injunction against the violator. The revised civil monetary penalty provisions establish a tiered system, ranging from a minimum of $110 per violation for an unknowing violation to $1,100 per violation for a violation due to reasonable cause, but not willful neglect. For a violation due to willful neglect, the penalty is a minimum of $11,002 or $55,010 per violation, depending on whether the violation was corrected within 30 days of the date the violator knew or should have known of the violation. Maximum penalties may reach $1,650,300 for identical violations.

Criminal penalties will be enforced against persons who knowingly obtain or disclose personal health information in violation of HIPAA. The Office for Civil Rights ("*OCR*"), the administrative office that is tasked with enforcing HIPAA, is also beginning to perform periodic audits of health care providers and group

health plans to ensure that required policies under HIPAA (as amended by the HITECH Act) are in place. Finally, OCR is working to establish a methodology under which an individual who is harmed by an offense punishable under HIPAA may be able to recover a percentage of the civil monetary penalty or monetary settlement collected with respect to the offense. These enforcement actions may significantly increase the number of HIPAA-related complaints from individuals, as well as increase penalty and settlement amounts.

OCR has stated that it has now moved from education to enforcement in its implementation of the law. Recent settlements of HIPAA violations for breaches involving lost data have reached the millions of dollars. Any breach of HIPAA, regardless of intent or scope, may result in penalties or settlement amounts that are material to a covered health care provider or health plan.

The HITECH Act also established programs under Medicare and Medicaid to provide incentive payments to certain eligible hospitals and health care professionals ("*Eligible Providers*") that demonstrate the "meaningful use" of CEHRT. Eligible Providers demonstrate meaningful use of CEHRT by meeting and attesting to meaningful use objectives and associated measures specified by CMS for using CEHRT and by reporting on certain quality measures. Incentive payments under the Medicare program sunset in 2016. Pursuant to the HITECH Act, and commencing in 2015, Eligible Providers who have not satisfied the performance and reporting criteria for demonstrating meaningful use in the applicable meaningful use reporting year will have their Medicare payments reduced. The payment reduction starts at 1% and increases each year that an eligible hospital or professional does not demonstrate meaningful use, up to a maximum 5% reduction. CMS has engaged a contractor that conducts pre-payment and post-payment audits of certain selected Eligible Providers that have submitted meaningful use attestations. An Eligible Provider that fails the audit will have an opportunity to appeal. Ultimately, Eligible Providers that elect not to appeal or fail on appeal will have to repay any incentive payments that they received through these programs or refund Medicare reimbursement that would have been reduced as part of the payment reductions.

Moreover, MACRA ends the payment reductions for physicians who fail to demonstrate meaningful use after 2018. However, beginning in 2019, use of CEHRT will be a performance category under MACRA's MIPS for certain physicians and other health care professionals who do not meet MACRA's thresholds for participation in certain alternative payment models designated by Medicare. A physician's failure to use CEHRT consistent with MIPS' requirements would lower the physician's performance score under MIPS and could result in reduced Medicare reimbursement for professional services performed by the physician. CMS has issued a final rule to implement MIPS with numerous, complex requirements. The need to implement technology, operational and other changes to address MIPS requirements for use of CEHRT may have a material adverse impact on the System. Generally, MACRA did not change hospital participation in the Medicare EHR Incentive Program or participation for physicians in the Medicaid EHR incentive program.

Business Associates – HIPAA and HITECH

Under existing HIPAA regulations, covered entities must include certain required provisions in their contractual relationships with organizations that perform functions on their behalf which involve use or disclosure of protected health information. These organizations are called business associates, and have been indirectly regulated by HIPAA through those contractual obligations. The HITECH Act and the final rules promulgated thereunder provide that all of the HIPAA security administrative, physical, and technical safeguards, as well as security policies, procedures and documentation requirements now apply directly to all business associates. In addition, the HITECH Act makes certain privacy provisions directly applicable to business associates. These changes are significant because business associates will now be directly regulated by OCR for those requirements, and as a result, will be subject to penalties imposed by OCR and/or state attorneys general. Likewise, to the extent a business associate is deemed to be an agent of the covered entity under the federal common law, the covered entity will be liable for the breaches of the business associate. Covered entities have had to review and amend their business associate agreements in recent years in order to comply with these changing rules, which can be costly and administratively burdensome.

Security Breaches and Unauthorized Releases of Personal Information

As noted above, state and local authorities are increasingly focused on the importance of protecting the confidentiality of individuals' personal information, including patient health information. Many states have enacted laws requiring businesses to notify individuals of security breaches that result in the unauthorized release of personal information, which may include demographic information, social security numbers, financial information and health 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 incidents exposes health organizations to increased risk of individual or class action lawsuits from patients or other affected persons, in addition to government enforcement and negative media attention. 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 damage a health care provider's reputation and materially adversely affect business operations.

In a large hospital or health system, there can often be security incidents related to patient information, which stem from a variety of causes ranging from external or internal deliberate invasions by individuals or employees, to inadvertent loss or misdirection of paper or electronic records, to theft of hardware or software.

Cybersecurity Risks

Health care providers are highly dependent upon integrated electronic medical record and other information technology systems to deliver high quality, coordinated and cost-effective health care. These systems necessarily hold large quantities of highly sensitive protected health information that is highly valued on the black market. As a result, the electronic systems and networks of health care providers are considered likely targets for cyber-attacks and other potential breaches of their systems. In addition to regulatory fines and penalties, the health care entities subject to the breaches may be liable for the costs of remediating the breaches, damages to individuals (or classes) whose information has been breached, reputational damage and business loss, and damage to the information technology infrastructure. The System has taken, and continues to take, measures to protect its information technology system against such cyber-attacks, but there can be no assurance that the System will not experience a significant breach. If such a breach occurs, the financial consequences of such a breach could have a material adverse impact on the System.

Exclusions from Medicare or Medicaid Participation

The government may exclude a health care provider from Medicare/Medicaid program participation if it is convicted of a criminal offense relating to the delivery of any item or service reimbursed under Medicare or a state health care program, any criminal offense relating to patient neglect or abuse in connection with the delivery of health care, fraud against any federal, state or locally financed health care program or an offense relating to the illegal manufacture, distribution, prescription, or dispensing of a controlled substance. The government also may exclude individuals or entities under certain other circumstances, such as an unrelated conviction of fraud, or other financial misconduct relating either to the delivery of health care in general or to participation in a federal, state or local government program. Exclusion from the Medicare/Medicaid program means that a health care provider would be decertified from program participation and no program payments can be made. Any health care provider exclusion could be a materially adverse event. In addition, exclusion of health care organization employees or independent contractors or their employees under Medicare or Medicaid may be another source of potential liability for hospitals or health systems based on services provided by those excluded employees.

Administrative Enforcement

Administrative regulations may require less proof of a violation than do criminal laws, and, thus, health care providers may have a higher risk of imposition of monetary penalties as a result of administrative enforcement actions.

Compliance with Conditions of Participation

Hospitals must comply with standards called "Conditions of Participation" in order to be eligible for continuing enrollment in Medicare and Medicaid. CMS may determine that a provider is not in compliance with its conditions of participation. In that event, a notice of termination of participation may be issued and a provider may be required to develop and implement a potentially burdensome corrective action plan. If the corrective action plan is not accepted by CMS, or if the corrective action plan is not successfully implemented, the provider's Medicare provider agreement could be terminated. Other sanctions could potentially be imposed, including, in limited instances, monetary penalties. Failure by the System to comply with the Conditions of Participation could result in the loss of the System's eligibility to participate in the Medicare and Medicaid programs, which would have a material negative effect on the financial condition and results of operation of the System. Such requirements also apply to home health, hospice and skilled nursing facilities.

Patient Transfers; the Emergency Medical Treatment and Labor Act

The Emergency Medical Treatment and Labor Act ("*EMTALA*") is a federal civil statute that requires Medicare-participating hospitals with an emergency department to conduct a medical screening examination to determine the presence or absence of an emergency medical condition and to provide treatment sufficient to stabilize such emergency medical condition before discharging or transferring the patient. A hospital that violates EMTALA is subject to civil penalties of up to $103,139 per offense and termination of its Medicare provider agreement. EMTALA also provides for a limited private right of action against hospitals, and as a result a hospital could be subject to claims for personal injury where an individual suffers harm as result of an EMTALA violation.

Over the last few years, the federal government has increased its enforcement of EMTALA. Failure to comply with the law can result in exclusion from the Medicare and/or Medicaid programs, as well as civil and criminal penalties. In addition, a hospital may be held liable to a patient who suffered injuries as a result of a violation of EMTALA and may be liable to the receiving hospital for financial losses suffered as a result of a transfer in violation of EMTALA. Substantial failure of the System to meet its responsibilities under EMTALA could materially adversely affect the financial condition of the System. Outpatient facilities that are included as part of a hospital by virtue of a provider-based status designation are required to adhere to EMTALA's requirements, regardless of whether they are located on or away from the hospital's main campus.

Management is not aware of any pending or threatened claim, investigation or enforcement action regarding patient transfers that, if determined adversely to the System, would have material adverse consequences to the System.

International Classification of Diseases, 10th Revision Coding System

In 2009, CMS published a final rule requiring health care organizations to implement the International Classification of Diseases, 10th Revision coding system ("*ICD-10*"). ICD-10, implementation of which became effective on October 1, 2015. 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, diagnosis, and treatment codes. The System successfully transitioned to ICD-10 on the stated deadline, but remains dependent upon the ability of Medicare, Medicaid and other payors to process and pay claims under ICD-10.

Licensing, Surveys, Investigations and Accreditations

Health facilities are subject to numerous legal, regulatory, professional and private licensing, certification and accreditation requirements. These include, but are not limited to, requirements of state licensing agencies and The Joint Commission. Renewal and continuation of certain of these licenses, certifications and accreditations are based on inspections or other reviews generally conducted in the normal course of business of health facilities. Loss of, or limitations imposed on, hospital licenses or accreditations could reduce hospital utilization or revenues, or a hospital's ability to operate all or a portion of its facilities or to bill various third party payors. Certain states can levy penalties against hospitals that experience certain significant patient care events, including those that are classified as posing "immediate jeopardy" to patient health and safety.

Environmental Laws and Regulations

Health facilities 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: air and water quality control requirements; waste management requirements; specific regulatory requirements applicable to asbestos and radioactive substances; requirements for providing notice to employees and members of the public about hazardous materials handled by or located at the health facilities; and requirements for training employees in the proper handling and management of hazardous materials and wastes.

Hospitals that participate in the Medicare and Medicaid programs are subject from time to time to audits and other investigations relating to various aspects of their operations and billing practices, as well as to retroactive audit adjustments with respect to reimbursements claimed under those programs. Medicare and Medicaid regulations also provide for withholding reimbursement payments under certain circumstances. New billing rules and reporting requirements for which there is not clear guidance from CMS or state Medicaid agencies could result in claims submissions being considered inaccurate. The penalties for violations may include an obligation to refund money to the Medicare or Medicaid program, payment of criminal or civil fines and, for serious or repeated violations, exclusion from participation in federal health care programs.

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 above.

Enforcement authorities are often in a position to compel settlements by providers charged with or being investigated for false claims violations by withholding or threatening to withhold Medicare, Medicaid and similar payments or to recover higher damages, assessments or penalties 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 dictate settlement. Therefore, 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 any settlement agreement. Prolonged and publicized investigations could be damaging to the reputation and business of a health care organization, regardless of outcome.

Certain acts or transactions may result in violation or alleged violation of a number of the federal health care fraud laws described above, and therefore penalties or settlement amounts often are compounded. Generally these risks are not covered by insurance. Enforcement actions may involve multiple hospitals or other facilities in a health system, as the government often extends enforcement actions regarding health care fraud to other entities in the same organization. Therefore, Medicare fraud related risks identified as being materially adverse to a health care organization could have materially adverse consequences to a health system taken as a whole.

Issues Related to the Health Care Market

Affiliation, Merger, Acquisition and Divestiture

Significant numbers of affiliations, mergers, acquisitions and divestitures have occurred in the health care industry recently. As part of its ongoing planning process, management considers potential affiliations and acquisition of operations or properties that may become affiliated with or become part of the Credit Group or System in the future. As a result, it is possible that the organizations and assets that currently comprise the System and Credit Group may change from time to time. *See* APPENDIX C – "SUMMARY OF MASTER DOCUMENTS AND DEFINITIONS – Summary of Certain Provisions of the Master Indenture – Merger, Consolidation, Sale or Conveyance".

Possible Increased Competition

The System could face increased competition in the future from other hospitals, from skilled nursing facilities and from other forms of health care delivery that offer health care services to the populations which the System currently serves. This could include the construction of new or the renovation of existing hospitals and skilled nursing facilities, health maintenance organization facilities, ambulatory surgery centers, freestanding emergency facilities, private laboratory and radiological services, skilled and specialized nursing facilities, home care, intermediate nursing home care, preventive care and drug and alcohol abuse programs.

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 System. These services could be substituted for some of the revenue-generating services currently offered by the System. The services that could serve as substitutes for hospital services include skilled and specialized nursing facilities, diagnostics, home care, intermediate nursing home care, preventive care, and drug and alcohol abuse programs. Competition may also come from specialty hospitals or organizations, particularly those facilities providing specialized services in areas with high visibility and strong margins, such as cardiac services and surgical services, and having specialty physicians as investors.

Risks Related to Tax-Exempt Status

Tax Exemption for Nonprofit Hospitals

Loss of tax-exempt status of Parkview Health, Parkview Hospital or other user of bond financed property could result in loss of tax exemption of the Bonds and of other tax-exempt debt issued for the benefit of Parkview Health, Parkview Hospital or other Affiliated Entities, and defaults in covenants regarding the Bonds and other related tax-exempt debt would likely be triggered. Such an event would have material adverse consequences on the financial condition of the System. Management is not aware of any transactions or activities currently ongoing that are likely to result in the revocation of the tax-exempt status of Parkview Health, Parkview Hospital or other user of bond financed property.

The maintenance by an entity of its status as an organization described in Section 501(c)(3) of the Code is contingent upon 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 educational purposes and their avoidance of transactions that may cause their assets to inure to the benefit of private individuals. The IRS has announced that it intends to closely scrutinize transactions between not-for-profit corporations and for-profit entities, and in particular has issued audit guidelines for tax-exempt hospitals. Although specific activities of hospitals, such as medical office building leases and compensation arrangements and other contracts with physicians, have been the subject of interpretations by the IRS in the form of Private Letter Rulings, many activities have not been addressed in any official opinion, interpretation or policy of the IRS. Because the System conducts large-scale and diverse operations involving private parties, there can be no assurances that certain of its transactions would not be challenged by the IRS.

The IRS has taken the position that hospitals which are in violation of the Anti-Kickback Law may also be subject to revocation of their tax-exempt status. *See* the information herein under the caption,

"BONDHOLDERS' RISKS – Regulation of the Health Care Industry – Civil and Criminal Fraud and Abuse Laws and Enforcement". As a result, tax-exempt hospitals, such as those of the System, which have, and will continue to have, extensive transactions with physicians are subject to an increased degree of scrutiny and perhaps enforcement by the IRS.

The Taxpayers Bill of Rights 2, referred to for purposes of this Official Statement as the Intermediate Sanctions Law, allows the IRS to impose "intermediate sanctions" against certain persons in circumstances involving the violation by tax-exempt organizations of the prohibition against private inurement. Prior to the enactment of the Intermediate Sanctions Law, the only sanction available to the IRS in such circumstances was revocation of an organization's tax-exempt status. Intermediate sanctions may be imposed in situations in which a "disqualified person" (such as an "insider") (i) engages in a transaction with a tax-exempt organization on other than a fair market value basis, (ii) receives unreasonable compensation from a tax-exempt organization or (iii) receives payment in an arrangement that violates the prohibition against private inurement. These transactions are referred to as "excess benefit transactions". 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 $10,000. 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.

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 and all other users of bond financed property, are 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 herein which apply to health care systems, these liabilities are probable from time to time and could be substantial, and in extreme cases could be materially adverse.

Bills have been introduced in Congress that would require a tax-exempt hospital to provide a certain amount of charity care and care to Medicare and Medicaid patients in order to maintain its tax-exempt status and avoid the imposition of an excise tax. Other legislation would have conditioned a hospital's tax-exempt status on the delivery of adequate levels of charity care. Congress has not enacted such bills. However, there can be no assurance that similar legislative proposals or judicial actions will not be adopted in the future.

In recent years, the IRS and state, county and local taxing authorities have been undertaking audits and reviews of the operations of tax-exempt hospitals with respect to their exempt activities and the generation of unrelated business taxable income. The Obligated Group participates in activities that may generate unrelated business taxable income. Management of Parkview Health believes it has properly accounted for and reported unrelated business taxable income; nevertheless, an investigation or audit could lead to a challenge which could result in taxes, interest and penalties with respect to unreported unrelated business taxable income and in some cases could ultimately affect the tax-exempt status of any Member of the Obligated Group as well as the exclusion from gross income for federal income tax purposes of the interest payable on the Bonds and other tax-exempt debt of any Member of the Obligated Group. In addition, legislation, if any, which may be adopted at the federal, state and local levels with respect to unrelated business income cannot be predicted. Any legislation could have the effect of subjecting a portion of the income of the System to federal or state income taxes.

In 1990, the Employee Plans and Exempt Organizations Division of the IRS expanded the Coordinated Examination Program, or CEP, of the IRS to tax-exempt health care organizations. CEP audits are conducted by teams of revenue agents. The CEP 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.

Not-for-profit health care organizations are subject to audits by the IRS. Management of Parkview Health believes that it has 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 CEP audit could result in additional taxes, interest and penalties. A CEP audit could ultimately affect the tax-exempt status of a Member of the Obligated Group as well as the exclusion from gross income for federal income tax purposes of the interest payable with respect to the Bonds and other tax-exempt debt of any Member of the Obligated Group.

In addition to the foregoing proposals with respect to income by not-for-profit corporations, various state and local governmental bodies have challenged the tax-exempt status of not-for-profit institutions and have sought to remove the exemption of property from real estate taxes of part or all of the property of various not-for-profit institutions 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. Several of these disputes have been determined in favor of the taxing authorities or have resulted in settlements.

It is not possible to predict the scope or effect of future legislative or regulatory actions with respect to taxation of not-for-profit corporations. There can be no assurance that future changes in the laws and regulations of federal, state or local governments will not materially adversely affect the operations and financial condition of the System by requiring it to pay income or local property taxes.

Tax-Exempt Status of the Bonds

The tax-exempt status of the Bonds is based on the continued compliance by the Authority, Parkview Health and any other users of property financed or refinanced with proceeds of the Bonds with certain covenants relating generally to restrictions on the use of the facilities financed or refinanced with the proceeds of the Bonds, arbitrage limitations, rebate of certain excess investment earnings to the federal government and status of users of the properties financed or refinanced with the proceeds of the Bonds as organizations described in Section 501(c)(3) of the Code (*See* "Tax Exemption for Nonprofit Hospitals" above). Failure to comply with such covenants could cause interest on the Bonds to become subject to federal income taxation retroactive to the date of issuance of the Bonds. In the event that the Bonds become subject to federal income taxation retroactive to the date of issuance, such Bonds are not subject to redemption solely as a consequence thereof. No additional interest or penalty is payable in the event of the taxability of interest on any of the Bonds.

Charity Care

Hospitals are permitted to acquire 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 for tax-exempt status should be eliminated. Management of Parkview Health cannot predict the likelihood of such a dramatic change in the law. Federal and state tax authorities are beginning to demand that tax-exempt hospitals justify their tax-exempt status by documenting their charitable care and other community benefits.

Schedule H to the Form 990 asks whether the organization has a charity care policy and asks for a description of that policy. This schedule also requires an organization to report the community benefits that it provides, including the cost of providing charity care and other benefits. The reporting of this information on the Form 990 makes the information more readily available and may perhaps lead to additional IRS compliance efforts.

Bond Audits

IRS officials have indicated that more resources will be invested in audits of tax-exempt bonds in the charitable organization sector. The Bonds may be, from time to time, subject to audits by the IRS. The Obligated Group believes that the Bonds properly comply with the tax laws applicable to tax-exempt bonds. In addition, Bond Counsel will render an opinion with respect to the tax-exempt status of the Bonds, as described herein under the caption, "TAX MATTERS". No ruling with respect to the tax-exempt status of the Bonds has been or will be sought from the IRS, however, and opinions of counsel are not binding on the IRS or the courts and are not guarantees. There can be no assurance that an audit of the Bonds will not adversely affect the Bonds.

Labor Relations

Not-for-profit health care providers and their employees are under the jurisdiction of the National Labor Relations Board. At the present time, none of the System's employees are members of the unions or receive union wages and benefits. Management of Parkview Health considers its relationship with its employees to be satisfactory. Unionization of employees or a shortage of qualified professional personnel could cause an increase in payroll costs beyond those projected. Additionally, the System cannot control the prevailing wage rates in its service areas, and any increase in such rates will directly affect the costs of its operations. *See* APPENDIX A – "INFORMATION CONCERING PARKVIEW HEALTH SYSTEM, INC. AND ITS AFFILIATES – Employees".

Nursing Shortage

The health care industry has experienced a shortage of nursing and other technical staff, which has resulted in increased costs and lost revenues due to the need to hire agency nursing personnel at higher rates and increased compensation levels. The System has periodically incurred agency nursing costs at their facilities. If the System incurs increasing agency nursing costs over an extended period of time, it could adversely affect the System's operations or financial condition.

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. Currently, the System has no capitated contracts, other than for Medicaid managed care plans which pay on a capitated per member per-month fee at standard Medicaid rates.

Incurrence of Additional Indebtedness

The Master Indenture permits Additional Indebtedness to be incurred by Members of the Obligated Group, and permits Additional Indebtedness to be secured by additional Master Notes that will be on a parity with the Series 2017A Note and may also be secured by security in addition to that provided for the Series

2017A Note and other outstanding Master Notes. *See* "SUMMARY OF MASTER DOCUMENTS AND DEFINITIONS – Summary of Certain Provisions of the Master Indenture – Permitted Additional Indebtedness" in APPENDIX C attached hereto.

Certain Matters Relating to Security for the Bonds

The enforceability, priority and perfection of the security interest in the Pledged Revenues of the Obligated Group may be limited by a number of factors, including: (i) provisions prohibiting the direct payment of amount due to health care providers from Medicaid and Medicare programs to persons other than such providers; (ii) the absence of an express provision permitting assignment of receivables due under the contracts between the Obligated Group and third-party payors, and present or future legal prohibitions against such assignment; (iii) certain judicial decisions which cast doubt on the right of the Master Trustee, in the event of the bankruptcy of a Member of the Obligated Group, to collect and retain accounts receivable from Medicare, Medicaid and other governmental programs; (iv) commingling of proceeds of accounts receivable with other moneys of the Obligated Group not so pledged under the Master Indenture; (v) statutory liens; (vi) rights arising in favor of the United States of America or any agency thereof; (vii) constructive trusts of equitable or other rights impressed or conferred thereon by a federal or state court in the exercise of its equitable jurisdiction; (viii) federal bankruptcy laws which may affect the enforceability of the Master Indenture, the Loan Agreement or the covenant relating to Pledged Revenues which are earned by the Obligated Group and during the dependency of such proceedings; (ix) rights of third parties in Pledged Revenues converted to cash and not in the possession of the Master Trustee; and (x) claims that might arise if appropriate financing or continuation statements are not filed in accordance with the Uniform Commercial Code, as from time to time in effect. Under the Indiana Uniform Commercial Code, such security interest ceases to attach to proceeds of Pledged Revenues, e.g., collections of accounts receivable which cannot be traced to a specific account of the a Member of the Obligated Group or otherwise have ceased to be "identifiable cash proceeds".

The facilities of the Obligated Group are not pledged or mortgaged as security for the Bonds. Consequently, in the event of a default under the Indenture, the Bondholders would have the status of general unsecured creditors (except with respect to the pledge of revenues). The facilities of the Obligated Group are not general purpose buildings and generally would not be suitable for industrial or commercial use. Consequently, it could be difficult to find a buyer or lessee for the facilities if it were necessary to proceed against such facilities, whether pursuant to a judgment, if any, against the Obligated Group or otherwise. As a result, upon any such default, the Trustee may not realize the amount necessary to pay the Bonds in full from the sale or lease of such facilities. The Bonds are not secured by a mortgage on the facilities of the Obligated Group.

Pursuant to the terms of the Master Indenture, the Obligated Group may incur additional Indebtedness (including Indebtedness secured by additional Obligations) that is entitled to the benefits of security that does not extend to any other Indebtedness (including the Series 2017A Note). Such security may include liens on the Obligated Group's Property (including health care facilities) or any depreciation reserve, debt service or interest reserve or similar fund established for such additional Indebtedness. *See* "SUMMARY OF MASTER DOCUMENTS AND DEFINITIONS – Summary of Certain Provisions of the Master Indenture – Pledged Revenues" in APPENDIX C hereto.

The Indenture and the Master Indenture each provide that, except during the continuance of an event of default, the Trustee or the Master Trustee, as the case may be, undertakes to perform such duties and only such duties as are specifically set forth in the Indenture or Master Indenture, and no implied covenants or obligations should be read into the Indenture or Master Indenture against the Trustee or the Master Trustee, as the case may be. If any event of default has occurred and is continuing, the Trustee or the Master Trustee, as the case may be, is required to exercise such of the rights and powers vested in it under the Indenture or the Master Indenture, as the case may be, and use the same degree of care and skill in their exercise, as an ordinary, prudent person would exercise or use in the conduct of such person's own affairs.

Certain material amendments to the Indenture and the Loan Agreement may be made without the consent of the owners of the Bonds.

In addition, certain material amendments to the Master Indenture may be made with the consent of the holders of not less than a majority of the principal amount of outstanding Master Notes. Such amendments may adversely affect the security of the Bondholders.

The remedies available to the Trustee, the Master Trustee and the owners of the Bonds upon an event of default under the Indenture, the Master Indenture, the Loan Agreement and the Series 2017A Note are in many respects dependent upon judicial actions which are often subject to discretion and delay. Under existing constitutional and statutory law and judicial decisions, including, specifically, Title 11 of the United States Code (the "*United States Bankruptcy Code*"), the remedies provided in the Indenture, the Master Indenture, the Loan Agreement and the Series 2017A Note may not be readily available or may be limited. The various legal opinions to be delivered concurrently with the delivery of the Bonds will be qualified as to the enforceability of the various legal instruments by limitations imposed by general principles of equity and by bankruptcy, reorganization, insolvency or other similar laws affecting the rights of creditors' generally and laws relating to fraudulent conveyances.

Changes in Credit Group

Additional entities may be added to the Obligated Group and Obligated Group Members may withdraw from the Obligated Group and additional entities may be designated as Designated Affiliates by the Obligated Group Representative from time to time, and such designation may be rescinded by the Obligated Group Representative from time to time, each in accordance with the Master Indenture, resulting in an Credit Group which is financially and operationally different from the current Credit Group.

See APPENDIX C – "SUMMARY OF MASTER DOCUMENTS AND DEFINITIONS – Summary of Certain Provisions of the Master Indenture –The Master Notes; Payment of the Master Notes; Designated Affiliates," "– Entrance into the Obligated Group" and "– Cessation of Status as a Member of the Obligated Group".

Matters Relating to Enforceability of the Master Indenture

The Members of the Obligated Group are jointly and severally liable for Master Notes issued under the Master Indenture. At closing, the Members of the Obligated Group will be Parkview Health and Parkview Hospital. The financial results of the Designated Affiliates will be combined for financial reporting purposes and will be used in determining whether various covenants and tests contained in the Master Indenture (including tests relating to the incurrence of Additional Indebtedness) are met, notwithstanding the uncertainties as to the enforceability described in the preceding paragraphs and below. Members of the Obligated Group contained in the Master Indenture which bear on the availability of the assets and revenues of the Members of the Obligated Group for payment of debt service on Master Notes, including the Series 2017A Note pledged under the Indenture as security for the Bonds. The joint and several obligations described herein of the Members of the Obligated Group to make payments of debt service on Master Notes issued under the Master Indenture (including transfers in connection with voluntary dissolution or liquidation) to enable the Members of the Obligated Group to make payments of debt service on the Master Notes may not be enforceable to the extent (1) enforceability may be limited by applicable bankruptcy, moratorium, reorganization or similar laws affecting the enforcement of creditors' rights and by general equitable principles and (2) such payments (i) are requested to make payments on any Master Notes which are issued for a purpose which is not consistent with the charitable purposes of the Members of the Obligated Group from which such payments are requested or which are issued for the benefit of any entity other than a tax-exempt organization; (ii) are requested to be made from any moneys or assets which are donor restricted or which are subject to a direct or express trust which does not permit the use of such moneys or assets for such a payment; (iii) would result in the cessation or discontinuation of any material portion of the health care or related services previously provided by the Member of the Obligated Group from which such payment is requested; or (iv) are requested to be made pursuant to any loan violating applicable usury laws.

A Member of the Obligated Group may not be required to make any payment or to transfer funds to provide for the payment of any Master Note, or portion thereof, the proceeds of which were not loaned or otherwise disbursed to such Member of the Obligated Group to the extent that such payment or transfer would

render the Member of the Obligated Group insolvent or which would conflict with, not be permitted by or which is subject to recovery for the benefit of other creditors of such Member of the Obligated Group under applicable fraudulent conveyance, bankruptcy or moratorium laws. There is no clear precedent in the law as to whether such payments or transfers from a Member of the Obligated Group in order to pay debt service on the Obligations may be voided by a trustee in bankruptcy in the event of bankruptcy of the Member, or by third-party creditors in an action brought pursuant to state fraudulent transfer or fraudulent conveyance statutes. Under the United States Bankruptcy Code, a trustee in bankruptcy and, under state fraudulent transfer or fraudulent conveyance statutes and common law, a creditor of a related guarantor, may avoid any obligation incurred by a related guarantor if, among other bases therefor, (1) the guarantor has not received fair consideration or reasonably equivalent value in exchange for the guaranty and (2) the guaranty renders the guarantor insolvent, as defined in the United States Bankruptcy Code or applicable state fraudulent transfer or fraudulent conveyance statutes, or the guarantor is undercapitalized.

Application by courts of the tests of "insolvency," "reasonably equivalent value" and "fair consideration" has resulted in a conflicting body of case law. It is possible that, in an action to force a Member of the Obligated Group to pay debt service on a Master Note for which it was not the direct beneficiary, a court might not enforce such a payment in the event it is determined that the Member of the Obligated Group is analogous to a guarantor of the debt of the Member of the Obligated Group who directly benefited from the borrowing and that sufficient consideration for the Member of the Obligated Group's guaranty was not received and that the incurrence of such obligation has rendered or will render the Member of the Obligated Group insolvent or the Member of the Obligated Group is or will thereby become undercapitalized.

There exist, in addition to the foregoing, common law authority and authority under applicable state statutes pursuant to which the courts may 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 or has taken some action which renders it unable to carry out such purposes. Such court action may arise on the court's own motion pursuant to a petition of the Indiana 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.

Potential Effects of Bankruptcy

If any Member of the Obligated Group were to file a petition for relief (or if a petition were filed against such Member of the Obligated Group) under the United States Bankruptcy Code, the filing would operate as an automatic stay of the commencement or continuation of any judicial or other proceeding against such Member of the Obligated Group and its property. If the bankruptcy court so ordered, such Member of the Obligated Group's property, including its accounts receivable and proceeds thereof, could be used for the benefit of such Member of the Obligated Group despite the claims of its creditors. Amounts received by Bondholders with respect to the payment of principal of, redemption premium, if any, and interest on the Bonds during an applicable preference period could be required to be disgorged by the Bondholders to a bankruptcy trustee.

In a bankruptcy proceeding, the petitioner could file a plan for the adjustment of its debts which modifies the rights of creditors generally, or the rights of any class of creditors, secured or unsecured. The plan, when confirmed by the court, would bind all creditors who had notice or knowledge of the plan and discharge all claims against the debtor provided for in the plan. No plan may be confirmed unless, among other conditions, the plan is in the best interests of creditors, is feasible and has been accepted by each class of claims impaired thereunder. Each class of claims has accepted the plan if at least two-thirds in dollar amount and more than one-half in number of the allowed claims of the class that are voted with respect to the plan are cast in its favor. Even if the plan is not so accepted, it may be confirmed if the court finds that the plan is fair and equitable with respect to each class of non-accepting creditors impaired thereunder and does not discriminate unfairly.

Other Risk Factors Affecting the System

In the future, the following factors, among others, may adversely affect the future operations or financial performance of the System, to an extent that cannot be determined at this time:

(1) Employee strikes and other adverse labor actions that could result in a substantial reduction in revenues without corresponding decreases in costs, and shortage of skilled professionals, such as nurses and technicians.

(2) Reduced need for hospitalization, skilled or intermediate nursing care, elderly housing or other services arising from increased utilization management by third-party payors or from future medical and scientific advances.

(3) Reduced demand for the services provided by the System that might result from decreases in population in its service area.

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

(5) Any increase in the quantity of indigent care provided which is mandated by law or required due to increased needs of the community in order to maintain the charitable status of the hospitals in the System.

(6) Regulatory actions that might limit the ability of the System to undertake capital improvements to their facilities or to develop new institutional health services.

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

(8) Inflation or other adverse economic conditions.

(9) Inability of the System to meet or continue to comply with legal, regulatory, professional and private licensing and accreditation requirements, all or some of which may be subject to renewal based on inspection or other criteria.

(10) The attempted imposition of or the increase in taxes related to the property and operations of not-for-profit organizations.

(11) The occurrence of natural disasters, including floods and earthquakes, which may damage the facilities of the System, interrupt utility service to the facilities, or otherwise impair the operation and generation of revenues from said facilities.

(12) Laws requiring particular staffing levels at hospitals.

Cost and Availability of Insurance

In the past few years, the insurance market for casualty and professional liability insurance has tightened significantly with respect to both cost and availability of coverage, resulting in escalating fees and premiums and in some cases a lack of adequate coverage. *See* APPENDIX A – "CERTAIN INFORMATION CONCERNING PARKVIEW HEALTH SYSTEM, INC. AND ITS AFFILIATES – Additional Information – Insurance" hereto for additional information regarding insurance coverage of the System.

Bond Ratings

There is no assurance that the ratings assigned to the Bonds at the time of issuance will not be lowered or withdrawn at any time, the effect of which could adversely affect the market price for, and marketability of, the Bonds. *See* "RATINGS" herein.

ABSENCE OF MATERIAL LITIGATION

Authority

To the best of the Authority's knowledge, there is no controversy or litigation of any nature, now pending or threatened against the Authority, restraining or enjoining the issuance, sale, execution or delivery of the Bonds, or in any way contesting or affecting the validity of the Bonds.

System

There is no controversy or litigation of any nature, to the knowledge of their officers, now pending or threatened against the System restraining or enjoining the issuance, sale, execution or delivery of the Series 2017A Note by the Obligated Group, or in any way contesting or affecting the validity of the Series 2017A Note.

As with most health care corporations, the System is subject to certain legal actions which, in whole or in part, are not or may not be covered by insurance or self-insurance because of the type of action or damages requested (*e.g.* punitive damages), because of a reservation of rights by an insurance carrier or self-insurance program, or because the action has not proceeded to a stage which permits full evaluation. Since such actions either claim punitive damages which could become a liability of the System and/or state or threaten causes of action which may not be covered by insurance or self-insurance, insurers for the System and the self-insurance program have not provided assurance of coverage, and to the extent any cases have not been served, counsel has not been retained to evaluate them.

No litigation is now served upon or, to the knowledge of Parkview Health, otherwise pending or threatened against the System (i) which the probable ultimate recoveries and the estimated costs and expenses of defense will be entirely within the applicable insurance policy limits (subject to applicable deductibles) or for which adequate reserves exist and (ii) which in the aggregate would have a material adverse effect on the System's operations or condition, financial or otherwise.

TAX MATTERS

In the opinion of Ice Miller LLP, Indianapolis, Indiana ("*Bond Counsel*"), under existing federal statutes, decisions, regulations and rulings, interest on the Bonds is excludable from gross income for purposes of federal income taxation pursuant to Section 103 of the Internal Revenue Code of 1986, as amended (the "*Code*"), is not an item of tax preference for purposes of the federal alternative minimum tax imposed on individuals and corporations, but is taken into account in determining adjusted current earnings for the purpose of computing the federal alternative minimum tax imposed on certain corporations. This opinion relates only to the exclusion from gross income of interest on the Bonds for federal income tax purposes under Section 103 of the Code and is conditioned on continuing compliance by the Authority, the Obligated Group and certain other affiliates with the Tax Covenants (as hereinafter defined). Failure to comply with the Tax Covenants could cause interest on the Bonds to lose the exclusion from gross income for federal income tax purposes retroactive to the date of issue. In the opinion of Bond Counsel, under existing laws, regulations, judicial decision and rulings, interest on the Bonds is exempt from income taxation in the State. This opinion relates only to the exemption of interest on the Bonds for State income tax purposes. See APPENDIX D hereto for the form of the approving opinion of Bond Counsel.

The Code imposes certain requirements which must be met subsequent to the issuance of the Bonds as a condition to the exclusion from gross income of interest on the Bonds for federal income tax purposes. The Authority, the Credit Group and certain other affiliates will covenant not to take any action, nor fail to take any action within their respective power and control, with respect to the Bonds that would result in the loss of the exclusion from gross income for federal income tax purposes of interest on the Bonds pursuant to Section 103 of the Code (collectively, the "*Tax Covenants*"). The Indenture, the Loan Agreement and certain certificates and agreements to be delivered on the date of delivery of the Bonds establish procedures under which compliance with the requirements of the Code can be met. It is not an event of default under the Indenture if

interest on the Bonds is not excludable from gross income for federal income tax purposes or otherwise pursuant to any provision of the Code which is not in effect on the issue date of the Bonds.

Indiana Code § 6 5.5 imposes a franchise tax on certain taxpayers (as defined in Indiana Code § 6-5.5) which, in general, are all corporations which are transacting the business of a financial institution in the State. The franchise tax is measured in part by interest excluded from gross income under Section 103 of the Code minus associated expenses disallowed under Section 265 of the Code. Taxpayers should consult their own tax advisors regarding the impact of this statute on their ownership of the Bonds.

Although Bond Counsel will render an opinion on the federal and state tax matters described above, the accrual or receipt of interest on the Bonds may otherwise affect a Bondholder's federal or state income tax liability. The nature and extent of these other tax consequences will depend upon the Bondholder's particular tax status and the Bondholder's other items of income or deduction. Taxpayers who may be affected by such other tax consequences include, without limitation, financial institutions, certain insurance companies, S corporations, certain foreign corporations, individual recipients of Social Security or railroad retirement benefits and taxpayers who may be deemed to have incurred (or continued) indebtedness to purchase or carry the Bonds. Bond Counsel expresses no opinion regarding any other such tax consequences. Prospective purchasers of the Bonds should consult their own tax advisors with regard to the other tax consequences of owning the Bonds.

Amortizable Bond Premium

The initial offering prices of the Bonds (collectively, the "*Premium Bonds*") are greater than the principal amount payable at maturity or call date. As a result, the Premium Bonds will be considered to be issued with amortizable bond premium (the "*Bond Premium*"). An owner who acquires a Premium Bond in the initial offering will be required to adjust the owner's basis in the Premium Bond downward as a result of the amortization of the Bond Premium, pursuant to Section 1016(a)(5) of the Code. Such adjusted tax basis will be used to determine taxable gain or loss upon the disposition of the Premium Bonds (including sale, redemption or payment at maturity or call). The amount of amortizable Bond Premium will be computed on the basis of the owner's yield to maturity, with compounding at the end of each accrual period. Rules for determining (i) the amount of amortizable Bond Premium and (ii) the amount amortizable in a particular year are set forth in Section 171(b) of the Code. No income tax deduction for the amount of amortizable Bond Premium will be allowed pursuant to Section 171(a)(2) of the Code, but amortization of Bond Premium may be taken into account as a reduction in the amount of tax-exempt income for purposes of determining other tax consequences of owning the Premium Bonds. Owners of the Premium Bonds should consult their tax advisors with respect to the precise determination for federal income tax purposes of the treatment of Bond Premium upon the sale or other disposition of Premium Bonds and with respect to the state and local tax consequences of owning and disposing of Premium Bonds.

Special rules governing the treatment of Bond Premium, which are applicable to dealers in tax exempt securities are found at Section 75 of the Code. Dealers in tax exempt securities are urged to consult their own tax advisors concerning treatment of Bond Premium.

LEGAL MATTERS

Legal matters incident to the issuance of the Bonds are subject to the unqualified approving opinion of Ice Miller LLP, Indianapolis, Indiana, Bond Counsel. Certain other legal matters will be passed upon for the Authority by Krieg DeVault LLP, Carmel, Indiana; for the Obligated Group by its counsel, Rothberg Logan & Warsco LLP, Fort Wayne, Indiana; and for the Underwriter by its counsel, Hawkins Delafield & Wood LLP, Ann Arbor, Michigan.

RATINGS

Moody's Investors Service, Inc. ("*Moody's*") and S&P Global Ratings Inc. ("*S&P*") have assigned ratings to the Bonds of "Aa3" (stable) and "AA-" (stable), respectively. Any explanation of the significance of such ratings may only be obtained from the rating agency furnishing the same. Parkview Health furnished to

the rating agencies certain information and material concerning itself, the System Affiliates and the Bonds. Generally, rating agencies base their ratings on such information and materials and on investigations, studies and assumptions made by the rating agencies themselves. There is no assurance that the ratings mentioned above will remain in effect for any given period of time or that they might not be lowered or withdrawn entirely by the rating agencies, if in their judgment circumstances so warrant. Parkview Health and the Underwriter (as defined herein) have undertaken no responsibility either to bring to the attention of the holders of the Bonds any proposed change in or withdrawal of any rating or to oppose any such proposed revision or withdrawal. Any such downward change in or withdrawal of any rating might have an adverse effect on the market price or marketability of the Bonds.

CONTINUING DISCLOSURE

Parkview Health has agreed, pursuant to the terms of a continuing disclosure agreement, to provide secondary market disclosure with respect to the Bonds as required by Rule 15c2-12, as amended, under the Securities Exchange Act of 1934, as amended (the "*Continuing Disclosure Agreement*"). The form of Continuing Disclosure Agreement is attached as APPENDIX E.

The Authority has undertaken no responsibility with respect to any reports, notices or disclosures provided or required under the Continuing Disclosure Agreement, and shall have no liability to any person, including any owner or Beneficial Owner of the Bonds, with respect to the Rule. The Authority shall have no continuing disclosure obligations.

UNDERWRITING

The Bonds are being purchased by J.P. Morgan Securities LLC ("*JPMS*" or the "*Underwriter*") pursuant to a Bond Purchase Agreement dated July 18, 2017, among Parkview Health, the Authority and the Underwriter (the "*Purchase Agreement*"). The Bonds are being purchased at a price of $129,959,974, which represents the par amount of the Bonds, less an Underwriter's discount of $531,432 and plus an original issue premium of $19,861,406. The Purchase Agreement provides that the Underwriter will purchase all of the Bonds if any are purchased and contains the agreements of the Obligated Group to indemnify the Underwriter and the Authority against certain liabilities to the extent permitted by law.

The Underwriter intends to offer the Bonds to the public initially at the prices set forth in the maturity schedule immediately following the cover page. The Underwriter reserves the right to join with dealers and other underwriters in offering the Bonds to the public. The Underwriter may offer and sell the Bonds to certain dealers at prices lower than the public offering prices. In connection with this offering, the Underwriter may overallot or effect transactions that stabilize or maintain the market price of the Bonds at a level above that which might otherwise prevail in the open market. Such stabilizing, if commenced, may be discontinued at any time. The obligation of the Underwriter to accept delivery of the Bonds will be subject to various conditions of the Purchase Agreement.

INDEPENDENT AUDITORS

The consolidated financial statements of Parkview Health and subsidiaries, as of December 31, 2016 and 2015 and for the years then ended, included in APPENDIX B to this Official Statement have been audited by RSM US LLP, independent auditors, as stated in their report appearing in APPENDIX B hereto.

ESCROW VERIFICATION REPORT

Causey Demgen & Moore P.C., certified public accountants (the "*Verifier*"), will, concurrently with the issuance of the Bonds, deliver to Parkview Health a verification report indicating that it has verified, in accordance with standards established by the American Institute of Certified Public Accountants, the arithmetical accuracy of certain computations provided by the Underwriter relating to the (a) computation of forecasted receipts of principal and interest on the obligations deposited in the Escrow Fund under the Escrow Agreement and the forecasted payments of principal and interest to pay the Bonds to be Refunded at their redemption or maturity dates, and (b) the computation of the yields on the Bonds and the obligations deposited

in the Escrow Fund, supporting the conclusion of Bond Counsel that the Bonds are not "arbitrage bonds" within the meaning of the Code and the regulations promulgated under the Code. All such computations will be based solely upon assumptions and information supplied by the Underwriter and reviewed and approved by Parkview Health. The Verifier will restrict its procedures to verifying the arithmetical accuracy of certain computations and will not make any study or evaluation of the assumptions and information on which the computations are based, and the Verifier will not express any opinion on the data used, the reasonableness of the assumptions or the achievability of the forecasted outcomes.

FINANCIAL ADVISOR

Ponder & Co. has served as financial advisor (the "*Financial Advisor*") to Parkview Health for purposes of assisting with the development and implementation of a bond structure in connection with the Bonds. Ponder & Co. is not obligated to undertake, and has not undertaken, an independent verification or to assume responsibility for the accuracy, completeness, or fairness of the information contained in this Official Statement. Ponder & Co. is an independent advisory firm and is not engaged in the business of underwriting or distributing municipal securities or other public securities.

MISCELLANEOUS

The foregoing and subsequent summaries and descriptions of provisions of the Bonds, the Indenture, the Loan Agreement, the Master Indenture, the Series 2017 Supplemental Indenture, Supplemental No. 8 and the Series 2017A Note and all references to other materials not purporting to be quoted in full are only brief outlines of some of the provisions thereof and do not purport to summarize or describe all of the provisions thereof. Reference is made to said documents for full and complete statements of their provisions. The Appendices attached hereto are a part of this Official Statement.

This Official Statement has been approved by the Authority and executed by Parkview Health, as Obligated Group Representative. This Official Statement is not to be considered as a contract or agreement between the Authority, or the Obligated Group and the purchasers or holders of any of the Bonds.

PARKVIEW HEALTH SYSTEM, INC., on behalf of itself and Parkview Hospital, Inc., as Obligated Group Representative

By: */s/ Jeanné Wickens*
Jeanné Wickens
Chief Financial Officer

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APPENDIX A

INFORMATION CONCERNING
PARKVIEW HEALTH SYSTEM, INC. AND ITS AFFILIATES

Capitalized terms used, but not defined in this Appendix A, are defined in the forepart of this Official Statement and in Appendix D to this Official Statement.

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INTRODUCTION

Overview

Parkview Health System, Inc. (the "Corporation" or "PH"), a community based Indiana nonprofit corporation, operates, directly and through its affiliates, subsidiaries and joint ventures, a physician-led, regionally integrated health care delivery system. The Corporation and its affiliates, subsidiaries and joint ventures (collectively, "Parkview Health" or the "System") provide a full array of services to patients in 15 counties in northeast Indiana and northwest Ohio in hospital, physician office, and ambulatory surgery center settings. Parkview Health endeavors to deliver on its brand promise of "*excellent care, every person, every day*".

Parkview Health's comprehensive continuum of health care services includes acute, non-acute, and tertiary care services on an inpatient, outpatient and emergency basis; managed care services; diagnostic and therapeutic services; continuing care services including - home health care, hospice, skilled nursing, and in-patient rehab; behavioral health care; primary and specialty physician care; a pluralistic clinically integrated network; and research. In Fort Wayne and northeast Indiana, the System operates six acute care facilities, a behavioral health hospital, a tertiary care center and through a joint venture, an orthopedic specialty hospital, with a combined total of 898 beds in service. The System has four facilities located in the City of Fort Wayne and five others in the northern Indiana communities of Columbia City, Huntington, Kendallville, LaGrange, and Wabash. As of June 1, 2017, the System had a medical staff of approximately 911 members and had more than 10,700 employees. Through the Parkview Physicians Group, the System currently employs approximately 392 physicians and 176 advanced practice providers at over 150 locations.

Parkview Health is the recipient of numerous awards for quality care and service, including *Magnet*® designation from the American Nurses Credentialing Center, a national accreditation for nursing excellence (achieved by all System hospitals), and recognition as one of the nation's 15 Top U.S. Health Systems by Truven Health Analytics®.

History, Mission, Vision and Values

History

The Corporation was formed in 1995 as an Indiana nonprofit corporation to provide leadership and serve as the parent organization to an integrated health care delivery system. In 1997, the System was created when PH became the sole corporate member of Parkview Hospital Inc. ("Parkview Hospital" or "PVH"), Whitley Memorial Hospital, Inc. ("Parkview Whitley") and Huntington Memorial Hospital, Inc. ("Parkview Huntington"). Subsequently, the System continued to grow, adding Community Hospital of Noble County, Inc. ("Parkview Noble") in 2000, adding Community Hospital of LaGrange County, Inc. ("Parkview LaGrange") in 2008, and Wabash County Hospital ("Parkview Wabash") in 2015 and expanding programs services, facilities, and physical practices. *See* "INTRODUCTION – Corporate Structure" herein.

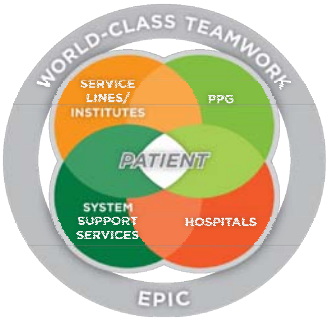
Parkview Health's mission, vision and values, which follow below, serve as guiding principles and impact every aspect of the organization.

Mission and Vision

As a community owned, not-for-profit organization, Parkview Health is dedicated to improving your health and inspiring your well-being by:

- tailoring a personalized health journey to achieve a patient's unique goals,
- demonstrating world-class teamwork as the System partners with its patient along that journey, and
- providing the excellence, innovation and value a patient seeks in terms of convenience, compassion, service, cost and quality.

The System uses the following graphics to depict its mission and vision to internal and external audiences.



Values

The System is guided by the following values: adaptability, enthusiasm, excellence, humility, integrity, quality, safety, service, stewardship and teamwork.

Recent Accomplishments and Awards

Since 1997, Parkview Health has been implementing a strategy to develop a fully integrated medical delivery system throughout its market, which is able to provide high quality, effective health care services through its affiliates in an ever changing environment. The System has focused on connecting all care sites to deliver the right care to its patients, and delivering that care on an efficient basis. Interwoven through the strategy are multiple quality initiatives to promote patient safety and improve care. Campus expansion and reinvestment have been a critical component in developing the organization. In the last ten years, the System has expended approximately $1.3 billion to improve digital technology and create modern facilities within its expanding network of care. The average age of the System's plant is approximately 8 years.

Recent System accomplishments include:

- In 2012, Parkview Health opened the Parkview Regional Medical Center ("PRMC"), a state-of-the-art medical center located on the System's main campus, for secondary and tertiary services. Additionally, in 2012, PRMC opened a new approximately 126,000 square foot medical office building. *See* "OBLIGATED GROUP MEMBERS AND AFFILIATED ENTITIES – Obligated Group Members – Parkview Hospital, Inc." for more information on PRMC.

- In 2013, Parkview Health created Parkview Care Partners, LLC ("PCP"), a pluralistic clinically integrated network, to improve health care value for patients, employers and providers in its service area. *See* "REGIONAL INTEGRATED DELIVERY SYSTEM AND CLINICAL INITIATIVES – Parkview Physicians Group" for more information on PCP.

- Also in 2013, Parkview launched, Parkview Community Connect, to extend EpicCare to its partners in the region. As of June 1, 2017, two independent hospitals (with a third under contract for 2017/2018), over ten non-Parkview Health (independent or independent hospital employed) physician practices comprising approximately fifty providers, and three community health clinics utilize Parkview Community Connect. See "INFORMATION TECHNOLOGY" for more information the System's information technology initiatives.

- In 2014, Parkview Health completed the migration of all hospitals, ambulatory/physician clinics, home health, and other services onto EpicCare to develop a single story of care across the organization. All new providers and practices are activated on EpicCare as they join the System.

- Also in 2014, Parkview Health acquired Parkview Wabash.

- In 2015, Parkview Health opened the Parkview Mirro Research Center and acquired the remaining 50% of Premier Surgery Center, a joint venture surgery center.

- In 2016, Parkview Health commenced construction of a $35 million two-story replacement hospital facility at Parkview Wabash. *See* "OBLIGATED GROUP MEMBERS AND AFFILIATED ENTITIES – Non-Obligated Group Member System Affiliates – Parkview Wabash."

- In 2016, Parkview Health began a $55 million renovation project at Parkview Hospital Randallia ("Parkview Randallia") and an $100 million project on the campus of PRMC. The project at Parkview Randallia will increase bed capacity, add 12 intensive care unit beds, enhance the Family Birthing Center, add operating rooms and add a hybrid cath lab/interventional suite. Completion of the multi-year project is expected is in 2018/2019. The project at PRMC involves construction of an approximately 175,000 square foot five story building which will house the Parkview Cancer Institute. *See* "OBLIGATED GROUP MEMBERS AND AFFILIATED ENTITIES – Obligated Group Members – Parkview Hospital, Inc." and "REGIONAL INTEGRATED DELIVERY SYSTEM AND OTHER CLINICIAL INITIATIVES – Service Line Initiatives" for further information, respectively, on PRMC, Parkview Randallia and the Parkview Cancer Institute.

- In April 2016, Parkview Whitley opened a state-of-the-art free-standing emergency room and ambulatory facility, Parkview Warsaw, in Kosciusko County, Indiana.

- Also in 2016, The Orthopaedic Hospital at Parkview North, LLC ("Parkview Ortho") acquired Therapy ONE, a physical therapy practice.

- In early 2017, Parkview Health launched a virtual consult model within the network to eliminate unnecessary transfers to the Parkview Heart Institute.

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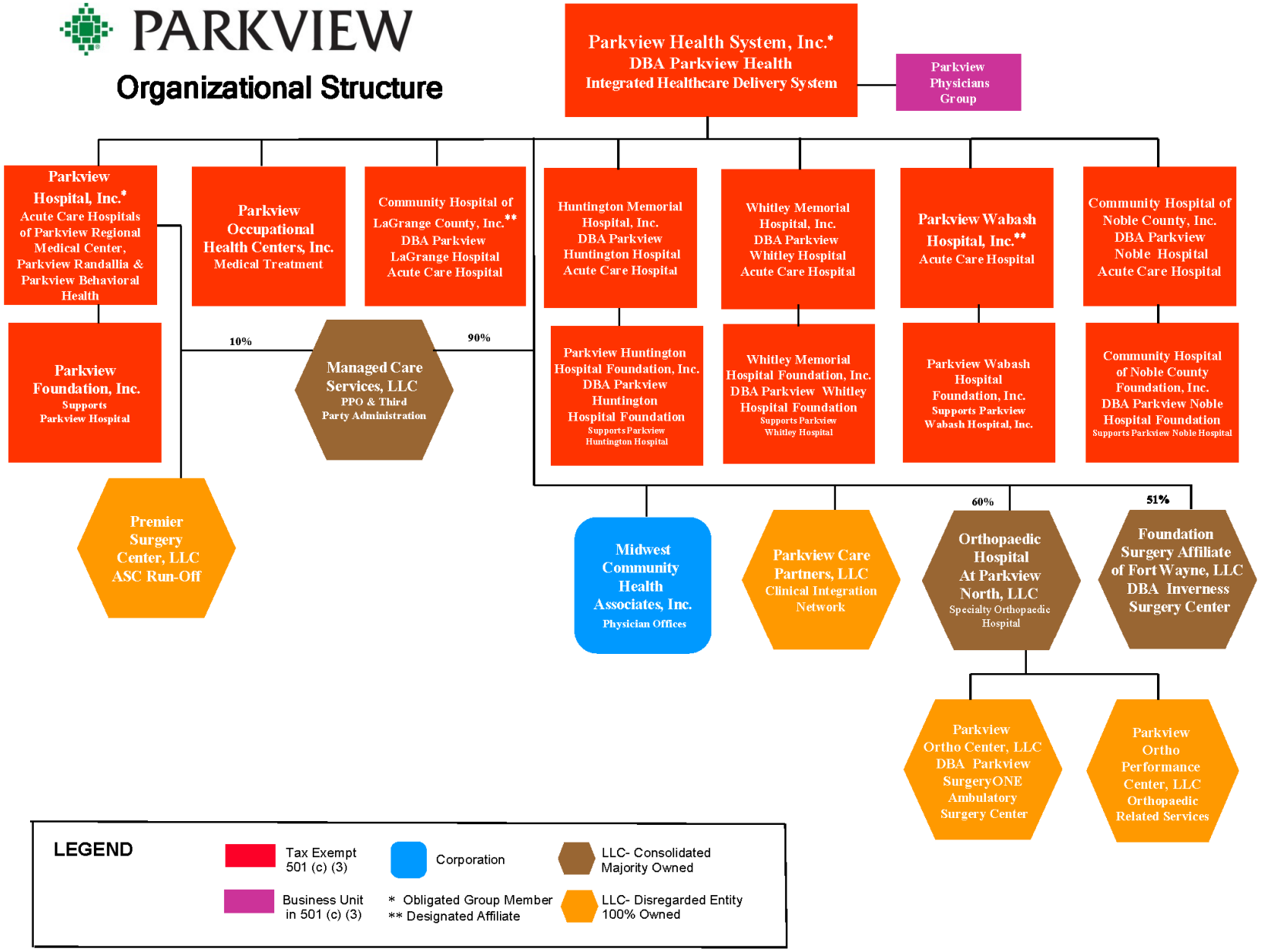
The System has been recognized by many organizations for providing high quality health care.

Selected PH Awards		
Recognition/Award	Description	Award Granter
15 Top U.S. Health System	First received in 2017 by the System.	Truven Health Analytics®
Magnet Designation	Designation awarded to all System hospital facilities. National accreditation recognizing excellence in nursing clinical outcomes, patient experience and nursing engagement. (2017)	American Nurses Credential Center
100 Top Hospital	First received in 2012 by Parkview Huntington, five times since. First received in 2014 by PRMC, three times since.	Truven Health Analytics®
Work Place of the Year	First received in 2014, three times since.	Advisory Board
Stage 6 Certification	An eight-stage maturity model that allows hospitals to track their progress towards a paperless environment and complete electronic medical records system. (2014)	Healthcare Information and Management Systems
Top Performers on Key Quality Measures®	Achieved by PRMC, Parkview Randallia, Parkview Ortho, Parkview Whitley, Parkview Huntington, Parkview Wabash, and Parkview LaGrange. (2015)	The Joint Commission
Most Wired® Hospital	First received in 2014 by the System, three times since.	American Hospital Association Health Forum
Platinum Quality Award	PRMC was the first hospital in Indiana to receive this award. (2016)	Midas +
National Performance Leader Award	Parkview Huntington, Parkview Noble, Parkview LaGrange, Parkview Wabash and Parkview Whitley recognized. (2016)	iVantage Health Analytics
Top Hospital Award – Safety Grade of A	First received in 2014 by the System, three times since.	Leapfrog

Corporate Structure

An organizational chart which depicts the organizational structure of the System and significant operating divisions, subsidiaries, affiliates and joint ventures is set forth on the following page. Except as noted, the Corporation is the sole shareholder or member of each of the entities in the System.


PARKVIEW
Organizational Structure
Parkview Health System, Inc.*
DBA Parkview Health
Integrated Healthcare Delivery System
Parkview Physicians Group
Parkview Hospital, Inc.*
Acute Care Hospitals of Parkview Regional Medical Center, Parkview Randallia & Parkview Behavioral Health
Parkview Occupational Health Centers, Inc.
Medical Treatment
Community Hospital of LaGrange County, Inc.**
DBA Parkview LaGrange Hospital
Acute Care Hospital
Huntington Memorial Hospital, Inc.
DBA Parkview Huntington Hospital
Acute Care Hospital
Whitley Memorial Hospital, Inc.
DBA Parkview Whitley Hospital
Acute Care Hospital
Parkview Wabash Hospital, Inc.**
Acute Care Hospital
Community Hospital of Noble County, Inc.
DBA Parkview Noble Hospital
Acute Care Hospital
Parkview Foundation, Inc.
Supports Parkview Hospital
10%
Managed Care Services, LLC
PPO & Third Party Administration
90%
Parkview Huntington Hospital Foundation, Inc.
DBA Parkview Huntington Hospital Foundation
Supports Parkview Huntington Hospital
Whitley Memorial Hospital Foundation, Inc.
DBA Parkview Whitley Hospital Foundation
Supports Parkview Whitley Hospital
Parkview Wabash Hospital Foundation, Inc.
Supports Parkview Wabash Hospital, Inc.
Community Hospital of Noble County Foundation, Inc.
DBA Parkview Noble Hospital Foundation
Supports Parkview Noble Hospital
Premier Surgery Center, LLC
ASC Run-Off
Midwest Community Health Associates, Inc.
Physician Offices
Parkview Care Partners, LLC
Clinical Integration Network
60%
Orthopaedic Hospital At Parkview North, LLC
Specialty Orthopaedic Hospital
51%
Foundation Surgery Affiliate of Fort Wayne, LLC
DBA Inverness Surgery Center
Parkview Ortho Center, LLC
DBA Parkview SurgeryONE
Ambulatory Surgery Center
Parkview Ortho Performance Center, LLC
Orthopaedic Related Services
LEGEND
Tax Exempt 501 (c) (3)
Corporation
LLC- Consolidated Majority Owned
Business Unit in 501 (c) (3)
* Obligated Group Member
** Designated Affiliate
LLC- Disregarded Entity 100% Owned

OBLIGATED GROUP MEMBERS AND AFFILIATED ENTITIES

As described in the forepart of this Official Statement, the Master Indenture creates a Credit Group consisting of Members of the Obligated Group and certain entities designated from time to time by the Obligated Group Representative as Designated Affiliates under and in accordance with the Master Indenture. *See* "INTRODUCTION – The Obligated Group, the Credit Group and the Master Indenture" in the forepart of this Official Statement. Presently, the Corporation and Parkview Hospital are Members of the Obligated Group and Parkview LaGrange and Parkview Wabash are Designated Affiliates under the Master Indenture. The Corporation, Parkview Hospital, and certain of its affiliates, including the current Designated Affiliates, are exempt from federal taxation under section 501(a) of the Internal Revenue Code of 1986 (the "Code"), as organizations described in section 501(c)(3) of the Code.

The financial information within this APPENDIX A is that of the System rather than that of the Credit Group or the Obligated Group. *See* "FINANCIAL INFORMATION – General" herein.

Obligated Group Members

Parkview Health System, Inc. The Corporation provides overall management, planning, financial services, human resources, information technology, compliance, risk management and marketing functions for the System. PH operates to provide a full continuum of health care services, promotes the provision of cost-effective, high quality health care services, directs the System to operate in a cost-effective manner, preserves and promotes long-standing commitments of the System to the provision of charitable health care, supports the activities of and provides a source of capital for Parkview Health. Through the exercise of reserved powers, PH maintains and exercises certain reserve powers over the operations of the System, including, but not limited to, approving budgets of the System, directing the transfer of System assets, appointing or removing board members, approving the incurrence of debt, and approving changes to bylaws or articles of incorporation. The central governance structure provides efficiency of decision-making with appropriate representation of physician and community input and consideration for regional health issues and practice.

PPG, a primary care and multi-specialty physician practice, is a business unit within the Corporation. *See* "REGIONAL INTEGRATED DELIVERY SYSTEM AND OTHER CLINICAL INITIATIVES – Parkview Physicians Group" for additional information about PPG. In addition, PH owns and operates a PPO, Signature Care, which has approximately 56,000 covered lives in the System's service area.

Parkview Hospital, Inc. Parkview Hospital owns and operates PRMC, Parkview Randallia and the Parkview Behavioral Health Psychiatric Hospital ("Parkview Behavioral Health") and related health care facilities located in the greater Fort Wayne, Indiana region. PRMC is a modern 410-bed regional health center, located on the System's 60 acre main campus. Patients from over fifteen counties in Indiana and Ohio are referred to PRMC, for secondary and tertiary services. PRMC is an American College of Surgeons Level II Trauma Center and a Level II Pediatric Trauma Center, an accredited pain center, and a certified primary stroke center.

Parkview Hospital also operates Parkview Randallia, a tertiary care hospital, located on Randallia Drive in Fort Wayne. The services at the Parkview Randallia are being reconfigured and the number of beds currently in service is 185. Services currently offered at Parkview Randallia include acute care, inpatient rehabilitation, and skilled nursing units. *See* "INTRODUCTION – Recent Accomplishments and Awards" for further information about Parkview Randallia's reconfiguration.

In addition to the hospital facilities of PRMC and Parkview Randallia, other facilities owned by PVH located in the Fort Wayne area include: Parkview Behavioral Health, a 107-bed free-standing facility, several physician and medical office buildings, Parkview Fitness Center, and free-standing ancillary service centers. PVH also owns and operates a regional reference lab.

Non-Obligated Group System Affiliates

The Corporation is the sole corporate member or shareholder of each related entity, as applicable, unless otherwise described.

Whitley Memorial Hospital, Inc. d/b/a Parkview Whitley Hospital is an Indiana nonprofit corporation that owns and operates an acute care hospital and other related health care facilities located in Columbia City, Indiana. Parkview Whitley has served the Whitley County, Indiana community since 1951. On October 20, 2011, Parkview Whitley placed into service a new 30-bed hospital on the east edge of Columbia City to replace the former 37-bed facility. The Parkview Whitley hospital facility is owned by PH and leased to Parkview Whitley. Parkview Whitley also owns and operates Parkview Warsaw.

Huntington Memorial Hospital, Inc. d/b/a Parkview Huntington Hospital is an Indiana nonprofit corporation that operates an acute care hospital and other related facilities located in Huntington, Indiana. Parkview Huntington was established in 1902 as a county-owned facility serving Huntington County, Indiana. In 2000, a 24-bed acute care facility replaced the previous facility. Due to increased demand, a 12-bed addition was completed in 2003. In addition, a medical office building was constructed by the Corporation, adjacent to the current Parkview Huntington hospital facility. The Parkview Huntington hospital facility is owned by PH and leased to Parkview Huntington.

Community Hospital of Noble County, Inc. d/b/a Parkview Noble Hospital is an Indiana nonprofit corporation that operates an acute care hospital and other related health care facilities located in Kendallville, Indiana. In July 2004, Parkview Noble opened a 31-bed acute care facility, replacing an existing facility that was operated by the county. A medical office building was constructed adjacent to the Parkview Noble hospital facility. The Parkview Noble hospital facility is owned by PH and leased to Parkview Noble.

Community Hospital of LaGrange County, Inc. d/b/a Parkview LaGrange Hospital is an Indiana nonprofit corporation that owns and operates an acute care hospital and other related care facilities located in LaGrange, Indiana. Parkview LaGrange is designated as a "Critical Access Hospital" by the Centers for Medicare and Medicaid Services. In July 2008, Parkview LaGrange opened a new 25-bed hospital facility on its existing campus. **Parkview LaGrange is a Designated Affiliate under the Master Indenture.**

Parkview Wabash Hospital, Inc. d/b/a Parkview Wabash Hospital is an Indiana nonprofit corporation that operates an acute care hospital and other related care facilities in Wabash, Indiana. Parkview Wabash is designated as a "Critical Access Hospital" by the Centers for Medicare and Medicaid Services. Originally organized in 1919 as a county-owned facility, the hospital was acquired by the Corporation in December 2014. A new 24-bed facility and adjacent medical office building are currently under construction off US 24, a major east-west highway through Wabash County, and will replace the existing hospital facility. Construction is expected to be complete in April, 2018. **Parkview Wabash is a Designated Affiliate under the Master Indenture.**

The Orthopaedic Hospital at Parkview North, LLC, a 37-bed orthopedic specialty hospital located on the PRMC campus, is a for profit joint venture with a large orthopedic physician group. PH holds a 60% ownership share of the joint venture.

Managed Care Services, LLC ("MCS") is an Indiana for-profit, limited liability company. PH and PVH are the sole members of MCS, with PH holding a majority interest in MCS. MCS (i) provides third party administrative services to PH's employee health plan; (ii) provides a preferred provider organization network of providers to self-funded employers; and (iii) assumes risk on a capitated Medicaid program through MDwise. *See* "REGIONAL INTEGRATED DELIVERY SYSTEM AND OTHER CLINICAL INITIATIVES – Population Health Initiatives" herein.

Parkview Care Partners, LLC ("PCP") is an Indiana for-profit, limited liability company which operates the System's clinically-integrated network. PCP: (i) is a clinically-integrated network of physicians who voluntarily commit to invest heavily in performance and operational improvements to enhance evidence-based outcomes and reduce costs; and (ii) holds performance improvement and shared savings contracts with Medicare Advantage and commercial payers. *See* "REGIONAL INTEGRATED DELIVERY SYSTEM AND OTHER CLINICAL INITIATIVES – Population Health Initiatives" herein.

Midwest Community Health Associates ("PPG OH") is an Ohio for-profit corporation that offers services in family practice, pediatrics, internal medicine, general surgery, physical medicine, podiatry, audiology, OB/GYN, urology, orthopedics, oncology and cardiology. Additionally, PPG OH provides walk-in clinics in its Bryan and Archbold, Ohio locations and a full range of ancillary services including lab, radiology, physical therapy and nuclear camera. PPG OH provides care through three independent community hospitals in its service area, including to PH facilities.

Parkview Foundation, Inc. (the "Foundation") is an Indiana nonprofit corporation, exempt from federal taxation under section 501(a) of the Code, as an organization described in section 501(c)(3) of the Code. The Foundation, organized in 1972 to obtain funds through charitable contributions, is authorized by PVH to solicit contributions on its behalf. PVH became the sole corporate member of the Foundation in 1998. PVH's reserve powers with respect to the Foundation include the right to appoint directors, adopt budgets, transfer assets and approve any amendments to the bylaws.

Whitley Memorial Hospital Foundation, Inc., Community Hospital of Noble County Foundation, Inc., Huntington Memorial Hospital Foundation, Inc., and Parkview Wabash Hospital Foundation, Inc. (collectively, the "Community Hospital Foundations") are Indiana nonprofit corporations, exempt from federal taxation under section 501(a) of the Code, as organizations described in section 501(c)(3) of the Code. They were organized in 1985, 1999, 2002, and 1994, respectively, to solicit and receive contributions on behalf of the respective hospitals. Gifts of cash, securities, property, bequests, trusts, gift annuities and life insurance are received by the Community Hospital Foundations from individuals, corporations, foundations and other entities.

GOVERNANCE AND MANAGEMENT

Board of Directors

The Corporation is currently governed by a 23-member Board of Directors (the "Board"), of which 22% are physicians. The Board consists of both elected and ex officio members. Ex officio members serve without the necessity of election but have full voting powers equal to elected members. The bylaws of PH provide that the Board composition (i) contain no more than sixteen elected directors, (ii) must include six ex-officio voting members, who are the chairs of the hospital affiliates and Parkview Ortho and the chair of PPG's management group; and (iii) must include two ex-officio members who are the President and Chief Executive Officer and the Chief Physician Executive of PH. In addition, up to eight at-large physician or community leaders and a majority of the Board must be independent, as defined by the Internal Revenue Service.

Elected directors serve for a term of three calendar years and/or until a successor has been duly elected and qualified. Terms of elected directors are set so that each year one-third of the Board is elected at each annual meeting to ensure overlapping terms. Elected directors are eligible for election up to three consecutive three year terms.

Board Member	Occupation or Affiliation	Position	Term Expires
Michael Axel	President, AMI Investment Management, Inc.	Elected Director Treasurer	2018
Margaret Brooks	Project Manager, Brooks Construction	Elected Director	2017
Vicky Carwein	Chancellor, Indiana University- Purdue University Fort Wayne	Elected Director	2019
Roger Cromer	President, Crossroads Bank Chair, Parkview Whitley Board of Directors	Ex Officio	N/A
Brian DeCamp	Owner, Hite Funeral Home Chair, Parkview Noble Board of Directors	Ex Officio	N/A
Raymond Dusman, MD	Executive Vice President, Parkview Health Chief Physician Executive	Ex Officio Vice Chair	N/A
Brian Emerick	President & CEO, MicroPulse, Inc.	Elected Director Secretary	2017
Robert Godley, MD	Physician, PPG Cardiology Chair, PPG Board of Managers	Ex Officio	N/A
David Haist	Retired, Do it Best Corp.	Elected Director Chair	2017
James Heuer	Judge, Whitley County Chair, Parkview Whitley Board of Directors	Ex Officio	N/A
Thomas Kimbrough	Attorney, Barrett & McNagny, LLP	Elected Director	2017
Joshua Kline, MD	Physician, PPG Family Medicine	Elected Director	2019
Kevin Lambright	Part Owner, Shipshewana Auction, Inc. Chair, Parkview LaGrange Board of Directors	Ex Officio	N/A
Jerry Long	Chief Financial Officer, Rea Magnet Wire	Elected Director	2018
Alan McGee, MD	Physician, Parkview Ortho	Elected Director	2017
Marilyn Moran-Townsend	CEO, CVC Communications	Elected Director	2018
Mike Packnett	President & CEO, Parkview Health	Ex Officio	N/A
Wendy Robinson	Superintendent, Fort Wayne Schools	Elected Director	2017
Larry Rowland	Retired, Executive Director Parkview Foundations	Elected Director	2019
Dan Starr	President & CEO, Do it Best Corp. Chair, Parkview Randallia Board of Directors	Ex Officio	N/A
Ryan Warner	President, Bippus State Bank Chair, Parkview Huntington Board of Directors	Ex Officio	N/A
Luther Whitfield	Senior Pastor, New Covenant Worship Center	Elected Director	2019
Stephen Wright, MD	Physician, Parkview Ortho	Ex Officio	N/A

Conflict of Interest Policy

PH has adopted a policy on conflicts of interest, which policy is applicable to the Corporation and its affiliate and subsidiary corporations and to each of their board members, committee members, officers and key management personnel. The conflict of interest policy requires that these individuals disclose any actual or potential conflict of interest (whether they themselves have or may have such actual or potential conflict, or that of a family member or close personal friend). Such actual or potential conflicts of interest address existing or potential financial arrangements, familial relationships, personal relationships, and vendor gifts.

This conflict of interest policy permits the Corporation or its affiliate or subsidiary corporations to enter into a transaction with a person who has an actual or potential conflict of interest, as long as that fact is disclosed to the appropriate board and executive management leader and the person having such conflict does not participate in the decision for which the actual or potential conflict of interest exists.

System corporations distinguish between a situational conflict of interest and a pervasive conflict of interest. Where there is a situational conflict of interest, the perceived or actual conflict of interest is limited to an issue or matter that is not of significant consequence to the overall operation of the corporation. In these isolated situations, the person involved is recused from decision-making on the issue or matter that creates the actual or potential conflict of interest. A pervasive conflict of interest however, presents grounds for removal of the individual, as it is distinguished by its chronic nature and its significant impact to the organization.

The Board Compliance Committee provides oversight and adherence to the PH conflict of interest disclosure and review process.

Standing Committees

Standing committees of the Board include the Audit Committee, the Compensation Committee, the Corporate Compliance Committee, the Executive Committee, the Finance Committee, the Governance Committee, the Information Technology Governance Committee, the Strategic Planning Committee and the Quality Committee.

In 2016, the Board added two new committees, the Strategic Planning Committee and the Investment Sub-Committee) to ensure that the Corporation has an integrated strategic financial plan that facilitates PH achieving strategic plan goals, ensures the System is integrated and aligned, and optimizes the use and leverage of System assets.

Management

The strategic planning and operations of the System are overseen by the key officers described below.

Michael Packnett, *President and Chief Executive Officer, Parkview Health*. Mr. Packnett joined Parkview Health as president and CEO in June 2006. He oversees the not-for-profit health care system that employs more than 11,000 employees. Prior to joining Parkview Health, Mr. Packnett served eight years as president and CEO at Mercy Health System of Oklahoma. He had been with the parent organization, Sisters of Mercy Health of St. Louis, since 1993. From 1995-1999, Mr. Packnett served as President and CEO of their health system in northwest Arkansas.

Mr. Packnett is very active in the community and serves on several boards throughout the region, including the Indiana Hospital Association (serving as Board Chair in 2014), the Northeast Indiana Regional Partnership, the Regional Chamber of Northeast Indiana, the Indiana State Chamber, the Fort Wayne/Allen County Economic Development Alliance, and the Allen County Capital Improvement Board.

Mr. Packnett has a bachelor's degree in business administration from the University of Central Oklahoma and a master's degree in hospital administration from the University of Minnesota.

Ray Dusman, M.D., *Chief Physician Executive, Parkview Health*. Dr. Ray Dusman joined Parkview Health as a member of Fort Wayne Cardiology in 1989. Fort Wayne Cardiology became PPG – Cardiology in 2010. He was named chief physician executive of Parkview Health in 2009. He provides oversight for health system safety and quality, clinical integration/health care delivery, population health management, cardiovascular services and research. Dr. Dusman also serves as vice-chairman of the Parkview Health Board of Directors and chairman of the board's quality and governance committees.

Dr. Dusman has a master's degree in business administration from the University of Notre Dame and a medical degree from the University of Medicine and Dentistry of New Jersey, New Jersey Medical School.

He is board-certified in internal medicine, cardiology and cardiac electrophysiology. He is a fellow of the American College of Cardiology and the Heart Rhythm Society and a clinical associate professor of medicine at the Indiana University School of Medicine.

Mitchell B. Stucky, M.D., *President, Parkview Physicians Group*. Dr. Mitchell B. Stucky joined Parkview Health in 2009 and was named president of PPG in 2011. Dr. Stucky also serves as associate chief medical officer for Parkview Hospital and other hospital affiliates, and is on the Parkview Health Board of Directors.

Prior to his role with PPG, he was president and managing partner of FirstCare Family Physicians. He has a bachelor's degree from Indiana University and a medical degree from Indiana University School of Medicine. Dr. Stucky is certified by the American Board of Family Physicians.

Rick Henvey, *Chief Operating Officer, Parkview Health*. Mr. Rick Henvey was named chief operating officer of Parkview Health in 2014. He joined the System in 2006 with the mission of improving the organization's focus on patient, physician, co-worker and community excellence. In 2009, Mr. Henvey became regional chief operating officer of Parkview Health, overseeing community and independent hospital operations and strategies. Mr. Henvey has more than 20 years of health care experience in support, operations and service areas.

Prior to joining Parkview Health, Mr. Henvey was vice president of support services at Mercy Health Center, Oklahoma, where patient satisfaction ranked in the top 10 percent of hospitals nationwide. Mr. Henvey has a bachelor's degree in business administration and a master's degree in management from Southern Nazarene University.

Jeanné Wickens, **CPA,** *Chief Financial Officer, Parkview Health*. Ms. Jeanné Wickens joined Parkview Health as chief financial officer in May 2016. Ms. Wickens is responsible for financial decision support, fiscal services, health plan services, managed care contracting, strategic financial planning and budget, reimbursement, revenue cycle, tax, and treasury services. She has 28 years of progressive health care strategic and financial leadership experience.

Prior to joining Parkview Health, Ms. Wickens served as chief financial and strategy officer for Allegiance Health Services, an integrated health system, now part of the Henry Ford Health System. In addition, she served as Controller/Director of Finance from September 1994 – August 2000 with Battle Creek Health System, then an affiliate of Trinity Health. From June 1989 – December 1992, Ms. Wickens served as Staff Accountant and Senior Accountant with Ernst & Young. Additionally, Ms. Wickens serves on the Turnstone Board.

Ms. Wickens has a bachelor's degree in business administration degree from Western Michigan University and a master's degree in management from Purdue University.

Sue Ehinger, Ph.D., *Chief Experience Officer, Parkview Health*. Ms. Sue Ehinger was named chief experience officer in 2014. She has held several positions at Parkview Hospital, including president in 2012, chief operating officer in 2006, chief quality officer in 2006 and chief information officer in 2005. Before becoming chief information officer, Ms. Ehinger was senior vice president of support services/quality for Parkview Hospital. She joined the System in 1993 and was responsible for quality improvement and customer service.

Ms. Ehinger has a bachelor's degree from Indiana University, a master's degree from Saint Francis College, and a doctorate from Kennedy Western University.

Dena Jacquay, *Chief Human Resources Officer*. Ms. Dena Jacquay began serving as the chief human resources officer for Parkview Health in 2015. She previously served in the roles of vice president of human resources and the director of human resources and workforce planning for Parkview Health dating back to 2000.

Ms. Jacquay is certified in Lominger Leadership Architect, Voices 360, viaEdge and Choices, all targeted tools around leadership competency development, 360 assessments and succession planning. She is also certified as a Professional Human Resources consultant by the Society of Human Resource Management and a member of the American Society for Healthcare Human Resources Administration.

Ms. Jacquay has a bachelor's degree in organizational leadership and supervision from Indiana University-Purdue University and a master's degree in business administration from Western Governor's University.

Ron Double, *Chief Information Officer, Parkview Health*. Mr. Ron Double was named Chief Information Officer for Parkview Health in May 2008. He oversees all information technology-related activities throughout the System. Mr. Double's responsibilities include overall management of the staff and technology in support of all application software, the voice and data network, mainframe computing environment, client/server computing environment, end-user devices, data center operations, and information system service center/help desk.

Mr. Double has worked for the System since 1989 in various capacities, including technology services director, manager of information system client services, operations supervisor, information center analyst, and analyst – patient financial systems.

Mr. Double has a master's degree from Indiana University and a bachelor's degree from Purdue University.

David Storey, *Chief Compliance Officer; Senior Vice President, General Counsel, Parkview Health.* Mr. David Storey has served as chief compliance officer, senior vice president and general counsel for Parkview Health since 2013. Mr. Storey joined Parkview in 2010 as an attorney with the

Parkview Corporate Counsel Office, concentrating his practice in health care law, business transactions and health care compliance.

Prior to joining Parkview, Mr. Storey was in private practice with the law firm of Baker & Daniels (n/k/a Faegre Baker Daniels). He has a law degree from the Indiana University Maurer School of Law and a bachelor's degree in business from Indiana University. He also passed the Indiana CPA examination.

Mark Pierce, *M.D., Chief Medical Informatics Officer, Parkview Health*. Dr. Mark Pierce was named Chief Medical Informatics Officer in 2011. He joined Parkview Health in 2000. Throughout his nearly 20 years of clinical and 10 years of IT experience, Dr. Pierce has served in numerous leadership roles, including the integration of information technology, cognitive design and knowledge management to help patients traverse the "knowing-doing" gap to achieve healthy outcomes.

Dr. Pierce has a bachelor's degree from Indiana University and a medical degree from the Indiana University School of Medicine.

Michael Mirro, *M.D., Chief Academic & Research Officer, Parkview Health*. Dr. Michael Mirro began serving as chief academic & research officer of Parkview Health in 2014. Prior to his role as chief academic & research officer, Dr. Mirro served as medical director of the Parkview Research Center. Dr. Mirro joined Parkview Health when Fort Wayne Cardiology joined Parkview Physicians Group in 2010.

Dr. Mirro has a bachelor's degree from Loyola University and a medical degree from Indiana University's School of Medicine. In 2004, he was presented with an honorary doctor of science degree from Indiana University.

Greg Johnson, D.O., *Chief Clinical Integration Officer, Parkview Health*. Dr. Greg Johnson joined Parkview Health in 2008 and transitioned into his role as chief clinical integration officer in 2015. He works alongside the clinical integration team to further develop leadership skills to better serve patients and the health system.

Prior to his current role, he served as the chief medical officer for Parkview Hospital and practiced as a nephrologist with Parkview Physicians Group. Dr. Johnson has a bachelor's degree from Rockford College and a master's degree from Carnegie Mellon University.

Judy Boerger, *Chief Nurse Executive, Parkview Health*. Ms. Judy Boerger joined Parkview Health in 2007 as chief nurse executive and senior vice president. She represents all of Parkview Health's nurses at the executive council level. Throughout her career, she has led a variety of clinical areas, including inpatient, outpatient and home health. Ms. Boerger also has experience in new health care facility construction.

Ms. Boerger has a master's degree in business administration from Xavier University and a master's degree from Indiana University of Pennsylvania. She was also a nursing fellow at the University of Pennsylvania's Wharton School of Business. She is a member of the American Organization of Nurse Executives, the National Honor Society for Nursing Sigma Theta Tau, and a 2012 American Hospital Association National Patient Safety Fellow.

Jeffery Boord, M.D., *Chief Quality Officer, Parkview Health*. Dr. Jeffrey Boord joined Parkview Health in 2015 as the chief quality and safety officer. Prior to joining Parkview Health, he was an assistant professor of medicine at Vanderbilt University School of Medicine and a medical director for

quality at Vanderbilt Heart and Vascular Institute. He provides oversight of the Quality and Accreditation and Infection Prevention Departments at Parkview Health, and collaborates closely with leadership teams for each hospital facility and service line on health care quality, accreditation, patient and worker safety, and process improvement.

Dr. Boord has a medical degree and a master's degree in public health from Wake Forest University School of Medicine, completed internal medicine residency at University of Michigan Hospitals and held an endocrinology fellowship at Vanderbilt University Medical Center. He is board certified in internal medicine and endocrinology. He also completed a fellowship in health care quality with the Veterans Affairs National Quality Scholars Fellowship Program. He serves as chair of the Parkview Health Safety and Quality Committee, and is a member of the Indiana Hospital Association Council on Quality and Patient Safety. He also serves as co-chair of the Northeast Indiana Patient Safety Coalition. He is a volunteer clinical assistant professor of medicine at the Indiana University School of Medicine – Fort Wayne.

Centralized Support Services

In addition to serving as the parent organization of Parkview Health, the Corporation also provides centralized support services to System affiliates on a cost-effective basis. All business support services operate on a consolidated basis with carve-outs for physician practice differences as appropriate. The consolidated services include Human Resources, Finance, Purchasing and Materials, Information Systems, Health Information Systems, Legal and Corporate Compliance, Payer Contracting, Marketing and Public Relations, Quality and Regulatory Management, Safety and Security. With the increased integration of physicians, through shared support services, PH has been able to align health practice standards and linkage of specialty physicians across the System.

REGIONAL INTEGRATED DELIVERY SYSTEM AND OTHER CLINICAL INITIATIVES

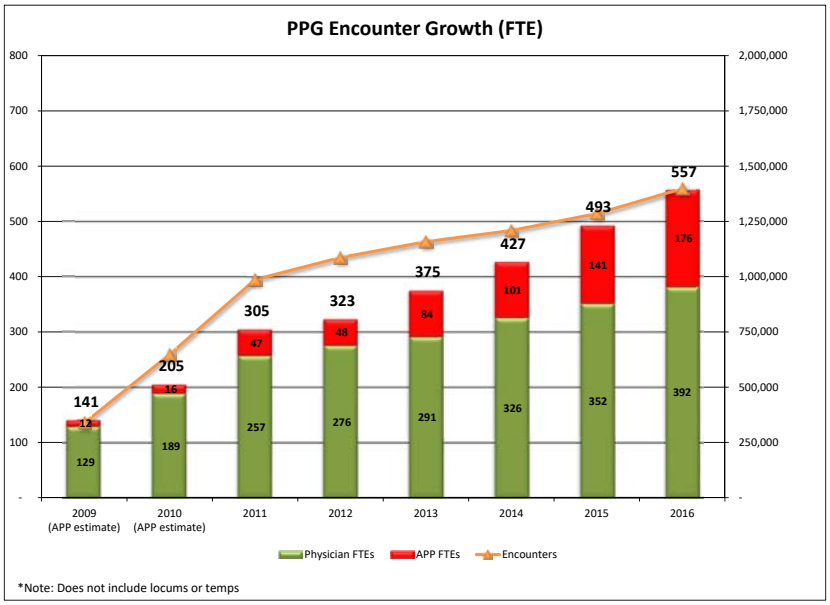
Parkview Physicians Group

The Corporation owns and operates Parkview Physicians Group ("PPG"), a physician led and governed primary care and multi-specialty physician practice that is fully integrated as part of PH. PPG has physician practices in the following nine Indiana counties: Allen, DeKalb, Huntington, Whitley, Noble, LaGrange, Wabash, Kosciusko and DeKalb. These practices employ 392 physician full time equivalents ("FTEs"), and 176 advanced practice provider FTEs at 150 different clinical locations. Disciplines represented in PPG include primary care, obstetrics-gynecology, orthopedics, allergy and asthma, cardiology, colon and rectal surgery, cardiovascular surgery, gastroenterology, general surgery, neurosciences, hospitalists/intensivists, infectious disease services, neonatology, pain medicine, podiatry, psychiatry and pulmonology. Further detail regarding the percentage of PPG primary care and specialty care physicians and advanced practice providers follows below.

	% of Total as of December 31, 2016
Physician FTEs	
Primary Care	37%
Specialty Care	63%
Advanced Practice Provider FTEs	
Primary Care	38%
Specialty Care	62%
Total Primary Care Physicians/Providers	38%
Total Specialty Care Physicians/Providers	62%

In addition, PPG OH provides care in four counties in eight location in northwest Ohio. PPG OH employs 38 physician FTEs and 18 advanced practice provider FTES in 17 specialties.

As of June 1, 2017, PPG was the largest physician group headquartered in northeast Indiana and continues to grow. Below follows a graphic representing PPG's provider and encounter growth over the past eight years.



Source: Parkview Health

As evidenced by the growth in providers and favorable physician satisfaction and engagement survey results, the System's focus on being the best place for employees to work, providers to practice medicine and patients to receive care has made PPG a "destination of choice" for physician and advance practice practitioners. As of June 1, 2017, approximately 120 physicians had signed letters of intent to join PPG.

The alignment and engagement of physicians through PPG allows the System to better support its brand promise of "*excellent care, every person, every day*", drives growth and innovation for care delivery systems and enhances the System's ability to improve health outcomes and manage total cost of care.

Service Line Initiatives

Investments in Centers of Excellence and Institutes

Parkview Health has developed eight Centers of Excellence and Institutes: Primary Care, Orthopedic, Cardiovascular, Emergency Services and Inpatient, Cancer, Neurosciences, Behavioral Health, Women's and Children's and Surgical Services. Key elements of these Centers of Excellence and Institutes include: dyad clinical and administrative leadership, multidisciplinary operating councils, co-located facilities (if possible) and patient/people centric coordinated care.

Below is PH's inpatient market share for key Centers of Excellence and Institutes for its 11 Indiana county service area:

	Calendar Year				
Center of Excellence and Institutes	**2012**	**2013**	**2014**	**2015**	**2016**
Orthopedic	44%	45%	47%	48%	48%
Cardiovascular	42%	45%	46%	45%	48%
Emergency Services and Inpatient	44%	45%	49%	50%	53%
Cancer	34%	42%	42%	39%	39%
Neurosciences	42%	46%	48%	51%	51%
Behavioral Health	64%	62%	64%	66%	65%
Women's & Children's	41%	43%	45%	45%	47%
Surgical Services	38%	41%	41%	42%	45%

Source: Indiana Hospital Association Inpatient Database

Parkview Cancer Institute

Within its region, Parkview Health has seen significant growth in the number of patients needing cancer treatment. In 2015, the System announced its intent to create the Parkview Cancer Institute (the "Cancer Institute"), a new state-of-the-art, patient centered cancer facility. Construction for the Cancer Institute is underway, and it is expected to open as anticipated and as budgeted in summer 2018. The Cancer Institute will allow Parkview Health to consolidate comprehensive cancer services onto the campus of PRMC. The Cancer Institute will be a physician led facility using an enhanced care navigator system that will allow for a coordinated process to help improve quality of care and patient experience. It is expected that the cancer institute physicians and care providers will expand work with The Mirro Center for Research and Innovation to enhance and increase the number of clinical trials patients have access to.

The Mirro Center for Research and Innovation

Seeking to expand and improve current areas of research, Parkview Health recently established The Mirro Center for Research and Innovation (the "Center") to bring the newest technology, procedures and medicines to area patients now rather than years later when final approval is obtained from regulatory agencies. The Center conducts translational research, advanced medical simulation, and device and pharmaceutical clinical trials. Currently, the Center conducts translational research in approximately 118 trials in the following categories: drugs and device studies, health informatics and outcome research; and in the following core areas: cardiovascular, neuroscience, oncology/radiation oncology, health informatics, and pilot areas (primary care, palliative care, hospitalists, women and children, and trauma).

The opening of the Center in 2015 has allowed the System to collaborate with pharmaceutical companies, medical device manufacturers and academic research organizations such as Duke University and Harvard University. Additionally, the Center provides virtual training options for physicians, caregivers, paramedics, and other health care personnel. The Center plays a pivotal role in attracting providers and further aids the System in making Parkview Health the best place to work for co-workers, for physicians to practice medicine and for patients to receive care. See "PATIENT SERVICES – Overview of Services" for further information about the System's clinical research.

Population Health Initiatives

Recognizing the changing reimbursement environment from fee-for-service with performance incentive to value based payment, the System has implemented population health initiatives to better

position Parkview Health to lead the transformation necessary to be the regional leader in value. Significant investments in key technology, structures and services include:

Parkview Care Partners, LLC. PCP is a pluralistic clinically integrated network, which aligns the System, PPG and independent physicians in northeast Indiana and northwest Ohio. PCP supports the use of best practices in evidence-based medicine, technology and electronic medical record based knowledge management in order to improve the coordination and quality of care and patient experience while providing value to patients, providers and insurers. PCP was integral in helping the System achieve a reduction in readmissions per 1,000 patients from 25.4 to 16.4 and reduction in avoidable emergency department visits from 40% to 31% in fiscal year 2015.

Managed Care Services, LLC. MCS provides third party administrative services to Parkview Health's employee health plan, acts as a preferred provider organization network of providers to self-funded employers, and offers other employer sponsored services including occupational medicine, employee assistance program and a My Well-Being employee engagement program. The My Well-Being program is utilized by Parkview Health for its own employees as well as sold through MCS to local employers. The My Well-Being program is designed to engage employees in their own health journey.

Parkview Value Plus ("PVP"). PVP, a department within the Corporation, includes enterprise wide care management, credentialing and clinical documentation teams. PVP partners with PCP to improve the quadruple aim by partnering with the providers and patients to create the personalized health journey and to navigate the patient's journey across the continuum of care.

Additionally, the System's Community Health Initiative aides Parkview Health in addressing the social determinants of health through partnerships with other health care agencies.

INFORMATION TECHNOLOGY

In 2011, the System signed a contract with EpicCare to move to a unified electronic medical record solution. Migration to EpicCare began shortly thereafter through a rolling activation process. All of the System's facilities successfully migrated to EpicCare in 2014, creating a single story of care across the organization. As the organization grows, the System continues to expand the use of EpicCare. All new providers and practices are activated on EpicCare as they join the System. Presently, there are over 1.6 million unique patient records managed within Parkview Health's instance of EpicCare with approximately 12 hospitals and more than 600 providers actively providing care to patients leveraging this single instance of EpicCare. Patient information is available, on a need to know basis, to health care providers and institutions throughout the county using a set of interoperability and information exchange platforms and protocols.

As the need for real time actionable information and analytics has increased, the System has invested resources, both human and capital, into developing an enterprise data warehouse while providing tools to allow stakeholders throughout the organization to analyze and visualize the information stored in the data warehouse in order to improve outcomes, improve quality, identify risk factors, perform research, support population health management, enable clinical integration activities, and much more.

In an era of cyber-crime, Parkview Health has made investments into resources to protect the security and privacy of the information that it holds. The System has invested in state-of-the-art cyber protection tools, skilled security experts, and enterprise-wide cyber security education. In addition, Parkview Health has developed mutually beneficial relationships with local and national cyber security enforcement agencies while taking a leadership role in educating and assisting the community in cyber protection and response.

Parkview Health will continue to invest in a leading-edge standards-based technological infrastructure to support the System's strategic initiatives.

STRATEGIC PLAN

PH leadership believes that the health care industry is undergoing fundamental changes, including changes in the health care purchaser and insurance market. For example, an increase in high-deductible plans is creating different and greater incentives for patients to behave as consumers of health care. PH anticipates that the prevalence of fee-for-service reimbursement will decline and the market will see more value-based models within the next three years; per capita utilization of inpatient services will continue to decline while outpatient utilization will experience modest growth; competition among providers will heighten and new market entrants will compete more fiercely for consumers and the health care dollar; providers will continue to consolidate and systems in the Midwest will be larger and fewer in number in the future; and the overall cost of health care is unsustainable driving the need for more and better preventive care, innovative care coordination and management, greater patient engagement and delivery of the right care in the right setting at the right time.

The System is guided by a strategic plan which covers the period from 2016 to 2020 ("Parkview 2020"). Fundamental to Parkview 2020 is achieving "world class teamwork" which involves further integration of the System's leadership, employees, physician group, service lines, facilities and support areas into the "One Parkview Team". Parkview 2020 focuses on expanding and improving the System's health care services and maintaining the System's financial conditions and results. Parkview 2020 includes four key goals: quality/safety, customer service, human/financial resource efficiency and effectiveness and growth. For each goal, the System is focused on achieving top decile performance. Parkview 2020 is overseen and evaluated by the Strategic Planning Committee to assist the System in nimbly responding to the ever evolving health care industry.

PH believes that it is ideally positioned for varied outcomes and paces of change, as demonstrated by success in the current model even as it invests in the elements required for success in new models. The System launched the development of an enterprise resiliency plan ("ERP") in 2016 to further enhance tools and processes to achieve its efficiency and effectiveness and financial target goals. The ERP includes the development of five-year financial forecasts for the System's service-lines, institutes and individual entities. The ERP utilizes an eighteen month rolling quarterly forecast model, which allows Parkview Health to model updates in real time and adjust strategies accordingly to achieve goals. Additionally, PH recently completed an integrated asset liability management ("ALM") assessment and will continue to conduct annual ALM assessments to determine the financial resiliency of the organization under various scenarios and stress environments.

The System continually evaluates opportunities for growth using select criteria as part of the overall strategic planning and development process. The System's strategic growth may include growth through acquisitions, partnerships, and/or joint ventures.

CAPITAL EXPENDITURES

The System's strategic planning process helps drive its long term and five year capital expenditures. The System has continued to invest in its facilities to maintain state-of-the-art equipment and facilities, to add additional service lines and to keep pace with growth. Major capital projects include the Cancer Institute, a replacement hospital facility at Parkview Wabash and upgrades to Parkview Randallia. A portion of the System's capital expenditures will be applied to upgrade and develop information technology infrastructure, including telehealth and digital strategies. Management anticipates that these capital projects will expand capacity to accommodate increasing patient volumes and enable

Parkview Health to offer new locations, service lines and programs to meet the anticipated needs of the community. Funding for these capital expenditures is expected to be provided from a variety of sources, including but not limited to, charitable contributions, cash from operations, existing cash and investments, indebtedness secured by Master Notes, or other indebtedness. The type, amount, and timing of the issuance of any such additional Master Notes or other indebtedness are subject to a number of conditions that cannot be predicted, including Board approval, conditions in the credit markets and costs of construction.

PATIENT SERVICES

Overview of Services

The System and its medical staff provide a broad range of specialty and sub-specialty services to meet the health care needs of the System's patients. Services include:

Behavioral Health Services
Inpatient Behavioral Health Services – Child, Adolescent, Adult, Senior
Outpatient Behavioral Health Services – Partial Hospitalization, Intensive Outpatient Therapy
Psychiatrist
Therapist

Cancer Services
Chemotherapy Services
Radiation Therapy
Tumor Site Specific Care Teams
Medical Oncology
Tumor Registry

Cardiovascular Services
Antithrombolotic Clinic
Cardiac Catheterization
Cardiac Rehabilitation
Cardiovascular Surgery
Cardiac Telemetry
Cardiovascular Studies
Coronary Care
Nuclear Medicine
Electrocardiology

Emergency Services
Air Ambulance
Ground Ambulance
EMT Service
Emergency Department
Trauma Care

Neurological Services
Neurology
Neurosurgery
Stroke Center

Inpatient & Medical Services
Hospitalist Program
Intensivist Program
Intensive Care
Diagnostic Radiology and Special Procedures
Clinical and Anatomical Laboratory
Pharmacy
Diabetes Care
Respiratory Care
Acute Renal Dialysis
Progressive Care
Rehabilitation Services
Enterostomal Therapy
Epidemiology/Infection Prevention
Social Services
General Medicine
Palliative Care
Hospice
Informatics
Skilled Nursing Facility

Orthopedic Services
Orthopedic Surgery
Sports Medicine
Physical Therapy
Athletic Training

Primary Care Services
Family Practice
Internal Medicine
Pediatrics

Surgical Services
Surgical Facilities
Perioperative Services
Endoscopy
Gastroenterology

Women's & Children's Services	Other Ambulatory Services
Mammography	Audiology
Maternal/Fetal Medicine	Computerized Tomography (CT Scan)
Labor and Delivery Service	Magnetic Resonance Imaging (MRI)
Nurseries (Intensive and Special Care)	Occupational Health
Neonatology	Occupational Therapy
Pediatrics	Physical Therapy
Pediatric Clinics	Speech Therapy
Pediatric Neurology	Patient Education
Pediatric Surgery	Genetic Counseling
	Home Health Care

PH is a leader in clinical research in the northeast Indiana region. Current areas of research include:

- Acute Myocardial Infraction
- Acute Stroke
- Cardiac Arrhythmias
- Carotid Artery Disease
- Congestive Heart Failure
- Coronary Artery Disease
- Hyperlipidemia
- Informatics
- Interventional Cardiology
- Medical Informatics
- Medical Oncology
- Orthopedics
- Peripheral Vascular Disease
- Radiation Oncology

Beds in Service

The number of beds in service of the System as of March 31, 2017 is as follows:

Service	**Beds in Service**
Critical Care	162
Acute Care	537
Psychiatry	127
Rehab	31
Skilled Nursing Facility	41
Total	898

MEDICAL STAFF

The combined medical staff of the System as of March 1, 2017, consisted of a total of 911 individual physicians with full privileges at the System. Information with respect to these physicians as of March 1, 2017, is shown, collectively, on the following chart:

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Combined Medical Staffs of the System

	Total Physicians	Board Certified Physicians	
Primary Care			
Emergency Medicine	57	43	
Family Practice	163	154	
Internal Medicine	65	62	
OB, GYN & Subspecialties	54	49	
Pediatrics	64	61	
Psychiatry	25	20	
Other Specialties			
Allergy & Immunology	7	6	
Anesthesiology	51	50	
Cardiology	30	30	
ColoRectal Surgery	11	10	
Critical Care Medicine	5	5	
Critical Care Surgery	8	8	
Dermatology	3	3	
Endocrinology	6	6	
Gastroenterology	21	21	
General Surgery	20	19	
Hospice & Palliative Medicine	3	3	
Infectious Disease	7	7	
Medicine, Genetics	2	2	
Nephrology	15	15	
Neonatology	6	6	
Neurology	31	30	
Neurosurgery	6	5	
Occupational Medicine	1	1	
Oncology/Hematology	21	21	
Ophthalmology	18	15	
Orthodontics	1	1	
Oral & Maxillofacial Surgery	11	5	
Orthopaedic Surgery	43	35	
Orthopaedic Trauma	2	2	
Otolaryngology	15	15	
Pain Medicine	8	8	
Pathology	6	6	
Maternal & Fetal Medicine	3	3	
Phys. Medicine & Rehab	13	13	
Plastic Surgery	8	8	
Podiatry	15	8	
Pulmonary Medicine	7	7	
Pulmonary & Critical Care	10	10	
Radiation Oncology	8	7	
Radiology	26	21	
Rheumatology	3	3	
Sports Medicine	1	1	
Sleep Medcine	1	0	
Thoracic Surgery	11	11	
Undersea & Hyperbaric Med	2	2	
Urology	16	14	
Vitro-Retina Diseases in Surgery	1	1	
TOTAL	**911**	**833**	**91%**

Source: Medical Staff Records

The age distribution of the medical staff is as follows:

	30 & Under	31-39	40-49	50-59	60 & Over
All System Hospitals	1%	21%	26%	29%	23%

Source: Medical Staff Records

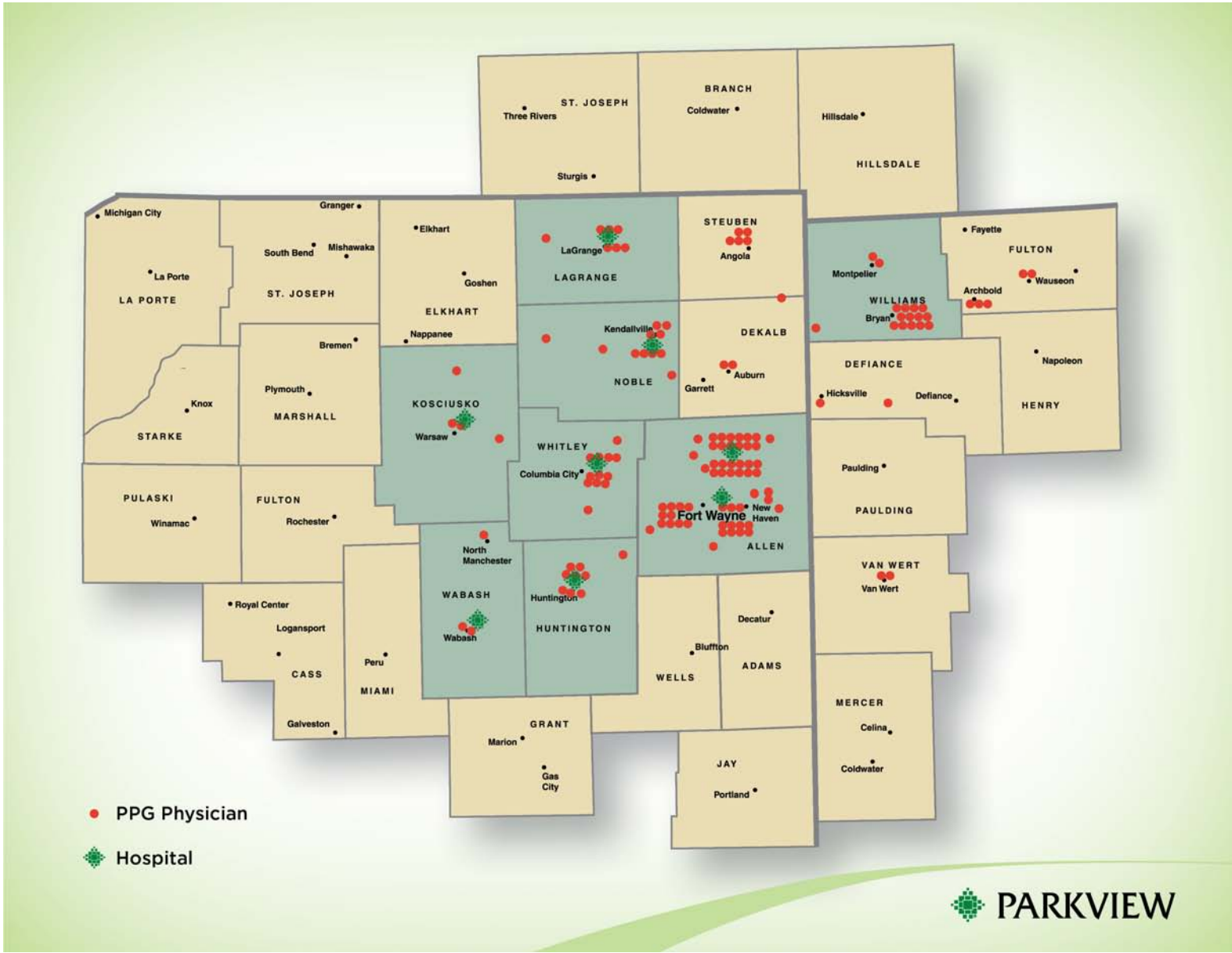
SERVICE AREA AND MARKET SHARE

Description of Service Area

The System identifies the primary service area ("PSA") for the System as the Indiana counties of Allen, Huntington, LaGrange, Noble, Wabash, Whitley, and Kosciusko, which collectively, had an estimated population of 635,307 in 2016. The System identifies the secondary service area ("SSA") for the System as the Indiana counties of Dekalb, Steuben, Adams, and Wells, and the Ohio counties of Defiance, Paulding, Williams and Van Wert. The System identifies the seven Indiana counties in the PSA and the four Indiana counties in the SSA as its regional service area ("RSA"). The population of the total service area is estimated at 890,643 in 2016.

A map of the System's service area is set forth on the following page.

System Service Area



PSA and SSA; green represents counties where Parkview provides clinical services.

The historical and projected population data for the System's service area are presented in the following table:

	2016	Projected 2021
PSA Population	635,307	651,111
SSA Population	255,336	256,163
Total	890,643	907,274

Source: The Nielsen Company, 2016 Truven Health Analytics, Inc.

Major Employers

Employment is highly fragmented within the System's PSA, with companies employing greater than 100 individuals representing only 3.0% of the employers in Parkview Health's seven county primary service area. The most recent employment data (2015 Indiana Workforce Development) shows the manufacturing sector accounting for 24.1% of the employment base. The health care/social service sector and the retail sector follow with 14.3% and 10.6%, respectively.

The unemployment rate in the PSA decreased in 2015 and was 4.4%, below Indiana's statewide unemployment rate of 4.8% (2015 Indiana Workforce Development).

The most recent data available for 2016 report the top ten employers in the Fort Wayne area as noted below. With the exception of Lutheran Health Network, these employers contract for providers with PH in their group health benefit plans.

	Employer Name	2016 # Employees -Total FTEs
1	Parkview Health	6,684
2	Lutheran Health Network	4,824
3	General Motors	4,100
4	Fort Wayne Community Schools	3,600
5	Lincoln Financial Group	1,970
6	City of Fort Wayne	1,829
7	BF Goodrich	1,580
8	Frontier Communications	1,355
9	Allen County Government	1,305
10	Indiana University Purdue University Fort Wayne	1,131

Source: Community Research Institute, Indiana University Purdue University; Ft. Wayne

Other Service Area Hospitals

Other acute-care general hospitals located in Allen County include The Lutheran Hospital of Indiana ("Lutheran Hospital"), which has a total complement of 396 beds, and St. Joseph Medical Center ("St. Joseph Hospital"), which has a total complement of 229 beds. Community Health Systems, Inc. ("CHS"), a publicly-owned hospital company, owns both Lutheran Hospital and St. Joseph Hospital. CHS also owns a 36 bed rehabilitation facility on the campus of Lutheran Hospital, the 39 bed Orthopaedic Hospital of Lutheran Health, and a 131 bed acute care hospital, Dupont Hospital, on the north side of Fort Wayne in Allen County. Dupont Hospital provides obstetrical, general medical, general surgery, and emergency services. Also located in Fort Wayne is a 26 bed Veterans Administration Medical Center.

There are no other acute care, general, community hospitals in Huntington, LaGrange, Noble, Wabash, or Whitley Counties. There are five other acute care, general, community hospitals, each under 150 beds, located in the northeast Indiana counties included in the SSA, including two hospitals owned by CHS. There also are seven other acute care, general, community hospitals, each under 150 beds, located in the Ohio counties in the SSA.

The System draws patients and referrals from throughout northeastern Indiana and northwestern Ohio. The geographic origin of patients discharged from the System is shown in the following chart:

System Inpatient Discharges
January 1, 2016 through December 31, 2016

Geographic Origin			
Primary Service Area		**Secondary Service Area**	
County		County	
Allen	49.2%	DeKalb	4.4%
Noble	8.3	Steuben	3.1
Huntington	5.6	Adams	1.0
Whitley	6.0	Wells	0.9
LaGrange	4.2	Defiance (Ohio)	0.8
Wabash	4.4	Paulding (Ohio)	1.2
Kosciusko	3.6	Williams (Ohio)	1.2
		Van Wert (Ohio)	0.6
Total Primary	**81.3%**	**Total Secondary**	**13.2%**
Total Primary and Secondary Service Area			**94.5%**

Source: System Records

Market Share

The System has been and continues to be the market share leader in its PSA when compared to other individual acute care hospitals. The following table identifies relative market share as identified by inpatient discharges.

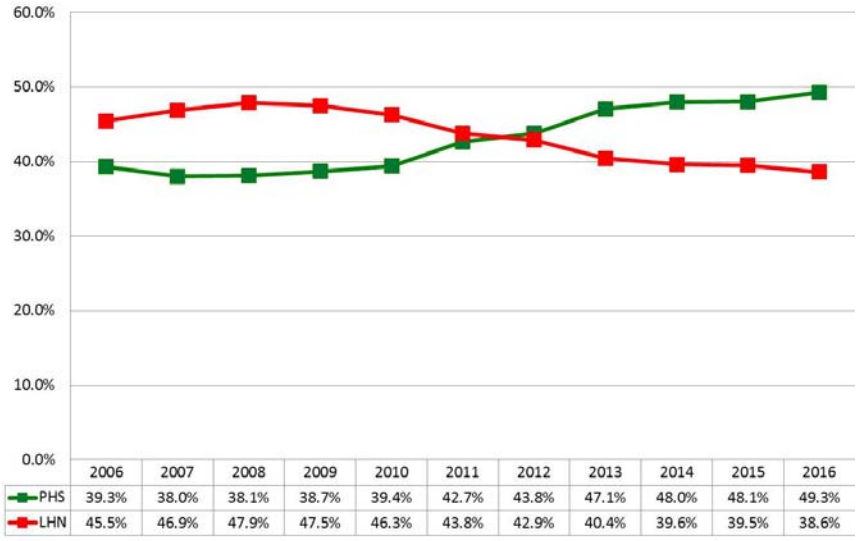
Parkview Health's Market Share
by PSA

County	2016
Allen	54%
Noble	76%
Huntington	58%
Whitley	73%
LaGrange	70%
Kosciusko	17%
Wabash	49%

Source: Indiana Hospital Association Inpatient Database

In spring 2016, the System opened Parkview Warsaw, a free standing emergency room and ambulatory facility in Kosciusko County. Since opening Parkview Warsaw, the System's market share in Kosciusko County has grown by 3.5%. Additionally, emergency room market share has grown from 11.5% to 42%, surpassing the local competitor's 40% market share.

The System's main competitor is Lutheran Health Network ("LHN"), a seven hospital network operated by CHS. As depicted in the chart below, the System has gained ten percentage points of market share over the LHN in its RSA during the period from 2006 to 2016. Market demand for the System's inpatient, outpatient and physician services has continued to demonstrate steady to robust growth.



	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
PHS	39.3%	38.0%	38.1%	38.7%	39.4%	42.7%	43.8%	47.1%	48.0%	48.1%	49.3%
LHN	45.5%	46.9%	47.9%	47.5%	46.3%	43.8%	42.9%	40.4%	39.6%	39.5%	38.6%

Source: Indiana Hospital Association Inpatient Database

OPERATING STATISTICS

The following table shows selected operating statistics for the System for the fiscal years ended December 31, 2014, 2015 and 2016, and for the three month periods ended March 31, 2016 and 2017.

	Year Ended December 31,			Three Month Period Ended March 31,	
	2014	**2015**	**2016**	**2016**	**2017**
Beds in Service [(1)]	837	887	898	887	898
Patient Days [(1)]	199,185	206,442	208,469	53,309	54,980
Discharges [(1)]	41,927	44,491	45,654	11,330	12,095
Occupancy % [(1)]	65.20%	63.76%	63.43%	66.04%	68.33%
Length of Stay [(1)]	4.75	4.64	4.57	4.71	4.55
Surgery Cases					
Inpatient	9,643	10,178	10,678	2,569	2,593
Outpatient	22,753	25,716	29,107	6,783	7,308
Emergency Room Visits	168,093	186,187	197,938	47,326	51,728
Outpatient Encounters[(2)]	419,117	467,334	511,122	120,815	134,313
Deliveries	4,444	4,417	4,530	1,088	1,075
All Payor Case Mix	1.46	1.47	1.53	1.53	1.50

(1) Data excludes newborn statistics
(2) Data excludes lab only visits
Source: System Records

FINANCIAL INFORMATION

General

The following summary consolidated financial information presented below provides information for the System for each of the years ended December 31, 2014, 2015 and 2016 and for the three month periods ended March 31, 2016 and 2017. The financial information for each of the years ended December 31, 2014, 2015 and 2016 has been derived by the System's management from the System's audited consolidated financial statements. The financial data for the three months ended March 31, 2016 and March 31, 2017 have been derived from the System's unaudited consolidated interim reports and include all adjustments which System management considers necessary to present such information in conformity with accounting principles generally accepted in the United States of America. The results of operations for the three month period ended March 31, 2017 are not necessarily indicative of the results that may be expected for the fiscal year ending December 31, 2017. The following summary consolidated financial information should be read in conjunction with the subsection herein entitled "Management Discussion on Recent Financial Performance," and the audited consolidated financial statements of the System for the years ended December 31, 2015 and 2016 and related notes that appear in APPENDIX B to this Official Statement.

The Credit Group represented approximately 90% of the annual net operating revenue of the System for the year ended December 31, 2016 and approximately 93% of the total assets of the System as of December 31, 2016. The members of the Credit Group control, directly or indirectly, non-member entities and joint ventures that are consolidated with the financial results of the respective member of the Credit Group.

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SYSTEM CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS

($ in Thousands)

	Years Ended December 31,			Three Months Ended March 31,	
	2014	2015	2016	2016	2017
Revenues:					
Net patient service revenues	$ 1,387,748	$ 1,454,499	$ 1,531,312	$ 377,310	$ 410,568
Provision for bad debts	(119,890)	(116,964)	(110,744)	(34,459)	(27,835)
Other revenues	78,084	103,833	143,687	32,588	24,106
Total Operating Revenue	1,345,942	1,441,368	1,564,255	375,439	406,839
Expenses:					
Salaries and benefits	582,433	677,201	766,375	185,590	209,298
Supplies	171,671	201,608	223,915	54,191	60,012
Purchased services	128,231	142,845	169,245	39,850	37,713
Utilities, repairs and maintenance	49,723	54,614	60,322	14,621	14,487
Depreciation and amortization	83,727	90,379	95,377	23,286	23,922
Hospital assessment fee	55,044	34,446	38,090	9,553	10,722
Interest expense[1][2]	27,473	26,489	27,546	6,139	6,415
Other	60,808	63,139	63,420	15,995	15,947
Total Operating Expenses	1,159,110	1,290,721	1,444,290	349,225	378,516
Total Operating Income	186,832	150,647	119,965	26,214	28,323
Nonoperating Income					
Interest, dividends, and realized gains on investments, net	32,486	12,830	21,750	666	6,106
Unrealized (losses) gains on investments, net	(13,898)	(32,502)	34,099	2,963	26,422
Unrealized and realized (losses) gains on swap, net	(29,943)	(224)	4,456	(14,483)	2,174
Contribution of unrestricted net assets of Parkview Wabash	-	37,444	-	-	-
Other[2]	(1,031)	9,813	(1,120)	(4)	3
	(12,386)	27,361	59,185	(10,858)	34,705
Excess of revenue over expenses	174,446	178,008	179,150	15,356	63,028
Excess of revenue over expenses attributable to non-controlling interest in subsidiaries	32,050	29,412	30,847	7,002	6,531
Excess of revenues over expenses attributable to System	$ 142,396	$ 148,596	$ 148,303	$ 8,354	$ 56,497

(1) Interest expense for the years ended December 31, 2014, 2015 and 2016, and for the three months ended March 31, 2016, has been reclassified from nonoperating to operating expenses to conform to the presentation for the three months ended March 31, 2017.

(2) Net payments made under the System's interest rate swap agreements for the years ended December 31, 2014, 2015 and 2016, and for the three months ended March 31, 2016, have been reclassified from other nonoperating expense to interest expense to conform to the presentation for the three months ended March 31, 2017.

SYSTEM CONDENSED CONSOLIDATED BALANCE SHEETS

($ in Thousands)

	December 31,			March 31,
	2014	2015	2016	2017
ASSETS				
Current Assets:				
Cash and cash equivalents	$ 64,862	$ 154,487	$ 100,032	$ 124,420
Short-term investments	40,216	7,961	306	306
Patient accounts receivables	168,490	175,100	183,477	206,414
Inventories	16,639	20,389	23,169	25,099
Prepaid expenses and other current assets	23,194	30,371	25,392	35,112
Estimated third-party payor settlements	4,811	4,908	3,960	4,379
Total Current Assets	318,212	393,216	336,336	395,730
Assets with Limited Use:				
Board designated investments	707,710	753,559	936,056	928,716
Funds held by trustees	25,041	25,446	49,969	46,959
Other investments	172	863	789	795
Total Assets with Limited Use	732,923	779,868	986,814	976,470
Property and equipment – net	995,659	998,675	1,025,138	1,018,535
Interest rate swaps	3,564	4,203	1,732	1,501
Investments in joint ventures	3,412	2,183	2,188	1,825
Goodwill and intangible assets, net	81,911	101,721	103,107	102,845
Other assets[1]	24,760	20,717	36,346	32,523
Total Assets	$ 2,160,441	$ 2,300,583	$ 2,491,661	$ 2,529,429
LIABILITIES AND NET ASSETS				
Current Liabilities:				
Accounts payable and accrued expenses	$ 54,472	$ 74,219	$ 91,360	$ 70,573
Salaries, wages and related liabilities	77,291	94,617	101,669	83,402
Accrued interest	2,653	2,599	2,806	5,911
Estimated third-party payor settlements	19,837	4,752	5,214	6,114
Current portion of long-term obligations	29,851	27,998	27,251	26,059
Total Current Liabilities	184,104	204,185	228,300	192,059
Non-Current Liabilities:				
Long-term debt, less current portion[1]	621,359	590,654	595,663	613,430
Interest rate swaps	79,288	80,128	73,144	70,880
Accrued pension obligations	81,670	94,080	90,826	94,059
Other	19,289	20,077	24,180	23,209
Total Non-Current Liabilities	801,606	784,939	783,813	801,578
Net Assets:				
Unrestricted	1,142,551	1,296,908	1,464,584	1,521,054
Temporarily restricted	31,270	12,941	13,420	13,190
Permanently restricted	910	1,610	1,544	1,548
Total Net Assets	1,174,731	1,311,459	1,479,548	1,535,792
Total Liabilities and Net Assets	$ 2,160,441	$ 2,300,583	$ 2,491,661	$ 2,529,429

[1] Unamortized net deferred financing costs of $2,348 have been reclassified from other assets as a reduction of long-term debt in the December 31, 2014, condensed consolidated balance sheet to conform to the presentation used in the subsequent periods.

Ratios

All ratios have been calculated in accordance with the Master Indenture, as amended by the Supplemental No. 8.

Debt Ratios

The System's Long-Term Debt Service Coverage Ratio, Maximum Annual Debt Service as a Percent of Total Operating Revenues, and Long-Term Indebtedness as a Percent of Total Capitalization, are set forth below. Past performance is not an assurance of and may not be indicative of future performance.

	Year Ended December 31,			
	2014	**2015**	**2016**	**Pro-Forma 2016**
		($ in Thousands)		
Net Excess of Revenues over Expenses[1]	$ 186,237	$ 181,322	$ 109,748	$ 109,748
Depreciation and Amortization	83,727	90,379	95,377	95,377
Interest Expense	27,473	26,489	27,546	27,546
Income Available for Debt Service (A)	$ 297,437	$ 298,190	$ 232,671	$ 232,671
Maximum Annual Debt Service (B)	$ 57,483	$ 57,717	$ 64,690	$ 46,274[4]
Long-Term Debt Service Coverage Ratio (A)÷(B)	5.2x	5.2x	3.6x	5.0x
Total Operating Revenues (C)	$ 1,345,942	$ 1,441,368	$1,564,255	$1,564,255
Maximum Annual Debt Service as a Percent of Total Operating Revenues (B)÷(C)	4.3%	4.0%	4.1%	3.0%
Long-Term Indebtedness (D)[2]	$ 621,359	$ 590,654	$ 595,663	$ 595,663
Unrestricted Net Assets[3]	1,117,321	1,269,008	1,433,217	1,433,217
Total Capitalization (E)	$ 1,738,680	$ 1,859,662	$ 2,028,880	$ 2,028,880
Long-Term Indebtedness as a Percent of Total Capitalization (D)÷(E)	35.7%	31.8%	29.4%	29.4%

[1] *Excludes excess of revenues over expenses attributable to non-controlling interest in subsidiaries, unrealized gains and losses on investments and unrealized gains and losses on the fair value of interest rate swaps and income from subsidiaries.*

[2] *Excludes current portion of Long-Term Indebtedness.*

[3] *Excludes non-controlling interest in subsidiaries.*

[4] *Maximum Annual Debt Service is calculated beginning in fiscal year 2018 and includes the refinancing of certain indebtedness in fiscal year 2017, including the Bonds To Be Refunded described in the forepart of this Official Statement. Balloon and put indebtedness has been smoothed in accordance with the Master Indenture.*

Historic Liquidity

The following table sets forth the liquidity, Days Cash on Hand and Unrestricted Cash and Investments to Long-Term Indebtedness of the System for the fiscal years ended December 31, 2014, 2015, and 2016.

	Year Ended December 31,		
	2014	**2015**	**2016**
		($ in Thousands)	
Cash and Cash Equivalents	$ 64,862	$ 154,487	$ 100,032
Board-Designated Investments[(1)]	707,710	753,559	936,056
Total Unrestricted Cash and Investments	$ 772,572	$ 908,046	$1,036,088
Days Cash on Hand[(2)]	262	276	280
Unrestricted Cash and Investments to Long-Term Indebtedness	1.24x	1.54x	1.74x

(1) *Excludes fair value of interest rate swaps.*

(2) *Calculated as Total Unrestricted Cash and Investments divided by an amount equal to total operating expenses less depreciation and amortization, and write-down of assets due to impairment charges, divided by 365. (Includes interest expense.)*

Third Party Payments

Payments on behalf of patients are made to the System by commercial insurance carriers, by the federal government under the Medicare program, by the state government under the Medicaid program, and by patients from their own personal resources. The percentages of gross revenues by payor for the System for the fiscal years ended December 31, 2014, 2015 and 2016 are as follows:

Percent of Revenue

	Year Ended December 31,		
Summary of Revenue	**2014**	**2015**	**2016**
Medicare	43.7%	43.6%	43.5%
HMO/PPO	34.4	33.9	33.5
Commercial Insurance	1.1	1.2	1.1
Other	2.1	1.9	2.2
Medicaid	13.0	15.4	16.8
Self-Pay	5.6	4.0	2.9
Total	100.0%	100.0%	100.0%

Parkview Health has effective working relationships with all payors and meets with them on a routine basis. Through PCP, the System participates in performance improvement and shared savings contracts with Medicare Advantage and commercial payers and through MCS a full risk Medicaid contract. Through 2016, Parkview Health had approximately 83,000 covered lives under value based arrangements.

Management Discussion on Recent Financial Performance

Three Month Period ended March 31, 2017. Operating income of $28,323,000 is above the prior year first quarter operating income by $2,109,000. Net patient revenue (net of provision for bad debts) increased $39,882,000 over prior year due to higher volume. Discharges and outpatient registrations are up 6.8% and 11.2%, respectively. Surgical case volume is up 5.7% and emergency

department visits are up 9.3%. Operating expenses, excluding Hospital Assessment Fees ("HAF"), increased 8.3% over prior year. Salaries and benefits are up 12.8% and reflect the increase in paid FTEs of 595, or 6.7%, and increased health insurance costs. Supply expense increased 10.7% due to the higher volume and continued price pressure on supplies and drugs. Excess of revenue over expenses attributable to Parkview Health of $56,497,000 is up $48,143,000 over prior year. Included in non-operating income for the first quarter 2017 is investment income of $32,528,000 and unrealized gains on the swap portfolio of $2,174,000. Included in non-operating income for the first quarter 2016 is investment income of $3,629,000 and losses on the swap portfolio of ($14,483,000).

Fiscal years ended December 31, 2016 and 2015. The operating income of $119,965,000 is below the prior year operating income of $150,647,000 by $30,682,000. Included in 2016 results is the recognition of Indiana Medicaid Disproportionate Share ("State DSH") income of $985,000 and Upper Payment Limit ("UPL") payments, net of the HAF, of $4,986,000. Included in the 2015 results is the recognition of State DSH income of $2,638,000 and UPL, net of the HAF, of $11,213,000. Excluding the DSH and net UPL/HAF income, the operating income in 2016 was $113,994,000, which is below the 2015 operating income, excluding State DSH and the net UPL/HAF payments, of $136,796,000 by $22,802,000. The System continues to strongly invest for continued growth and long-term financial vitality. This growth is reflected in the System's increased market share and patient care volume, but also in Parkview Health's increased expenses as a result of the successes of the System's investment. Net patient revenue, excluding State DSH and UPL payments, was up 6.9% over prior year. This increase is due primarily to volume growth over prior year as discharges and outpatient registrations increased 2.6% and 6.3%, respectively. Surgical case volume increased 5.7%, emergency department visits increased 6.3%, and births increased 2.6%. Operating expenses, excluding HAF, increased 11.9% over prior year. Salaries and benefits increased 13.2%. Paid FTEs increased 797, or 9.7%, over prior year primarily as a result of the System's growing volume and continued expansion of Parkview Health's employed physician model. Supply costs increased 11.1% as a result of the higher volumes and upward price pressure in supplies and drugs. Claims expense associated with Medicaid risk program, reported under purchased services, has risen dramatically as a result of Medicaid expansion in Indiana, but is offset by a like increase in other operating revenue. The excess of revenue over expenses attributable to Parkview Health of $148,303,000, including State DSH and the net UPL/HAF payments, is even with the 2015 excess of revenue over expenses attributable to Parkview Health of $148,596,000. Included in non-operating income in 2016 are total investment gains (realized and unrealized) of $55,849,000 and an increase in the fair value of interest rate swaps of $4,456,000. Included in non-operating income in 2015 are total investment losses of ($19,672,000), a decline in the fair value of the interest rate swaps of ($224,000), and a contribution of $37,444,000 from the affiliation of Parkview Wabash.

Fiscal years ended December 31, 2015 and 2014. The operating income of $150,647,000 is below the prior year operating income of $186,832,000 by $36,185,000. Included in the 2015 income is the recognition of State DSH income of $2,638,000 and UPL payments, net of HAF, of $11,213,000. Included in the 2014 income is the recognition of State DSH of $2,511,000 and UPL payments, net of the HAF, of $18,296,000. Excluding State DSH and net UPL/HAF payments, the operating income of $136,796,000 for 2015 was below prior year by $29,229,000, or 17.6%. The planned decline reflects the purposeful investment in Parkview Health's expanding employed physician model, infrastructure for greater capacity and access, and technology. Net patient revenue, excluding State DSH and UPL payments (HAF reported as an operating expense), exceeded prior year net patient revenue by 6.1%. Discharges exceeded prior year by 6.1% and outpatient registrations increased by 11.5% over prior year. Surgical cases increased 8.4% over prior year and emergency department visits increased 10.8%. Operating expenses, excluding HAF, increased at a rate of 13.8%. Salaries and benefits increased 16.3% over prior year as a result of an increase in paid FTEs of 700. In addition, supplies increased by 17.4% due to the greater volumes and upward price pressure in supplies and drugs. Purchased services increased 11.4% primarily due to increased claims expense with the Medicaid risk program and driven by Medicaid

expansion in Indiana, but offset by a like increase in capitation fee payments reported in other operating revenue. Utilities, repairs, maintenance and depreciation, combined, increased $11,543,000, or 8.6%, over prior year and reflects the System's continued investment in infrastructure and physical capacity. The excess of revenue over expenses attributable to Parkview Health of $148,596,000 for 2015 increased $6,200,000 over prior year. Included in non-operating income for 2015 is contribution income of $37,444,000 from the affiliation of Parkview Wabash, investment losses of ($19,672,000), and unrealized losses on the swap portfolio of ($224,000). Included in non-operating income for 2014 is investment income of $18,588,000 and unrealized losses on the swap portfolio of ($29,943,000).

Outstanding Indebtedness

The following table sets forth the principal amounts of all long-term debt of the System as of December 31, 2016:

	(numbers in 000s)
Type	**December 31, 2016**
Tax-Exempt Bonds	$554,114
Various Notes to Banks	49,822
Mortgages on Real Estate	9,416
Capitalized Leases	7,323
Other	581
Total Indebtedness[1]	621,256
Less: Current Maturities	27,251
Total Long-Term Indebtedness[(1)]	$594,005

[1] *Total Indebtedness and Total Long-Term Indebtedness do not account for bond discount or deferred financing costs.*

The System's long term debt is described in additional detail in Note 9 to the audited consolidated financial statements in APPENDIX B hereto.

PH is currently a party to six interest rate swap agreements, which were originally entered into in connection with the issuance of variable rate bonds. The interest rate swap agreements require either party to post collateral in certain circumstances. Under the terms of those interest rate swap agreements, no collateral was required to be posted at December 31, 2016 and 2015. The interest rate swap agreements are described in more detail in Note 10 to the audited consolidated financial statements in APPENDIX B hereto.

Investments

Parkview Health utilizes a centralized cash management and investment management program, which is coordinated and overseen by PH with specific funds managed by professional investment firms. The overall operation of the investment management program is annually reviewed and assessed by the Finance Committee to help ensure compliance with the existing investment policies and procedures that have been authorized by the Board. Additionally, the Investment Subcommittee oversees certain aspects of the investment management program. In general, PH utilizes an operating fund which handles the routine receipts and disbursements in the day-to-day management of PH. Additionally, PH utilizes an investment consultant to advise on asset allocation, select professional investment managers, and to monitor performance. Total portfolio and individual manager performance is reviewed regularly by PH management, Investment Subcommittee and the Finance Committee. As of December 31, 2016, the

System had approximately $918,786,000 invested in long-term investments. Approximately 73% of the System's investments can be liquidated within 7 days.

ACCREDITATIONS, MEMBERSHIPS AND LICENSURES

The System's hospitals are licensed to operate acute care hospitals by the Indiana State Board of Health. The System maintains CMS deemed status accreditation with The Joint Commission. The end dates of the current three-year accreditation cycles for each are: Parkview Hospital (PRMC and Parkview Randallia)-September 2017, Parkview Huntington-September 2019, Parkview LaGrange-November 2019, Parkview Noble-November 2018, Parkview Whitley-March 2018, Parkview Ortho-July 2017 and Parkview Wabash-January 2019. The System's hospitals are members of the American Hospital Association, the Indiana Health and Hospital Association, and Vizient, Inc. (formerly known as Voluntary Hospitals of America.)

EMPLOYEES

As of December 31, 2016, the System employed 4,934 full-time employees (1.0 FTE) and 5,705 part-time employees (temporary status through 0.9 FTE). The number of full-time equivalent employees as of December 31, 2016 was 8,610. None of the employees of the System are represented by a labor organization. Management believes a satisfactory relationship exists with employees.

	2016 PH	2016 Industry
Employee Turnover	14.2%	15.7%[(1)]
RN Turnover	11.0%	14.3%[(1)]
RN Vacancy Rate	10.5%	7.4%[(1)]

Source: [(1)] Saratoga Institute, 2016

ADDITIONAL INFORMATION

Pension Plan

PH sponsors a noncontributory defined benefit pension plan (the "Defined Benefit Plan"). The Defined Benefit Plan benefits are based on years of service and an employee's compensation during a consecutive five year term of employment within the 10 years prior to the benefit determination which results in the highest earnings. PH's funding policy is to contribute annually the amount necessary to meet the full funding requirement of the Pension Protection Act of 2006. The Defined Benefit Plan has been funded based on annual actuarial reports. As of December 31, 2016, the accrued pension liability for the Defined Benefit Plan was approximately $90,826,000.

Beginning January 1, 2005, PH implemented a new retirement program and offered a one-time choice to current employees (as of December 31, 2004) to remain in the Defined Benefit Plan, or freeze their Defined Benefit Plan benefits and move to an employer funded defined contribution plan (the "Defined Contribution Plan"). Employees hired after December 31, 2004 are only eligible for the Defined Contribution Plan. Contributions to the Defined Contribution Plan are based on a percentage of eligible employee salaries. The percentage is based on benefit service points, a combination of age and years of benefit service.

The Defined Benefit Plan and the Defined Contribution Plan are described in more detail in Note 11 to the audited consolidated financial statements in APPENDIX B hereto.

Insurance

Medical Malpractice. The Indiana Medical Malpractice Act, I.C. 34-18-1-1 et. seq. (the "Act") provides for a State Patient's Compensation Fund (the "Fund") to which a qualified health care provider contributes a surcharge. The amount of the surcharge for the System's hospitals is established by the Department of Insurance based upon an actuarial program. The amount must be sufficient to cover, but may not exceed, the actuarial risk posed to the Fund by the provider. The Act currently provides for a maximum recovery of $1,250,000 on any given claim. The health care provider is liable for up to the first $250,000 paid toward any recovery. The excess is paid by the Fund. The practical impact of this law is to limit the exposure and expense of malpractice cost and cap provider liability at $250,000 per claim. Various aspects of the Act, including the limitations on recovery, have been upheld on constitutional grounds by the Indiana Supreme Court.

PH maintains professional liability insurance for itself and its employed physicians through a private insurance carrier. With respect to the System's hospitals, the System maintained professional liability insurance through a private insurance carrier for claims made prior to October 1, 2004. For claims made against its hospitals after October 1, 2004, the System maintains a self-insured trust for professional liability claims. The insurance policies covering the System and hospital affiliates, as well as the trust, provide protection from liability in an amount not to exceed $250,000 per incident and aggregate liability protection not to exceed $7,500,000 per year. The insurance policies and trust conform to the Indiana Medical Malpractice Act. In addition, the System maintains a commercial excess liability policy with a limit of $20,000,000. The System believes that its risk management program embodies a mix of broad insurance coverages and retention programs that reflect an appropriate and prudent approach toward the protection of the System.

Other Insurance. The System maintains other insurance coverages (property, casualty, umbrella liability, etc.) in amounts that, based on review by its insurance consultant, are customary for systems of similar size and location.

Litigation

As with most multi-hospital systems, there may be, at any point in time, a number of medical malpractice actions filed or pending against providers in the System. Generally, these will be paid or settled from insurance and/or self-insurance coverage, and some will not be pursued by plaintiffs. However, certain actions may seek punitive or other damages, which may not be covered by insurance. Litigation also arises from the corporate and business activities of the members of the System, from their status as major employers, or as a result of medical staff peer review or the denial of medical staff privileges. According to a U.S. Supreme Court decision, physicians subject to adverse peer review proceedings are allowed to file federal antitrust and discrimination actions against hospitals and may seek recovery that is in addition to compensatory damages. As with medical malpractice, many of these risks are covered by insurance or self-insurance, but some are not. In the unlikely event that a substantial number of uncovered claims were determined adversely to any members of the System who are defendants in such claims, and substantial monetary damages were awarded in each, there could be a material adverse effect on the System's financial condition. Management believes that no litigation is currently pending or threatened that would materially adversely impact the operation or financial condition of the System.

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APPENDIX B

AUDITED CONSOLIDATED FINANCIAL STATEMENTS OF PARKVIEW HEALTH SYSTEM, INC. AND SUBSIDIARIES D/B/A PARKVIEW HEALTH

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Parkview Health System, Inc. and Subsidiaries d/b/a Parkview Health

Consolidated Financial Report
and Supplementary Information – Including
Obligated Group and Credit Group
December 31, 2016

Contents

RSM US LLP

Independent Auditor's Report

The Board of Directors
Parkview Health System, Inc.

Report on the Financial Statements

We have audited the accompanying consolidated financial statements of Parkview Health System, Inc. and subsidiaries (the Corporation), which comprise the consolidated balance sheets as of December 31, 2016 and 2015, the related consolidated statements of operations and changes in net assets and cash flows for the years then ended, and the related notes to the consolidated financial statements (collectively, financial statements).

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Parkview Health System, Inc. 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.

Other Matter
Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The accompanying details of consolidated balance sheets – including obligated group and credit group and details of consolidated statements of operations and changes in net assets – including obligated group and credit group, are presented for purposes of additional analysis rather than to present the financial position, results of operations, and changes in net assets of the individual groups and are not a required part of the 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 financial statements. The details of consolidated balance sheets – including obligated group and credit group and details of consolidated statements of operations and changes in net assets – including obligated group and credit group have been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, such information is fairly stated in all material respects in relation to the financial statements as a whole.

RSM US LLP

Chicago, Illinois
March 22, 2017

Parkview Health System, Inc. and Subsidiaries
d/b/a Parkview Health

Consolidated Balance Sheets
December 31, 2016 and 2015
(In Thousands)

	2016	2015
Assets		
Current assets:		
Cash and cash equivalents	**$ 100,032**	$ 154,487
Short-term investments	**306**	7,961
Patient accounts receivable, less allowances for bad debts of $79,034 and $65,249 in 2016 and 2015, respectively	**183,477**	175,100
Inventories	**23,169**	20,389
Prepaid expenses and other current assets	**25,392**	30,371
Estimated third-party payor settlements	**3,960**	4,908
Total current assets	**336,336**	393,216
Investments:		
Board-designated investments	**936,056**	753,559
Funds held by trustees	**49,969**	25,446
Other investments	**789**	863
	986,814	779,868
Property and equipment:		
Cost	**1,795,851**	1,718,641
Less accumulated depreciation and amortization	**770,713**	719,966
	1,025,138	998,675
Other assets:		
Interest rate swaps	**1,732**	4,203
Investments in joint ventures	**2,188**	2,183
Goodwill and intangible assets, net	**103,107**	101,721
Other assets	**36,346**	20,717
	143,373	128,824
Total assets	**$ 2,491,661**	$ 2,300,583

See notes to consolidated financial statements.

Parkview Health System, Inc. and Subsidiaries
d/b/a Parkview Health

Consolidated Balance Sheets
December 31, 2016 and 2015
(In Thousands)

	2016	2015
Liabilities and Net Assets		
Current liabilities:		
Accounts payable and accrued expenses	**$ 91,360**	$ 74,219
Salaries, wages and related liabilities	**101,669**	94,617
Accrued interest	**2,806**	2,599
Estimated third-party payor settlements	**5,214**	4,752
Current portion of long-term debt	**27,251**	27,998
Total current liabilities	**228,300**	204,185
Noncurrent liabilities:		
Long-term debt, less current portion	**595,663**	590,654
Interest rate swaps	**73,144**	80,128
Accrued pension obligations	**90,826**	94,080
Other	**24,180**	20,077
	783,813	784,939
Net assets:		
Parkview Health System, Inc.	**1,433,217**	1,269,008
Noncontrolling interest in subsidiaries	**31,367**	27,900
Total unrestricted net assets	**1,464,584**	1,296,908
Temporarily restricted net assets	**13,420**	12,941
Permanently restricted net assets	**1,544**	1,610
	1,479,548	1,311,459
Total liabilities and net assets	**$ 2,491,661**	$ 2,300,583

See notes to consolidated financial statements.

Parkview Health System, Inc. and Subsidiaries
d/b/a Parkview Health

Consolidated Statements of Operations and Changes in Net Assets
Years Ended December 31, 2016 and 2015
(In Thousands)

	2016	2015
Revenues:		
Net patient care service revenue	**$ 1,531,312**	$ 1,454,499
Provision for bad debts	**(110,744)**	(116,964)
Net patient care service revenue, less provision for bad debts	**1,420,568**	1,337,535
Capitation revenue	**98,514**	57,900
Other revenue	**45,173**	45,933
	1,564,255	1,441,368
Expenses:		
Salaries and benefits	**766,375**	677,201
Supplies	**223,915**	201,608
Purchased services	**169,245**	142,845
Utilities, repairs and maintenance	**60,322**	54,614
Depreciation and amortization	**95,377**	90,379
Hospital assessment fee	**38,090**	34,446
Other, net	**63,420**	63,139
	1,416,744	1,264,232
Operating income	**147,511**	177,136
Nonoperating income (expense):		
Interest, dividends and realized gains on sales of investments, net	**21,750**	12,830
Unrealized gains (losses) on investments, net	**34,099**	(32,502)
Interest expense	**(18,483)**	(17,525)
Unrealized gains (losses) on interest rate swaps, net	**4,456**	(224)
Contribution of unrestricted net assets of Wabash County Hospital	**-**	37,444
Other, net	**(10,183)**	849
	31,639	872
Excess of revenues over expenses	**179,150**	178,008
Excess of revenues over expenses attributable to noncontrolling interest in subsidiaries	**30,847**	29,412
Excess of revenues over expenses attributable to Parkview Health System, Inc.	**$ 148,303**	$ 148,596

See notes to consolidated financial statements.

Parkview Health System, Inc. and Subsidiaries
d/b/a Parkview Health

Consolidated Statements of Operations and Changes in Net Assets (Continued)
Years Ended December 31, 2016 and 2015
(In Thousands)

	Year Ended December 31, 2016		
	Total	Controlling Interest	Noncontrolling Interest
Unrestricted net assets:			
Excess of revenues over expenses	$ 179,150	$ 148,303	$ 30,847
Distributions to noncontrolling interests	(27,380)	-	(27,380)
Pension-related changes other than net periodic pension cost	16,316	16,316	-
Net assets released from restriction used for property and equipment, and other	(410)	(410)	-
Increase in unrestricted net assets	167,676	164,209	3,467
Temporarily restricted net assets:			
Contributions	1,419	1,419	-
Investment gain	75	75	-
Net assets released from restrictions	(1,015)	(1,015)	-
Increase in temporarily restricted net assets	479	479	-
Permanently restricted net assets:			
Contributions	1	1	-
Other	(67)	(67)	-
Decrease in permanently restricted net assets	(66)	(66)	-
Increase in net assets	168,089	164,622	3,467
Net assets:			
Beginning of year	1,311,459	1,283,559	27,900
End of year	$ 1,479,548	$ 1,448,181	$ 31,367

See notes to consolidated financial statements.

Parkview Health System, Inc. and Subsidiaries
d/b/a Parkview Health

Consolidated Statements of Operations and Changes in Net Assets (Continued)
Years Ended December 31, 2016 and 2015
(In Thousands)

	Year Ended December 31, 2015		
	Total	Controlling Interest	Noncontrolling Interest
Unrestricted net assets:			
Excess of revenues over expenses	$ 178,008	$ 148,596	$ 29,412
Distributions to noncontrolling interests	(27,223)	-	(27,223)
Pension-related changes other than net periodic pension cost	(1,165)	(1,165)	-
Net assets released from restriction used for property and equipment, and other	4,737	4,256	481
Increase in unrestricted net assets	154,357	151,687	2,670
Temporarily restricted net assets:			
Contributions	1,972	1,972	-
Contribution of temporarily restricted net assets of Wabash County Hospital	7,000	7,000	-
Investment gain	51	51	-
Net assets released from restrictions	(27,352)	(27,352)	-
Decrease in temporarily restricted net assets	(18,329)	(18,329)	-
Permanently restricted net assets:			
Contributions	700	700	-
Increase in permanently restricted net assets	700	700	-
Increase in net assets	136,728	134,058	2,670
Net assets:			
Beginning of year	1,174,731	1,149,501	25,230
End of year	$ 1,311,459	$ 1,283,559	$ 27,900

See notes to consolidated financial statements.

Parkview Health System, Inc. and Subsidiaries
d/b/a Parkview Health

Consolidated Statements of Cash Flows
Years Ended December 31, 2016 and 2015
(In Thousands)

	2016	2015
Cash flows from operating activities:		
Increase in net assets	**$ 168,089**	$ 136,728
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Provision for bad debts	**110,744**	116,964
Depreciation and amortization	**95,377**	90,379
Contributions restricted for capital	**(1,419)**	(8,972)
Undistributed loss (earnings) from alternative investments	**931**	(4,448)
Unrealized (gains) losses on interest rate swaps, net	**(4,555)**	158
Amortization of deferred financing costs and net premium	**(461)**	(592)
Loss from disposal of property and equipment	**1,157**	276
Gain from step acquisition	**-**	(10,073)
Pension-related changes other than net periodic pension cost	**(16,316)**	1,165
Contribution of net assets of Wabash County Hospital	**-**	(22,844)
Changes in operating assets and liabilities, net of effects from contribution of Wabash County Hospital and acquisitions:		
Patient accounts receivable	**(119,121)**	(116,110)
Inventories	**(2,780)**	(2,888)
Prepaid expenses and other current assets	**5,252**	(6,159)
Trading securities, net	**(200,223)**	(6,343)
Accounts payable, accrued expenses and other current liabilities	**24,400**	30,973
Estimated third-party payor settlements	**1,411**	(14,927)
Accrued pension obligation	**13,062**	11,245
Other	**12,281**	6,155
Net cash provided by operating activities	**87,829**	200,687
Cash flows from investing activities:		
Property and equipment additions	**(116,768)**	(62,909)
Business acquisitions, net of cash acquired	**(3,057)**	(10,907)
Proceeds from sale of property and equipment	**4,587**	343
Cash and cash equivalents received from contribution of Wabash County Hospital	**-**	13,810
Net cash used in investing activities	**(115,238)**	(59,663)
Cash flows from financing activities:		
Principal payments of long-term debt	**(35,130)**	(27,436)
Proceeds from issuance of long-term debt	**38,229**	-
Payments of capital lease obligations	**(4,060)**	(5,955)
Distributions to noncontrolling interests	**(27,380)**	(27,223)
Contributions restricted for capital	**1,419**	8,972
Other	**(124)**	243
Net cash used in financing activities	**(27,046)**	(51,399)
(Decrease) increase in cash and cash equivalents	**(54,455)**	89,625
Cash and cash equivalents:		
Beginning of year	**154,487**	64,862
End of year	**$ 100,032**	$ 154,487

Parkview Health System, Inc. and Subsidiaries
d/b/a Parkview Health

Consolidated Statements of Cash Flows (Continued)
Years Ended December 31, 2016 and 2015
(In Thousands)

	2016	2015
Schedule of noncash investing and financing activities:		
Assets acquired through capital leases	**$ 5,885**	$ 535
Contribution of Wabash County Hospital:		
Working capital	**$ -**	$ 17,191
Investments	**-**	3,899
Property and equipment	**-**	2,008
Long-term debt	**-**	(254)
	-	22,844
Less: cash and cash equivalents contributed	**-**	(13,810)
Noncash net identifiable assets contributed	**$ -**	$ 9,034
Equity method investment contributed in step acquisition	**$ -**	$ 10,873

See notes to consolidated financial statements.

Note 1. Organization

Nature of operations: Parkview Health System, Inc., d/b/a Parkview Health (PH or the Corporation), is a health care system that provides services in northeast Indiana and northwest Ohio. PH's mission is to provide quality health care services to all who entrust their care to PH and to improve the health of the community. Services provided by PH include acute, nonacute, and tertiary care services on an inpatient, outpatient, and emergency basis; managed care contracting, health care diagnostics, and treatment services for individuals and families; home health care; and behavioral health care. The principal operating activities of PH are conducted by wholly owned or controlled affiliates and subsidiaries.

PH is the sole corporate member of Parkview Hospital, Inc. (PVH). PVH comprises one acute care hospital; a behavioral health hospital; and a flagship tertiary care center, Parkview Regional Medical Center, which opened March 17, 2012. In total, PVH offers 714 beds in Fort Wayne, Indiana. PH is the majority owner (60%) of the Orthopaedic Hospital at Parkview North LLC (ORTHO), which is a for-profit joint venture hospital with a large orthopaedic physician group. ORTHO operates the Orthopaedic Hospital, a 37-bed orthopaedic specialty hospital, and an ambulatory surgical center, acquired on December 31, 2012. In addition, PH is the sole corporate member of Huntington Memorial Hospital, Inc.; Whitley Memorial Hospital, Inc.; Community Hospital of Noble County, Inc.; Community Hospital of LaGrange County, Inc.; and Parkview Wabash Hospital, Inc., each of which operates an acute care community hospital and related facilities in the northeast region of Indiana. These hospitals are referred to collectively as the Hospital Affiliates.

PH and PVH are the sole members of Managed Care Services, LLC, which provides third-party administrative services to PH's employee health plan and acts as a preferred provider organization network of providers for self-funded employers. Managed Care Services, LLC also assumes risk on a Medicaid managed care program through MDwise. Capitation revenue relating to this program was $98,514 in 2016 and $57,900 in 2015, and is recorded in other revenue in the consolidated statements of operations and changes in net assets.

Parkview Physicians Group (PPG), a division of PH, is a multidisciplinary group of employed physicians. PPG was developed to enhance the delivery of quality health care services in northeast Indiana and northwest Ohio. Disciplines represented in PPG include primary care, OB/GYN, orthopaedics, colon and rectal surgery, cardiovascular surgery, general surgery, hospitalists/intensivists, podiatry, psychiatry, urology, cardiology, pulmonology and critical care, gastroenterology, rheumatology, and physiatry.

(Dollars in Thousands)

Note 1. Organization (Continued)

The legal entity names, marketing brand names, and acronyms for each significant entity within PH are as follows:

Legal Name	Marketing Brand (d/b/a) Name	Acronym
Parkview Health System, Inc.	Parkview Health, including Parkview Physicians Group	PH and PPG
Parkview Hospital, Inc.	Parkview Regional Medical Center and Parkview Randallia Hospital	PVH
Orthopaedic Hospital at Parkview North, LLC	Parkview Ortho Hospital	ORTHO
Huntington Memorial Hospital, Inc.	Parkview Huntington Hospital	PHH
Whitley Memorial Hospital, Inc.	Parkview Whitley Hospital	PWH
Community Hospital of Noble County, Inc.	Parkview Noble Hospital	PNH
Community Hospital of LaGrange County, Inc.	Parkview LaGrange Hospital	PLH
Managed Care Services, LLC	Managed Care Services	MCS
Parkview Wabash Hospital, Inc.	Parkview Wabash Hospital	PWB
Parkview Foundation, Inc.	Parkview Foundation	PVHF
Whitley Memorial Hospital Foundation, Inc.	Parkview Whitley Hospital Foundation	PWHF
Community Hospital of Noble County Foundation, Inc.	Parkview Noble Hospital Foundation	PNHF
The Parkview Huntington Hospital Foundation, Inc.	Parkview Huntington Hospital Foundation	PHHF
Parkview Wabash Hospital Foundation, Inc.	Parkview Wabash Hospital Foundation	WBHF
Parkview Occupational Health Centers, Inc.	Parkview Occupational Health Centers	POH

Transactions deemed by management to be ongoing, major, or central to the provision of health care services are reported as net patient care service revenue. Other transactions are included with other revenue. Other revenue includes rentals of medical office buildings, capitation revenue, investment income from affiliated foundations, and equity income of unconsolidated affiliates and joint ventures.

Acquisitions: In 2016, PH acquired 3 physician groups and a physical therapy practice with a total purchase price of $3,057. In 2015, PH acquired a physician group and 50% of a surgery center for a total purchase price of $21,780. The physician groups are included in PPG. The 2015 50% acquisition of the surgery center increased PH's total ownership to 100% and is included in PVH. The acquisitions were accounted for as business combinations. Goodwill of $2,585 and $20,976 was recognized upon purchase in 2016 and 2015, respectively, which represents the excess of purchase price over identifiable assets and liabilities.

Note 1. Organization (Continued)

Effective January 1, 2015, PH, through Parkview Wabash Hospital, Inc., acquired Wabash County Hospital, which was renamed Parkview Wabash Hospital (PWB). PWB is a 25-bed inpatient critical access hospital located in the city of Wabash, Indiana. PWB provides critical care, surgery, emergency, cancer treatment, lab and other services. For accounting purposes, this transaction is considered an acquisition under Accounting Standards Codification (ASC) 958-805, *Not-for-Profit Entities: Business Combinations*.

Because no consideration was paid by PH, the acquisition was accounted for as a contribution to PH. Wabash County Hospital's land and buildings, valued at $21,600, were conveyed to PWB on December 31, 2014, and were recorded as a restricted contribution in the 2014 consolidated statement of operations and changes in net assets, and were released from restriction in 2015. The remainder of the contribution was recorded with the closing of the transaction effective January 1, 2015. The valuation of the net assets contributed was based on independent appraisals.

As a part of the acquisition agreement, PH was required to transfer $3,000 to Parkview Wabash Hospital Foundation, Inc., which occurred in 2015. PH is also required to build a new hospital in Wabash at a cost of not less than $35,000, to be completed by the end of 2019. If construction of the new hospital is not completed by the end of 2019, PH will be required to transfer $12,000 to the Community Foundation of Wabash County, Inc. Construction is currently underway and management believes the likelihood of this construction not being completed within this time frame to be remote.

Community benefits and charity care: The Corporation provides programs and services to address the needs of those in the communities it serves with limited financial resources, generally at no or low cost to those being served. Additional services are provided to beneficiaries of governmental programs (principally those relating to the Medicare and Medicaid programs) at substantial discounts from established rates and are considered part of the Corporation's benefit to the communities.

Assistance is also provided as needed to patients and their families for the submission of forms for insurance, financial counseling, and application to the Medicare and Medicaid programs for health service coverage. The costs of providing these programs and services are included in expenses.

Consistent with the Corporation's mission, care is provided to patients regardless of their ability to pay. Patients who meet certain criteria for charity care are provided care without charge or at amounts less than established rates. Such amounts determined to qualify as charity care are not reported as revenue. Records are maintained to identify and monitor the level of charity care provided at the amount of standard charges foregone for services and supplies furnished.

The cost of charity care provided in 2016 and 2015 approximates $15,744 and $14,159, respectively. The Corporation estimated these costs by calculating a ratio of cost to gross charges and then multiplying that ratio by the gross uncompensated charges associated with providing care to charity patients. The Corporation also offers a discount for all uninsured patients.

PVH and each of the community hospitals administer community benefit programs for the areas in which they serve. PVH targets $3,000 (unaudited) annually for community benefit, while the community hospitals each contribute generously for community benefit in their respective communities. These funds are controlled by the hospitals, and contributions made as part of their community benefit program are under the direction of their respective Boards of Directors (the Boards). The hospitals have a long tradition of community involvement, and their community benefit programs reflect their commitment and support to their respective communities and counties.

Note 1. Organization (Continued)

The Corporation and its subsidiaries have a commitment to improving the health of the citizens of the communities served. In all locations, PH has made a concerted effort to identify opportunities to partner with local organizations and to develop initiatives to improve the health of these communities. Health fairs and screenings are common efforts to identify problems before they become serious or life-threatening. Affiliates often partner with local organizations for community education and outreach, including Cancer Services of Northeast Indiana, YMCA, Boys & Girls Club and the Center for Whitely County Youth. PH provides subsidies for the emergency medical services of the counties where its community hospitals reside. An association with Fort Wayne Community Schools has provided nursing services and physicals to at-risk and underserved children. PH donations support nursing programs at Indiana University-Purdue University of Fort Wayne and the University of St. Francis. Efforts have helped provide health care to the medically underserved through support of the Neighborhood Health Clinics and Matthew 25 Health and Dental Clinic. PH affiliates have supported youth organizations, county councils on aging, emergency shelters and health clinics. Awareness and prevention programs focused on dealing with safety, trauma, drugs, and alcohol are projects of PH.

Note 2. Significant Accounting Policies

Principles of consolidation: The consolidated financial statements include the accounts of PH and all majority-owned or majority-controlled subsidiaries. Significant intercompany accounts and transactions have been eliminated in consolidation. The equity method of accounting is used for investments in joint ventures, partnerships, and companies where ownership is 20% to 50% and PH has significant influence. The equity method of accounting is also used for hedge funds with ownership of 3% to 50% and where PH has significant influence. For the years ended December 31, 2016 and 2015, PH's share of income recorded using the equity method approximated $644 and $2,372, respectively, and is recorded as other revenue in the consolidated statements of operations and changes in net assets.

Use of estimates: The preparation of consolidated financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Cash and cash equivalents: Investments in highly liquid debt instruments with a maturity of three months or less when purchased, excluding amounts classified with Board-designated investments and funds held by trustees, are considered cash equivalents. The Corporation routinely invests in money market mutual funds. These funds generally invest in highly liquid U.S. government and agency obligations. Financial instruments that potentially subject the Corporation to concentrations of credit risk include the Corporation's cash and cash equivalents. The Corporation places its cash and cash equivalents with institutions of high credit quality. However, at certain times, such cash and cash equivalents may be in excess of government-provided insurance limits.

Patient accounts receivable, estimated third-party payor settlements, and net patient care service revenue: Patient accounts receivable and net patient care service revenue are reported at the estimated net realizable amounts due from patients, third-party payors (including insurers), and others for services rendered and include estimated retroactive revenue adjustments due to settlement of audits, reviews, and investigations. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered, and such amounts are adjusted in future periods as adjustments become known or as years are settled and are no longer subject to such audits, reviews, and investigations.

Note 2. Significant Accounting Policies (Continued)

The Corporation grants credit to patients without requiring collateral or other security for the delivery of health care services. However, assignment of benefit payments payable under patients' health insurance programs and plans (e.g., Medicare, Medicaid, health maintenance organizations, and commercial insurance policies) is routinely obtained, consistent with industry practice.

The Corporation's estimation of the allowance for bad debts is based primarily upon the type and age of the accounts receivable and the effectiveness of collection efforts. PH's policy is to reserve a portion of all self-pay receivables, including amounts due from the uninsured and amounts related to copayments and deductibles, as charges are recorded. Accounts receivable balances are reviewed monthly as to the effectiveness of PH's reserve policies and various analytics to support the basis for its estimates. These efforts primarily consist of reviewing the following: historical write-off and collection experience using a hindsight, or look-back, approach; revenue and volume trends by payor, particularly the self-pay components; changes in the aging and payor mix of accounts receivable, including increased focus on accounts due from the uninsured and accounts that represent copayments and deductibles due from patients; cash collections as a percentage of net patient revenue less bad debt expense; trending of days' revenue in accounts receivable; and various allowance coverage statistics. Accounts receivable are charged to the allowance for bad debts when they are deemed uncollectible.

Inventories: Inventories consist primarily of drugs and supplies, are stated at the lesser of cost or market, and are valued using the average cost method.

Investments: Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value based on quoted market prices. Investments in hedge funds are recorded under the equity method of accounting, based on information provided by the funds' managers. Generally, the net asset value of these funds (NAV) reflects the contributed capital, as well as an allocated share of the underlying limited partnership's realized and unrealized gains and losses. Commingled investments are funds formed from the pooling of investments under common management. Unlike mutual funds, these investments are not registered investment companies and, therefore, are exempt from registering with the Securities and Exchange Commission.

Investment income or loss (including realized gains and losses on the sale of investments, unrealized gains and losses on investments, and changes in the carrying value of hedge funds), with the exception of investment income or loss, as defined, related to the various PH foundations, is reported as other nonoperating income (expense) unless the income is restricted by donor or law. Investment income or loss apportioned to the foundations is reported in other revenue. The cost of securities sold is based on the specific-identification method.

Board-designated funds represent certain funds from operations and other sources designated by the Board to be used for future capital asset replacement, for the retirement of long-term debt, and for other purposes. The Board retains control over these investments and may, at its discretion, subsequently designate the use of these investments for other purposes. Funds are invested in accordance with Board-approved policies, which, among other matters, require diversification of the investment portfolio, establish credit risk parameters, and limit the investment in any single organization. Substantially all investment transactions are managed by professional investment managers and are held in custody at financial institutions. All Board-designated funds are classified as trading securities, with the exception of land held as an investment, alternative investments and private investment funds.

Note 2. Significant Accounting Policies (Continued)

Funds held by trustees include investments restricted for payment of malpractice and general liability losses and proceeds of debt issuances restricted for payment of constructions costs. All funds held by trustees, as well as short-term investments, are classified as trading securities.

Short-term investments are comprised of corporate bonds with maturities less than twelve months and money market mutual funds with readily determinable fair values, that are used for short-term working cash management. Investment income or loss is reported as other nonoperating income (expense). Investments purchased and sold are reported based on transaction date.

Investment securities purchased and sold are reported based on the trade date. Due to the period lag between the trade and settlement date, PH reports receivables for securities sold but not settled and reports liabilities for securities purchased but not settled. These receivables and payables are settled from within the investment portfolio and are presented on a net basis within investments in the consolidated balance sheets.

Property and equipment: Property and equipment are initially stated at cost or, if donated, at fair value at the date of donation. Interest costs incurred as part of the related construction are capitalized during the period of construction. Depreciation is provided on a straight-line basis over the expected useful lives of the various classes of assets. Estimated useful lives range from 5 to 25 years for land improvements, 5 to 40 years for buildings, and 3 to 15 years for equipment. Property and equipment under capital leases are stated at the lower of the present value of the minimum lease payments or the fair value of the underlying asset and are generally amortized over the lease term. Amortization of capital leased assets is included within depreciation expense.

The costs of obtaining or developing internal-use software, including external direct costs for materials and services and directly related payroll costs, are capitalized. Amortization begins when the internal-use software is ready for its intended use. The software costs are amortized over the estimated useful lives of the software. The estimated useful lives range from 3 to 7 years. Costs incurred during the preliminary project stage and post-implementation stage, as well as maintenance and training costs, are expensed as incurred.

Goodwill: PH records goodwill arising from a business combination as the excess of purchase price over the fair value of identifiable tangible and intangible assets acquired and liabilities assumed. Management has determined that the Corporation is the reporting unit at which fair value is measured. PH annually reviews, as of the first day of the fourth quarter, the carrying value of goodwill for impairment. In addition, a goodwill impairment assessment is performed if an event occurs or circumstances change that would make it more likely than not that the fair value of a reporting unit is below its carrying amount. If such circumstances suggest that the recorded amounts of goodwill cannot be recovered, the carrying value is reduced to fair value. If the carrying value of goodwill is impaired, a material charge may be incurred to results of operations. No goodwill impairment charge was required in 2016 or 2015.

Intangible assets: Costs allocated to customer relationships and other intangible assets are based on their fair value at the date of acquisition. The cost of intangible assets is amortized on a straight-line basis over the assets' estimated useful life ranging from 3 to 20 years. Amortization expense recorded in the consolidated statements of operations and changes in net assets was $1,222 and $1,218 in 2016 and 2015, respectively.

Note 2. Significant Accounting Policies (Continued)

Impairment: Property and equipment and amortizable intangible assets are reviewed for impairment whenever conditions indicate that the carrying amount may not be recoverable. In evaluating the recoverability of long-lived assets, such assets are grouped at the lowest level for which identifiable cash flows are largely independent of the cash flows of other assets. Such impairment tests compare estimated undiscounted cash flows to the recorded value of the asset. If an impairment is indicated, the asset is written down to its fair value, and a corresponding loss is recorded. No impairment was recorded in 2016 or 2015.

Derivative financial instruments: As part of its debt management program, the Corporation has entered into several interest rate swap arrangements. Derivative instruments are recognized as either assets or liabilities in the consolidated balance sheets at fair value. The Corporation does not account for any of its interest rate swap agreements as hedges, and accordingly, changes in the fair value of interest rate swap agreements are recorded in the consolidated statements of operations and changes in net assets as nonoperating income (expense). Also included in other nonoperating income (expense) in the consolidated statements of operations and changes in net assets are net settlement payments on interest rate swaps.

Employee benefit plans: PH's retirement program, called the Trusted Choices Retirement Program, offers a defined contribution plan. Contributions to the defined contribution plan are based upon benefit service points and a combination of age and years of benefit service. Contributions are calculated as a percentage of eligible pay. In addition, active employees at December 31, 2004, were provided a one-time choice to remain in PH's defined benefit plan or freeze their defined benefit plan benefits and move to the employer-funded defined contribution plan. Definitions of eligibility, pay, benefit service, and vesting under the defined benefit plan are the same as the defined contribution plan.

In addition to participation in the defined contribution plan and/or defined benefit plan, eligible employees are provided a voluntary opportunity to participate in a 403(b) or a 401(k) plan based upon the tax status of the employing corporation. The 403(b) and 401(k) plans have match provisions. Benefits for eligible employees are based on the employee's compensation.

Income taxes: The Internal Revenue Service has determined that the Corporation and certain affiliated entities are tax-exempt organizations as defined in Section 501(c)(3) of the Internal Revenue Code. Certain subsidiaries of the Corporation are taxable entities, the tax expense and liabilities of which are not material to the consolidated financial statements.

The Corporation and its tax-exempt affiliated entities each file a Form 990 (Return of Organization Exempt from Income Tax) annually. When these returns are filed, it is highly certain that some positions taken would be sustained upon examination by the taxing authorities, while others are subject to uncertainty about the merits of the position taken or the amount of the position that would ultimately be sustained. Examples of tax positions common to health systems include such matters as the tax-exempt status of each entity, the continued tax-exempt status of bonds, the nature, characterization and taxability of joint venture income, and various positions relating to potential sources of unrelated business taxable income (reported on Form 990T). As of December 31, 2016 and 2015, there are no unrecognized tax benefits resulting from uncertain tax positions.

Forms 990 and 990T filed by the Corporation and its tax-exempt affiliated entities are subject to examination by the Internal Revenue Service up to three years from the extended due date of each return. Forms 990 and 990T filed by the Corporation and its tax-exempt affiliated entities are no longer subject to examination for the year 2012 and prior.

Note 2. Significant Accounting Policies (Continued)

Performance indicator: Excess of revenues over expenses as reflected in the accompanying consolidated statements of operations and changes in net assets includes operating income and nonoperating income and losses. With the exception of Wabash County Hospital, which was accounted for as a business combination, contributions of long-lived assets, pension-related changes other than net periodic pension cost, net assets released from restriction for acquisition of long-lived assets, and distributions to noncontrolling interests are excluded from excess of revenues over expenses.

Operating and nonoperating income (expense): Activities directly associated with the furtherance of PH's mission are considered operating activities. Other activities that result in gains or losses peripheral to PH's primary mission are considered to be nonoperating. Nonoperating activities include interest, dividends, and realized gains/losses on sales of investments, net; unrealized gains/losses on investments, net; interest expense; realized and unrealized gains/losses on interest rate swaps, net and related net settlement payments; and other.

Temporarily and permanently restricted net assets: Temporarily restricted net assets are those whose use by the Corporation has been limited by donors to a specific time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Corporation in perpetuity. Investment return is allocated to unrestricted and temporarily restricted net assets based on the respective net asset balances and the wishes of the donor. The net assets are generally restricted for indigent and other patient services, medical education and research programs, facilities, medical supplies, and equipment.

When a donor restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified as unrestricted net assets and are reported in the accompanying consolidated statements of operations and changes in net assets as net assets released from restriction and other revenue (if used for operating purposes) or other changes in unrestricted net assets (if used for the acquisition of long-lived assets). Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions related to long-lived assets are recognized when the long-lived asset is placed in service.

Distributions to noncontrolling interests: Certain consolidated subsidiaries of PH have members who hold a noncontrolling ownership interest. Upon authorization of the Boards of those subsidiaries, cash available for distribution, or a portion thereof, arising from operations or other sources may be distributed to PH and the noncontrolling members ratably in accordance with the members' respective membership interests.

Newly adopted accounting pronouncement: In April 2015, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2015-03, *Interest— Imputation of Interest (Subtopic 835-30): Simplifying the Presentation of Debt Issuance Costs*. This ASU requires that debt issuance costs related to a recognized debt liability be presented in the balance sheet as a direct deduction from the carrying amount of that debt liability, consistent with debt discounts. The recognition and measurement guidance for debt issuance costs are not affected by the amendments in this ASU. The Corporation adopted the provisions of ASU 2015-03, which require retrospective application, in the accompanying consolidated financial statements. Accordingly, the December 31, 2015 consolidated balance sheet has been restated to reclassify $2,105 of net deferred financing costs previously reported as other assets as a reduction of long-term debt.

Note 2. Significant Accounting Policies (Continued)

Recent accounting pronouncements: In May 2014, the FASB issued ASU 2014-09, *Revenue from Contracts with Customers (Topic 606)*, requiring an entity to recognize the amount of revenue to which it expects to be entitled for the transfer of promised goods or services to customers. The updated standard will replace most existing revenue recognition guidance in U.S. GAAP when it becomes effective and permits the use of either a full retrospective or retrospective with cumulative effect transition method. In August 2015, the FASB issued ASU 2015-14 which defers the effective date of ASU 2014-09 one year making it effective for the Corporation's December 31, 2018 consolidated financial statements. Earlier application is permitted only as of annual reporting periods beginning after December 15, 2016, including interim reporting periods within that period. The Corporation has not yet selected a transition method and is currently evaluating the effect that the pending adoption of the updated standard will have on the consolidated financial statements.

In January 2016, the FASB issued ASU 2016-01, *Financial Instruments—Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities,* which changes how entities account for equity investments that do not result in consolidation and are not accounted for under the equity method of accounting. Entities will be required to measure these investments at fair value at the end of each reporting period and recognize changes in fair value in net income. ASU 2016-01 also changes certain disclosure requirements and other aspects of current U.S. GAAP. ASU 2016-01 will be effective for the Corporation's December 31, 2019 consolidated financial statements. In 2015, the Corporation elected to early adopt the amendment within ASU 2016-01 that no longer requires disclosure of the fair value of financial instruments that are not measured at fair value and as such, these disclosures are not included herein. The Corporation is currently evaluating the effect of the pending adoption of the remaining provisions of ASU 2016-01 on the consolidated financial statements.

In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842)*, which supersedes the leasing guidance in Topic 840, *Leases*. Under the new guidance, lessees are required to recognize lease assets and lease liabilities on the balance sheet for all leases with terms longer than 12 months. Leases will be classified as either finance or operating, with classification affecting the pattern of expense recognition in the statement of operations. The new standard is effective for the Corporation's December 31, 2019 consolidated financial statements. A modified retrospective transition approach is required for lessees for capital and operating leases existing at, or entered into after, the beginning of the earliest comparative period presented in the financial statements, with certain practical expedients available. The Corporation is currently evaluating the effect of the pending adoption of the new standard on the consolidated financial statements.

In August 2016, the FASB issued ASU 2016-14, *Not-for-Profit Entities (Topic 958): Presentation of Financial Statements of Not-for-Profit Entities*. Key elements of the ASU include a reduction in the number of net asset categories from three to two, conforming requirements on releases of capital restrictions, several new requirements related to expense presentation and disclosure (including investment expenses), and new required disclosures communicating information useful in assessing liquidity. The ASU will be effective for the Corporation's December 31, 2018 consolidated financial statements. Early adoption is permitted. Retrospective application is required for many provisions of this guidance. The Corporation is currently evaluating the effect of the pending adoption of the new standard on the consolidated financial statements.

Note 2. Significant Accounting Policies (Continued)

In August 2016, the FASB issued ASU 2016-15, *Statement of Cash Flows (Topic 230): Classification of Certain Cash Receipts and Cash Payments.* ASU 2016-15 provides guidance on how certain cash receipts and cash payments should be presented and classified in the statement of cash flows with the objective of reducing existing diversity in practice with respect to these items. The new standard will be effective for the Corporation's December 31, 2019 consolidated financial statements. Early adoption is permitted. ASU 2016-15 requires a retrospective transition method. However, if it is impracticable to apply the amendments retrospectively for some of the issues, the amendments for those issues would be applied prospectively as of the earliest date practicable. The Corporation is currently evaluating the effect of the pending adoption of the new standard on the consolidated financial statements.

In November 2016, the FASB issued ASU 2016-18, *Statement of Cash Flows (Topic 230): Restricted Cash*. ASU 2016-18 applies to all entities that have restricted cash or restricted cash equivalents and are required to present a statement of cash flows. Its provisions require that a statement of cash flows explain the change during the period in the total of cash, cash equivalents, and amounts generally described as restricted cash or restricted cash equivalents. As a result, amounts generally described as restricted cash and restricted cash equivalents should be included with cash and cash equivalents when reconciling the beginning-of-period and end-of-period total amounts shown on the statement of cash flows. The new standard will be effective for the Corporation's December 31, 2019 consolidated financial statements. Early adoption is permitted. ASU 2016-18 requires a retrospective transition method. The Corporation is currently evaluating the effect of the new standard on the consolidated financial statements.

In January 2017, the FASB issued ASU 2017-04*, Intangibles—Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment*. This pronouncement eliminates Step 2 from the goodwill impairment test. The annual, or interim, goodwill impairment test is performed by comparing the fair value of a reporting unit with its carrying amount. An impairment charge should be recognized for the amount by which the carrying amount exceeds the reporting unit's fair value; however, the loss recognized should not exceed the total amount of goodwill allocated to that reporting unit.

The pronouncement also eliminates the requirements for any reporting unit with a zero or negative carrying amount to perform a qualitative assessment and, if it fails that qualitative test, to perform Step 2 of the goodwill impairment test. The Corporation will still has the option to perform the qualitative assessment for a reporting unit to determine if the quantitative impairment test is necessary.

The Corporation will be required to adopt ASU 2017-04 for its annual or any interim goodwill impairment tests in fiscal years beginning after December 15, 2021. Early adoption is permitted for interim or annual goodwill impairment tests performed on testing dates after January 1, 2017. ASU 2017-04 requires adoption on a prospective basis.

Reclassifications: Certain prior-year amounts have been reclassified to conform to the current-year presentation. Such reclassifications had no effect on previously reported excess of revenue over expenses or changes in net assets.

(Dollars in Thousands)

Note 3. Business Acquisitions

Effective January 1, 2015, PH became the sole member of Wabash County Hospital. The transaction was accounted for as an acquisition with no consideration, and accordingly the excess of the fair value of assets acquired over liabilities assumed was recognized as an inherent contribution received by PH. Transaction costs for legal and consulting services that are included in the consolidated statements of operations and changes in net assets were insignificant.

The table below summarizes the estimated fair value of the net assets acquired:

Current assets:		Current liabilities:	
Cash and cash equivalents	$ 13,810	Accounts payable	$ 4,215
Patient accounts receivable	7,460	Accrued expenses and other	1,812
Inventories	861	Current maturities of long-term debt	137
Estimated settlements due from third-party payors	255	**Total current liabilities**	6,164
Prepaid expenses and other assets	969	Noncurrent liabilities:	
Total current assets	23,355	Long-term debt, less current maturities	254
		Total liabilities	6,418
		Net assets:	
Investments	3,899	Unrestricted	37,444
		Temporarily restricted	7,000
Property and equipment	23,608	**Total net assets**	44,444
Total assets	$ 50,862	**Total liabilities and net assets**	$ 50,862

In October 2015, PH increased its ownership investment in Premier Surgery Center, LLC (Premier) from 50% to 100% through a “step acquisition.” Prior to this transaction, PH had accounted for Premier as an unconsolidated affiliate under the equity method of accounting.

As the buyer in a step acquisition, PH measured the acquisition date fair value of its previously held equity position in Premier and recognized a non-cash gain of $10,073. This gain of $10,073 is included in the 2015 consolidated statement of operations and changes in net assets in other nonoperating income (expense).

(Dollars in Thousands)

Note 3. Business Acquisitions (Continued)

The components of the consideration transferred and the amounts recognized as of the acquisition date for each major class of assets acquired and liabilities assumed were as follows:

Consideration:		
Fair value at acquisition date of previously held interest	$	10,873
Fair value of consideration exchanged for 50% interest in Premier		10,874
Total consideration	$	21,747
Recognized amounts of identifiable assets acquired and liabilities assumed:		
Cash and cash equivalents	$	149
Patient accounts receivable		4
Prepaid expenses and other assets		13
Property and equipment		652
Accounts payable		(3)
Accrued expenses and other		(16)
Total identifiable net assets	$	799
Goodwill		20,948
	$	21,747

The fair value of PH's previously held interest and the fair value of the equity exchange for the 50% interest in Premier were estimated using the income approach and market approach.

Goodwill resulting from this transaction consists of expected long-term revenue growth, reputation and knowledge, established patient relationships, and the location of the surgery center.

Note 4. Goodwill and Intangible Assets

The following table summarizes goodwill and other intangibles as of and for the years ended December 31, 2016 and 2015:

	2016	2015
Goodwill balance, beginning of year	$ 97,542	$ 76,566
Acquisitions	2,585	20,976
Goodwill balance, end of year	100,127	97,542
Intangible assets, end of year	8,701	8,678
Accumulated amortization	(5,721)	(4,499)
Intangible assets, net, end of year	2,980	4,179
Goodwill and intangible assets, net	$ 103,107	$ 101,721

(Dollars in Thousands)

Note 4. Goodwill and Intangible Assets (Continued)

Amortization expense of $1,222 and $1,218 was recognized in 2016 and 2015, respectively, and is included in depreciation and amortization expense in the consolidated statements of operations and changes in net assets.

Estimated future amortization of intangible asset balances is as follows:

Year Ending December 31:		
2017	$	1,222
2018		212
2019		132
2020		118
2021		34
Thereafter		54
	$	1,772

Note 5. Fair Value Measurement

ASC 820, *Fair Value Measurement*, defines fair value and establishes a fair value hierarchy that prioritizes the inputs used to measure fair value. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurement) and the lowest priority to unobservable inputs (Level 3 measurement).

Certain of PH's financial assets and financial liabilities are measured at fair value on a recurring basis, including money market funds, fixed income and equity instruments, and interest rate swap contracts. The three levels of the fair value hierarchy and a description of the valuation methodologies used for instruments measured at fair value are as follows:

Level 1. Quoted prices (unadjusted) in active markets for identical assets or liabilities as of the reporting date.

Level 2. Pricing inputs other than quoted prices included in Level 1 that are either directly observable or that can be derived or supported from observable data as of the reporting date.

Level 3. Pricing inputs include those that are significant to the fair value of the financial asset or financial liability and are not observable from objective sources. In evaluating the significance of inputs, management generally classifies assets or liabilities as Level 3 when their fair value is determined using unobservable inputs that individually, or in the aggregate, represent more than 5% of the fair value of the assets or liabilities. These inputs may be used with internally developed methodologies that result in management's best estimate of fair value based on assumptions about what market participants would use in pricing the asset or liability.

(Dollars in Thousands)

Note 5. Fair Value Measurement (Continued)

The fair value of financial assets and liabilities measured at fair value on a recurring basis was determined using the following inputs at December 31, 2016:

	Total	Level 1	Level 2	Level 3
Assets				
Short-term investments:				
Mutual funds	$ 306	$ 306	$ -	$ -
Total short-term investments	$ 306	$ 306	$ -	$ -
Investments:				
U.S. government and agency obligations	$ 40,297	$ 31,582	$ 8,715	$ -
Municipal bonds	9,387	-	9,387	-
Corporate bonds	89,226	-	89,226	-
Mortgage- and asset-backed securities	65,370	-	65,370	-
Domestic equities (includes preferred stock)	114,896	102,577	12,319	-
International equities	38,885	38,885	-	-
Mutual funds:				
Equity type	173,391	173,391	-	-
Balanced type	53,882	53,882	-	-
Fixed income type	3,869	3,869	-	-
Total investments at fair value	589,203	$ 404,186	$ 185,017	$ -
Investments not at fair value:				
Cash equivalents	16,186			
Commingled funds	144,411			
Real estate investment trust	39,002			
Real estate investment fund	37,797			
Hedge funds	144,175			
Real estate held for investment	16,555			
Amounts due brokers	(515)			
Total investments	$ 986,814			
Deferred compensation plan:				
Assets - mutual funds	$ 8,053	$ 8,053	$ -	$ -
Assets - guaranteed income fund	3,637	-	-	3,637
Interest rate swaps	1,732	-	1,732	-
	$ 13,422	$ 8,053	$ 1,732	$ 3,637
Liabilities				
Interest rate swaps	$ (73,144)	$ -	$ -	$ (73,144)

(Dollars in Thousands)

Note 5. Fair Value Measurement (Continued)

The fair value of financial assets and liabilities measured at fair value on a recurring basis was determined using the following inputs at December 31, 2015:

	Total	Level 1	Level 2	Level 3
Assets				
Short-term investments:				
Mutual funds	$ 452	$ 452	$ -	$ -
Corporate bonds	7,509	-	7,509	-
Total short-term investments	$ 7,961	$ 452	$ 7,509	$ -
Investments:				
U.S. government and agency obligations	$ 36,946	$ 29,312	$ 7,634	$ -
Municipal bonds	5,453	-	5,453	-
Corporate bonds	54,531	-	54,531	-
Mortgage- and asset-backed securities	50,682	-	50,682	-
Domestic equities (includes preferred stock)	79,204	78,882	322	-
International equities	40,549	31,960	8,589	-
Mutual funds:				
Equity type	126,856	126,856	-	-
Balanced type	50,634	50,634	-	-
Fixed income type	2,571	2,571	-	-
Total investments at fair value	447,426	$ 320,215	$ 127,211	$ -
Investments not at fair value:				
Cash equivalents	9,214			
Commingled funds	127,803			
Real estate investment trust	29,288			
Real estate investment fund	25,608			
Hedge funds	125,611			
Real estate held for investment	15,741			
Amounts due brokers	(823)			
Total investments	$ 779,868			
Deferred compensation plan:				
Assets - mutual funds	$ 6,437	$ 6,437	$ -	$ -
Assets - guaranteed income fund	3,841	-	-	3,841
Interest rate swaps	4,203	-	4,203	-
	$ 14,481	$ 6,437	$ 4,203	$ 3,841
Liabilities				
Interest rate swaps	$ (80,128)	$ -	$ -	$ (80,128)

(Dollars in Thousands)

Note 5. Fair Value Measurement (Continued)

Certain of PH's investments are made through alternative investments and private investment funds, primarily partnership trusts. PH accounts for its ownership in these funds under the equity method, and as a result, hedge fund, real estate investment trust, and real estate investment fund investments totaling $220,974 and $180,507 as of December 31, 2016 and 2015, respectively, are excluded from the fair value disclosure. Deferred compensation plan assets are included in other assets in the consolidated balance sheets. PH held real estate for investment purposes of $16,555 and $15,741 as of December 31, 2016 and 2015, which is accounted for at cost and assessed for impairment when indicators exist. The real estate is written down to fair value as estimated by third-party valuation experts when impairment exists (which are nonrecurring fair value measurements using Level 3 inputs), with losses recorded in realized gains (losses) on investments in the consolidated statements of operations and changes in net assets. The fair values of commingled funds are based on either the fair value of the underlying investments of the fund, as determined by the fund, or on the ownership interest in the NAV per share or its equivalent, of the respective fund and is excluded from the total investments at fair value.

Following is a description of the Corporation's valuation methodologies for assets and liabilities measured at fair value, not classified as Level 1. The fair values of assets listed as Level 2 investments are determined with the assistance of our custodian and are calculated from various observable inputs and other market data by a source contracted by the custodian. Funds not held by the custodian are reviewed by management for similarities with custodian-held assets and are assigned a comparable level. The fair values of the interest rate swap contracts are determined based on the present value of expected future cash flows using discount rates appropriate with the risks involved. The valuations reflect a credit spread adjustment to the London Interbank Offered Rate (LIBOR) discount curve in order to reflect the credit value adjustment for nonperformance risk. The credit valuation adjustments for asset and liability position interest rate swap contracts are internally valued with the assistance of a third party using other comparably rated entities' bonds priced in the market. Depending on the significance of the credit spread adjustment to the overall fair value of the interest rate swap, the instrument is included in Level 2 or Level 3.

The following table is a rollforward of the consolidated balance sheet amounts for financial instruments classified by the Corporation within Level 3 of the valuation hierarchy defined above:

	Financial Liabilities - Interest Rate Swaps
Fair value at January 1, 2015	$ (79,288)
Realized and unrealized gains/losses on interest rate swaps, net	(840)
Fair value at December 31, 2015	(80,128)
Realized and unrealized gains/losses on interest rate swaps, net	6,984
Fair value at December 31, 2016	$ (73,144)

PH transfers assets and liabilities in and/or out of Level 3 as significant inputs, including performance attributes, used for the fair value measurement become observable or unobservable. As of December 31, 2015, the credit valuation adjustment was $4,376 and significant relative to the fair value on the same swaps and resulted in maintaining the Level 3 classification. As of December 31, 2016, the credit valuation adjustment was $4,522 and significant relative to fair value on the same swaps and resulted in maintaining the Level 3 classification.

Note 6. Net Patient Care Service Revenue and Accounts Receivable

Certain agreements with third-party payors provide for payments at amounts different from established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare – Certain inpatient care services are paid at prospectively determined rates per discharge based on clinical, diagnostic, and other factors. Certain services are paid based on cost reimbursement methodologies subject to certain limits. Physician services are reimbursed based upon established fee schedules. Outpatient services are reimbursed using prospectively determined rates.

Medicaid – Reimbursements for Medicaid services are generally paid at prospectively determined rates per discharge, per occasion of service, or per covered member.

Other – Payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations provide for payment using prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Differences between established rates and payment under these agreements are reflected as contractual allowances.

Medicare and Medicaid revenue accounted for approximately 27% and 11%, respectively, of patient service revenue (net of contractual allowances and discounts) for the year ended December 31, 2016, and approximately 26% and 10%, respectively, for the year ended December 31, 2015. Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. The Corporation believes that it is in substantial compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of wrongdoing. While no such regulatory inquiries have been made, compliance with health care industry laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action, including fines, penalties, and exclusion from the Medicare and Medicaid programs. As a result, there is at least a reasonable possibility that recorded estimated settlements could change. It is also reasonably possible that recorded settlements could change by a material amount in the near term. PH received Medicare and Medicaid settlements and resolutions on prior year filed and appealed cost reports and other matters, which increased net patient care service revenue by $1,830 and $1,349 in 2016 and 2015, respectively.

The Corporation has determined, based on an assessment at the reporting-entity level, that the patient care service revenue is primarily recorded prior to assessing the patient's ability to pay, and as such, the entire provision for bad debts is recorded as a deduction from net patient care service revenue in the accompanying consolidated statements of operations and changes in net assets.

(Dollars in Thousands)

Note 6. Net Patient Care Service Revenue and Accounts Receivable (Continued)

The composition of net patient care service revenue (net of contractual allowance and discounts, but before the provision for bad debts) by payor for the years ended December 31 is as follows:

	2016	2015
Medicare	$ 417,411	$ 383,166
Medicaid	163,071	139,162
Managed care and other insurers	870,653	830,477
Uninsured	39,765	74,864
Other	40,412	26,830
	$ 1,531,312	$ 1,454,499

The allowance for bad debts was approximately $79,034 and $65,249 as of December 31, 2016 and 2015, respectively. These balances as a percentage of accounts receivable, net of contractual adjustments and other discounts, were approximately 28% and 27% as of December 31, 2016 and 2015, respectively. The increase in the allowance for bad debts during 2016 was primarily the result of increases within the write-off experience of insured payers. A summary of activity in the allowance for bad debts follows:

	Balance, Beginning of Year	Provision	Accounts Written Off, Net of Recoveries and Other	Balance, End of Year
Allowance for bad debts:				
December 31, 2015	$ 68,157	$ 116,964	$ (119,872)	$ 65,249
December 31, 2016	65,249	110,744	(96,959)	79,034

Components of patient accounts receivable, net, at December 31, 2016 and 2015, include Medicare, 19% and 18%, respectively; Medicaid, 4% and 7%, respectively; commercial insurers, 68% and 66%, respectively; and other, 9% and 9%, respectively. One managed care payor represented 26% and 23% of patient accounts receivable at December 31, 2016 and 2015, respectively.

Note 7. Investments

PH's investments are exposed to various kinds and levels of risk. Fixed income securities expose PH to interest rate risk, credit risk, and liquidity risk. As interest rates change, the value of many fixed income securities is affected, particularly those with fixed interest rates. Credit risk is the risk that the obligor of the security will not fulfill its obligation. Liquidity risk is affected by the willingness of market participants to buy and sell given securities. Certain investment funds held contain a 45-day to 90-day redemption notice requirement with up to a one year lock up period.

Equity securities expose PH to market risk, performance risk, and liquidity risk. Market risk is the risk associated with major movements of the equity markets, both foreign and domestic. Performance risk is the risk associated with a particular company's operating performance. Liquidity risk, as previously defined, tends to be higher for international equities and small capitalization equity companies.

(Dollars in Thousands)

Note 7. Investments (Continued)

Hedge funds also expose PH to market, performance, and liquidity risk. Hedge funds are not necessarily readily marketable. The funds often employ complex strategies, including short sales on securities and trading on futures contracts, options, foreign currency contracts, other derivative instruments, and private equity investments, and the composition of the individual investments within these funds is not readily determinable. The hedge fund investments are partnership interests in limited partnerships. These investments are not publicly traded, and the net asset value, or NAV, is based upon information provided by the fund manager. The hedge funds have restrictions on the timing of withdrawals ranging from one to three months, which may reduce liquidity. As of December 31, 2016, $0 was committed for the purchase of additional hedge funds and additional commingled funds.

The real estate investments are recorded at cost, less impairment charges recognized to date, and present valuation risks as they are not actively traded. Additionally, these investments present a concentration of risk, as they are held within the same geographic region, northeast Indiana.

Composition
The composition of investment return recognized in the consolidated statements of operations and changes in net assets and its presentation are as follows:

	2016	2015
Investment income:		
Unrealized gain (losses) on investments, net	$ 34,253	$ (32,948)
Dividend and interest income	15,223	11,743
Net realized gains on the sale of investments	6,998	1,597
Total investment return	$ 56,474	$ (19,608)
Presentation:		
Other revenue	$ 528	$ 13
Temporarily restricted – investment gain	97	51
Interest, dividends, and realized gains on sales of investments, net	21,750	12,830
Unrealized gain (losses) on investments, net	34,099	(32,502)
Total investment return	$ 56,474	$ (19,608)

(Dollars in Thousands)

Note 8. Property and Equipment

The costs of property and equipment consist of the following:

	2016	2015
Land and improvements	$ 142,904	$ 136,872
Buildings	862,548	830,072
Equipment	725,270	717,507
Construction in progress and items not yet placed into service	65,129	34,190
	$ 1,795,851	$ 1,718,641

The cost of commitments to complete construction-in-progress projects is estimated to be $102,804 at December 31, 2016. Depreciation expense recorded in the consolidated statements of operations and changes in net assets was $87,988 and $82,220 at December 31, 2016 and 2015, respectively.

Amortization expense on leasehold improvements recorded in the consolidated statements of operations and changes in net assets was $2,658 and $2,156 in 2016 and 2015, respectively. Amortization expense on other intangibles recorded in the consolidated statements of operations and changes in net assets was $1,222 and $1,218 in 2016 and 2015, respectively. Amortization expense on capital leases recorded in the consolidated statements of operations and changes in net assets was $3,509 and $4,785 in 2016 and 2015, respectively. Assets under capital leases at December 31, 2016 and 2015, were $11,573 and $29,163, respectively. Accumulated amortization on assets under capital leases at December 31, 2016 and 2015, was $4,280 and $18,491, respectively.

(Dollars in Thousands)

Note 9. Long-Term Debt

Long-term debt consists principally of tax-exempt bonds as follows:

	Interest rate as of December 31, 2016	2016	2015
Tax-exempt, variable rate bonds:			
Series 2016B due through 2046	1.19%	$ 12,789	$ -
Series 2016C due through 2040	1.08%	26,535	-
Series 2010A refunded in 2016	-	-	27,280
Series 2009BCD due through 2031	0.68-0.72%	223,665	223,665
Series 2007 due through 2032	0.77%	18,810	19,610
Series 2001 due through 2031	0.65%-1.12%	10,875	12,350
Tax-exempt, fixed rate serial and term bonds:			
Series 2016A due through 2041	3.20%	25,000	-
Series 2012A due through 2029	2.0%–5.0%	79,255	81,255
Series 2009A due through 2031	5.0%–5.75%	157,185	174,975
Various notes to banks	Various	49,822	61,959
Mortgages on real estate	Various	9,416	9,628
Other	Various	581	113
Capital leases	Various	7,323	5,498
		621,256	616,333
Unamortized original issue premium (discount), net		3,887	4,424
Unamortized deferred financing costs, net		(2,229)	(2,105)
		622,914	618,652
Less current portion		27,251	27,998
		$ 595,663	$ 590,654

(Dollars in Thousands)

Note 9. Long-Term Debt (Continued)

Following are the scheduled maturities and mandatory redemptions of long-term debt, assuming successful remarketing of variable rate bonds, and renewal of letter of credit agreements, as discussed below. If the bonds are not successfully remarketed and the letter of credit agreements are not renewed or drawn on, the annual maturities shown below may be materially different.

Year Ending December 31:	
2017	$ 27,251
2018	35,028
2019	44,682
2020	21,044
2021	20,644
Thereafter	472,607
	$ 621,256

Total interest paid was $18,834 and $18,168 in 2016 and 2015, respectively. Interest cost of $453 and $296 in 2016 and 2015, respectively, was capitalized as part of the cost of construction.

Obligations through use of Master Indenture
PH and PVH have issued tax-exempt revenue, revenue refunding, private placement, auction revenue, and variable rate demand bonds through the use of a Master Indenture, as amended and supplemented. The various agreements require PH and PVH not to incur indebtedness secured by an encumbrance and not to mortgage certain facilities except under certain circumstances. The agreements require the maintenance of debt service coverage ratios and contain certain other restrictive covenants.

On August 17, 2016, PWB issued $25,000 of fixed rate tax-exempt private placement bonds (the Series 2016A Bonds) using the Master Indenture and through the Indiana Finance Authority. The proceeds of the bonds and certain other funds will be used to finance construction and furnishings of the new Parkview Wabash Hospital facility. Interest on the Series 2016A Bonds is paid semiannually. The bonds mature in November 2041.

On August 17, 2016, PH issued variable rate, tax exempt private placement bonds (the Series 2016B Bonds) using the Master Indenture and through the Indiana Finance Authority. A total of $58,000 is available under this facility, of which $12,789 was drawn and outstanding as of December 31, 2016. The proceeds of the bonds and certain other funds will be used to finance construction and furnishings of the Parkview Cancer Institute on the PRMC campus. Interest on the Series 2016B Bonds is paid monthly. The bonds mature in November 2046, but contain a ten-year put option that expires in August 2026.

On August 17, 2016, PH issued $27,280 of variable rate, tax exempt private placement bonds (the Series 2016C Bonds) using the Master Indenture and through the Indiana Finance Authority. The proceeds of the bonds were used to refund all of the outstanding Indiana Finance Authority Series 2010A bonds. Interest on the Series 2016C Bonds is paid monthly. The bonds mature in November 2040, but contain a seven-year put option that expires in August 2023.

On May 24, 2012, PH and PVH issued $85,115 of fixed rate tax-exempt revenue bonds (the Series 2012A Bonds) using the Master Indenture and through the Indiana Finance Authority. The proceeds of the bonds were used to refund all of the remaining Series 1998 Bonds, legally defease $37,335 of the Series 2009A Bonds, and pay financing costs. Interest on the Series 2012A Bonds is paid semiannually. The Series 2012A Bonds mature through May 2029.

Note 9. Long-Term Debt (Continued)

In August 2009, PH and PVH issued $265,530 of fixed rate, tax-exempt revenue bonds (the Series 2009A Bonds) and $223,665 of variable rate, tax-exempt revenue bonds (the Series 2009B Bonds, the Series 2009C Bonds, and the Series 2009D Bonds) using the Master Indenture and through the Indiana Finance Authority. The proceeds of the bonds were used to refund all but $19,425 of the outstanding Indiana Health Facility Financing Authority Revenue Bonds, Series 2001A, 2001B, and 2001C (collectively, the Series 2001 Bonds); refund all of the outstanding Indiana Health and Educational Facility Financing Authority Revenue Bonds, Series 2005A and 2005B (collectively, the Series 2005 Bonds); pay certain costs related to the termination of a portion of swaps related to the Series 2001 Bonds; pay costs of issuance and costs of refunding; and finance, refinance, or reimburse certain costs for capital expenditures at the PVH facilities. Interest on the Series 2009A Bonds is paid semiannually. The Series 2009BCD Bonds bear interest weekly, and interest is paid monthly. The Series 2009A Bonds mature through May 2031. The Series 2009BCD Bonds mature through November 2039.

PH entered into four direct-pay Letter of Credit agreements (the LOCs) issued by PNC Bank (Series 2007 Bonds), Sumitomo Mitsui Banking Corporation (Series 2009C Bonds) and Wells Fargo Bank (Series 2009B&D Bonds) to enhance the marketability of the bonds. Under the terms of the LOCs, if bonds are not successfully remarketed and thereby purchased by the banks, the principal maturities of the bonds purchased are accelerated over the subsequent three-year period commencing at least one year and one day from the draw on the LOC, and PH would pay a defined rate, based on a formula in the agreements, at a minimum rate of 7.5%. The current Series 2007A, Series 2009B, and 2009D LOCs expire July 20, 2019, and the 2009C LOC was closed on July 22, 2016. At December 31, 2016, all bonds had been successfully remarketed.

On March 15, 2007, PLH issued $24,930 of adjustable rate, tax-exempt revenue bonds (the Series 2007 Bonds). These bonds were issued through the Indiana Health and Education Facility Financing Authority. The proceeds of the Series 2007 Bonds and certain other funds of PLH were used to finance the construction and furnishing of a new hospital facility and to pay financing costs. The Series 2007 Bonds bear interest at a weekly rate, and interest is paid monthly. The Series 2007 Bonds mature through March 2032.

In November 2001, PH and PVH issued $220,000 of variable rate, tax-exempt auction revenue bonds (the Series 2001 Bonds) using the Master Indenture and through the Indiana Health Facility Financing Authority. These Series 2001 Bonds auction every 28 days. The bonds have a maximum rate of 15%. Beginning in February 2008 and continuing through December 31, 2016, PH's Series 2001 Bonds failed to attract sufficient bids to be remarketed, and have not been successfully remarketed since. As a result of the failed auctions, interest rates are set based upon a formula contained in the bond documents. The interest rate formula is based upon the 7-day AA Composite Commercial Paper rate times a factor. This factor can vary from 125% to 225%, depending upon the credit rating of the bond. The bond rating is equal to the rating of either the insurer of the debt or the issuer, whichever is higher. At December 31, 2016 and 2015, the factor was 175%. The Series 2001 Bonds are secured by a financial guaranty insurance policy provided by Ambac Assurance Corporation (Ambac). Ambac's rating has been withdrawn by Moody's, while PH has been upgraded by Moody's to rating of Aa3. The Series 2001 Bonds mature through November 2031.

Term loan

On December 31, 2012, the ONE surgery center acquisition was completed and the transaction was financed through execution of a fully amortizable five-year loan with a bank in the amount of approximately $37,900. The loan has a floating rate with interest computed monthly based on the 30-day LIBOR plus 160 basis points. The loan is collateralized by all personal property assets of Orthopaedic Hospital at Parkview North, LLC.

Note 9. Long-Term Debt (Continued)

NMTC financing
In December 2014, PH entered into a New Markets Tax Credit (NMTC) financing transaction to fund a portion of the construction of a new medical complex in Warsaw, Indiana. The new complex will be reported as part of Parkview Whitley Hospital. The NMTC structure includes PH, as a leveraged lender, and a tax credit investor formed for purposes of this transaction. As part of this structure, PH made a $6,894 leveraged loan to an investment fund where, when coupled with a capital contribution from another party and after deducting certain fees, two loans were made to Parkview Whitley Hospital for a combined $9,700. The notes on these loans bear interest of 1% and mature in 2044. Interest-only payments are made during the first seven years of the notes. This transaction includes a put/call provision that becomes effective at the end of the seven-year compliance/recapture period by which the structure is unwound and all loans and obligations will be satisfied.

Debt guarantees
At December 31, 2016 and 2015, the Corporation had guaranteed approximately $2,511 and $1,862, respectively, of certain outstanding debt obligations of unconsolidated entities. If the unconsolidated entities default on their debt obligation, the Corporation would then be responsible for the obligation. At December 31, 2016 and 2015, the Corporation has no amounts accrued related to these guarantees.

Note 10. Interest Rate Swaps and Other Derivatives

PH uses a combination of interest rate swap agreements with the objective to mitigate the impact interest rate fluctuations have on its interest payments. PH uses fixed payor, fixed spread basis, fixed receiver, and forward fixed payor contracts entered into with various third parties. Interest rate swap contracts between PH and a third party (counterparty) provide for the periodic exchange of payments between the parties based on changes in a defined index and a fixed rate and include counterparty credit risk. This is the risk that contractual obligations of the counterparties will not be fulfilled. Concentrations of credit risk relate to groups of counterparties that have similar economic or industry characteristics that would cause their ability to meet contractual obligations to be similarly affected by changes in economic or other conditions. Counterparty credit risk is managed by requiring high credit standards for PH's counterparties. The counterparties to these contracts are financial institutions that carry investment-grade credit ratings. The interest rate swap contracts contain collateral provisions applicable to both parties to mitigate credit risk. PH does not anticipate nonperformance by its counterparties. The interest rate swap agreements require PH to post collateral if the liability balance, depending on the counterparty, is greater than $15,000 to $30,750. No collateral was required to be posted by PH at December 31, 2016 and 2015. PH's policy is to present the collateral on a gross basis in the consolidated balance sheets.

(Dollars in Thousands)

Note 10. Interest Rate Swaps and Other Derivatives (Continued)

The following table is a summary of the outstanding positions under these interest rate swap agreements at December 31:

Expiration Date	PH Pays	PH Receives	Notional Amount 2016	Notional Amount 2015
2020-2031	3.47% - 3.71%[1]	67% of one-month LIBOR	$ 32,025	$ 33,500
2028-2033	3.26% - 3.49%[1]	62.4% of one-month LIBOR + 0.29% margin	155,445	159,305
2016	BMA/SIFMA Index[2]	4.005%	-	30,000
2037	3.81%[3]	61.8% of one-month LIBOR + 0.31% margin	145,615	146,290
2025	BMA/SIFMA Index[4]	68% of one-month LIBOR + 0.514%-0.52% margin	120,000	120,000
			$ 453,085	$ 489,095

(1) The objective of these five interest rate swaps is to mitigate interest rate fluctuations and synthetically fix certain variable rate exposure.
(2) The objective of this interest rate swap was to create a basis swap.
(3) The objective of these two interest rate swaps is to mitigate interest rate fluctuations and synthetically fix certain variable rate exposure.
(4) The objective of these two interest rate swaps is to take advantage of yield curve differences and mitigate risk on future bond offerings. These interest rate swaps are not associated with outstanding debt.

(Dollars in Thousands)

Note 10. Interest Rate Swaps and Other Derivatives (Continued)

The fair value of derivative instruments is as follows:

Derivatives Not Designated as Hedging Instruments	Balance Sheet Classification	December 31 2016	December 31 2015
Interest rate swap agreements	Interest rate swaps (Other assets)	$ 1,732	$ 4,203
Interest rate swap agreements	Interest rate swaps (Noncurrent liabilities)	(73,144)	(80,128)
		$ (71,412)	$ (75,925)

The effects of derivative instruments on the consolidated statements of operations and changes in net assets are as follows:

Derivatives Not Designated as Hedging Instruments	Location of Gain (Loss) on Derivatives Recognized in Excess of Revenue Over Expenses	Amount of Gain (Loss) on Derivatives Recognized in Excess of Revenue Over Expenses December 31 2016	December 31 2015
Interest rate swap agreements - unrealized gain (loss)	Unrealized gains (losses) on interest rate swaps, net	$ 4,456	$ (224)
Interest rate swap agreements - settlement payments	Other, net - nonoperating	(9,226)	(9,075)
		$ (4,770)	$ (9,299)

Interest rate swap settlement payments, net were $9,390 and $9,186 in 2016 and 2015, respectively, of which $164 and $111 was capitalized as part of the cost of construction in 2016 and 2015, respectively.

(Dollars in Thousands)

Note 11. Pension Plans

Defined benefit pension plan
The Corporation sponsors a noncontributory defined benefit pension plan (the Plan) covering eligible employees employed prior to January 2005. Plan benefits are based on years of service and an employee's compensation during a consecutive five-year term of employment within the ten years prior to benefit determination, which results in the highest earnings.

The following table sets forth the changes in projected benefit obligation and changes in plan assets for the years ended December 31 and the funded status of the Plan and accrued pension obligation as of December 31 as actuarially determined:

	2016	2015
Change in projected benefit obligation:		
Projected benefit obligation at beginning of year	$ 465,276	$ 471,380
Service cost	8,674	9,609
Interest cost	20,186	19,096
Actuarial gain	(6,242)	(21,788)
Benefits paid	(14,493)	(13,021)
Projected benefit obligation at end of year	473,401	465,276
Change in plan assets:		
Plan assets at fair value at beginning of year	371,196	389,710
Actual return on plan assets	25,872	(5,493)
Benefits paid	(14,493)	(13,021)
Plan assets at fair value at end of year	382,575	371,196
Funded status of the Plan (recognized as accrued pension obligations)	$ (90,826)	$ (94,080)

Items included in unrestricted net assets that have not yet been recognized as a component of net periodic pension cost at December 31 are as follows:

	2016	2015
Unrecognized net actuarial loss	$ 135,581	$ 151,876
Unrecognized prior service cost	12	33
	$ 135,593	$ 151,909

(Dollars in Thousands)

Note 11. Pension Plans (Continued)

Changes in plan assets and benefit obligation recognized in unrestricted net assets during the years ended December 31 include the following:

	2016	2015
Current year actuarial gain (loss)	$ 5,455	$ (12,898)
Current year amortization of actuarial loss	10,839	11,711
Current year amortization of prior service cost	22	22
	$ 16,316	$ (1,165)

The actuarial loss and prior service cost included in unrestricted net assets and expected to be recognized in the net periodic pension cost during the year ending December 31, 2017, total $11,040 and $12, respectively.

Net periodic benefit cost included in salaries and benefits expense during the years ended December 31 consists of the following:

	2016	2015
Service cost	$ 8,674	$ 9,609
Interest cost	20,186	19,096
Expected return on plan assets	(26,658)	(29,193)
Amortization of unrecognized net loss	10,839	11,711
Amortization of unrecognized prior service cost	22	22
Net periodic benefit cost	$ 13,063	$ 11,245

The accumulated benefit obligation at December 31, 2016 and 2015 was $449,367 and $435,395, respectively.

The weighted-average assumptions used to determine benefit obligations at December 31 and net periodic benefit costs for the years then ended are as follows:

	2016	2015
Assumptions – benefit obligations:		
Discount rate	4.34%	4.41%
Rate of compensation increase	3.00	3.00
Assumptions – net periodic benefit cost:		
Discount rate	4.41%	4.11%
Expected return on plan assets	7.00	7.50
Rate of compensation increase	3.00	3.00

(Dollars in Thousands)

Note 11. Pension Plans (Continued)

The amortization of any prior service cost is determined using a straight-line amortization of the cost over the average remaining service period of employees expected to receive benefits under the Plan. The discount rate was changed from 4.41% to 4.34% for 2016. This change had the impact of increasing the projected benefit obligation by approximately $4,600.

In 2016, a change from the RP-2014 Healthy Annuitant Male and Female mortality tables with a generational improvement projection scale MP-2015 to the RP-2014 Healthy Annuitant Male and Female mortality tables with a generational improvement projection scale MP-2016 was made in the calculation of the benefit obligation. This change from the MP-2015 scale to the MP-2016 scale had the impact of decreasing the projected benefit obligation by approximately $6,500.

The principal long-term determinant of a portfolio's investment return is its asset allocation. The Plan's allocation is currently weighted toward growth assets (58%) versus fixed income (42%). The Corporation's policy on investment allocation for the Plan consists of an allocation of 35% to 75% for growth investments and 30% to 60% for fixed income investments. Within the growth investment classification, the Plan's asset strategy encompasses equity and equity-like instruments that are of both public and private market investments. These equity and equity-like instruments are public equity securities that are well diversified and invested in U.S. and international companies. Management believes its active strategies have added value relative to passive benchmark returns. The expected long-term rate of return assumption is based on the mix of assets in the Plan, the long-term earnings expected to be associated with each asset class, and the additional return expected through active management. This assumption is periodically benchmarked against peer plans.

The Plan's weighted-average asset allocations at December 31, by asset category, are as follows:

	2016	2015
Real estate investment trust	5 %	5 %
Real estate investment fund	4	4
Commingled funds	22	23
International equities	4	7
Domestic equities	21	17
Mortgage- and asset-backed securities	9	10
Corporate bonds	9	9
Municipal bonds	2	1
Mutual funds – equity	16	15
Mutual funds – balanced	4	3
US government and agency obligations	2	4
Cash and short-term investments	1	1
Guaranteed investment contract	1	1
	100 %	100 %

(Dollars in Thousands)

Note 11. Pension Plans (Continued)

The fair value of pension plan assets was determined using the following inputs at December 31, 2016:

		Fair Value Measurements Using		
	Fair Value	Level 1	Level 2	Level 3
International equity	$ 15,760	$ 15,760	$ -	$ -
Domestic equity	80,508	71,352	9,156	-
Mortgage- and asset-backed securities	34,584	-	34,584	-
Municipal bonds	6,569	-	6,569	-
Corporate bonds	34,412	-	34,412	-
Mutual funds - equity	62,208	62,208	-	-
Mutual funds - balanced	13,557	13,557	-	-
US government and agency obligations	9,473	9,473	-	-
Cash and short-term investments	5,537	15	5,522	-
Guaranteed investment contract	2,808	-	-	2,808
	265,416	$ 172,365	$ 90,243	$ 2,808
Investments not at fair value:				
Real estate investment trust	19,602			
Real estate investment fund	17,101			
Commingled funds	80,764			
Amount due to brokers	(308)			
Total investments	$ 382,575			

The fair value of pension plan assets was determined using the following inputs at December 31, 2015:

		Fair Value Measurements Using		
	Fair Value	Level 1	Level 2	Level 3
International equity	$ 23,768	$ 16,377	$ 7,391	$ -
Domestic equity	64,149	63,879	270	-
Mortgage- and asset-backed securities	37,817	-	37,817	-
Municipal bonds	5,097	-	5,097	-
Corporate bonds	33,529	-	33,529	-
Mutual funds - equity	55,614	55,614	-	-
Mutual funds - balanced	11,736	11,736	-	-
US government and agency obligations	12,440	11,916	524	-
Cash and short-term investments	4,423	4,423	-	-
Guaranteed investment contract	4,938	-	-	4,938
	253,511	$ 163,945	$ 84,628	$ 4,938
Investments not at fair value:				
Real estate investment trust	18,130			
Real estate investment fund	15,853			
Commingled funds	83,702			
Total investments	$ 371,196			

(Dollars in Thousands)

Note 11. Pension Plans (Continued)

Fair value methodologies for Level 1 and Level 2 investments are consistent with the inputs described in Note 4. The fair value of the Level 3 interest in the guaranteed investment contract (GIC) is based on information reported by the issuer of the GIC at year-end.

The following table is a rollforward of the pension plan assets classified within Level 3 of the valuation hierarchy:

	Financial Assets
Fair value at January 1, 2015	$ 5,253
Purchases, issuances, and settlements	(577)
Actual return on plan assets	262
Fair value at December 31, 2015	4,938
Purchases, issuances, and settlements	(2,402)
Actual return on plan assets	272
Fair value at December 31, 2016	$ 2,808

Estimated future benefit payments are as follows:

Year ending December 31:	
2017	$ 17,177
2018	18,863
2019	20,441
2020	22,060
2021	23,574
2022 - 2026	138,590

The Corporation expects to make no contributions to its defined benefit pension plan in 2017.

Defined contribution and other pension plans
Eligible employees hired after December 31, 2004, and employees who were active at December 31, 2004, and elected at that time to participate in the defined-contribution plan and freeze their benefits in the defined benefit plan, participate in the defined contribution plan. The accrued liability for the defined contribution pension plan is $19,178 and $16,797 at December 31, 2016 and 2015, respectively, and is recorded as a current liability on the consolidated balance sheets. During 2016 and 2015, expense for this plan totaled $19,265 and $16,799, respectively, and is included in salaries and benefits expense.

Contributions to the tax-sheltered annuity and 401(k) plans are based on a percentage of eligible employee salaries, as defined. The contributions for the tax-sheltered annuity and 401(k) plans were $9,308 and $8,714 in 2016 and 2015, respectively, and were reported as salaries and benefits expense.

Note 12. Malpractice Insurance

The Corporation and its affiliates are subject to pending and threatened legal actions that arise in the normal course of their activities. Medical malpractice coverage is provided through a program of self-insurance and commercial insurance and considers limitations imposed by the Indiana Medical Malpractice Act, as amended (the Act). The Act limits the amount of individual claims to $1,250 (effective July 1, 1999), of which $1,000 would be paid by the State of Indiana Patient Compensation Fund and $250 by the Corporation or by its commercial insurer, The Medical Protective Company.

Malpractice claims for incidents that may give rise to litigation have been asserted against the Corporation by various claimants. The claims are in various stages of resolution, and some may ultimately be brought to trial. There are also reported incidents that have occurred through December 31, 2016, which may result in the assertion of additional claims. There may be other claims from unreported incidents arising from services provided to patients. The liability for medical malpractice includes amounts for claims and related legal expenses for these incurred but not reported incidents. This liability is actuarially determined by combining industry data and the Corporation's historical experience. Accrued malpractice losses and insurance recovery receivables have been discounted at 4% in 2016 and 2015 and, in management's opinion, provide adequate reserve for loss contingencies. The Corporation recorded receivable balances to reflect the expected recovery from commercial insurance coverage. The Corporation is reporting receivables of $756 and $580 in prepaid expenses and other current assets at December 31, 2016 and 2015, respectively, and $1,070 and $910 in other assets at December 31, 2016 and 2015, respectively. The Corporation has recorded malpractice liabilities of $2,243 and $2,013 in accounts payable and accrued expenses as of December 31, 2016 and 2015, respectively, and $6,236 and $5,904 at December 31, 2016 and 2015, respectively, in other liabilities in the consolidated balance sheets.

The Corporation established a revocable, restricted trust for claims not covered by commercial insurance for the purpose of setting aside assets based on actuarial funding recommendations. Under the trust agreements, the trust assets can only be used for payment of malpractice and general liability losses, related expenses, and the cost of administering the trust. The balance of the trust was $5,845 and $4,349 at December 31, 2016 and 2015, respectively. The trust is included in Investments – Funds held by trustees in the consolidated balance sheets.

(Dollars in Thousands)

Note 13. Commitments and Contingencies

Certain property and equipment are leased using noncancelable operating and capital lease arrangements. Rental expense associated with the operating leases was $21,015 and $19,938 in 2016 and 2015, respectively. The leases expire in various years through 2027. Future minimum lease payments required under noncancelable operating and capital leases for property and equipment as of December 31, 2016, are as follows:

	Operating Leases	Capital Leases
Year ending December 31:		
2017	$ 6,465	$ 2,546
2018	4,979	2,110
2019	3,627	1,440
2020	2,366	1,284
2021	1,946	528
Thereafter	7,676	8
Total minimum lease payments	$ 27,059	7,916
Less amount representing interest		(593)
Present value of net minimum lease payments		$ 7,323

PVH owns the Ortho Hospital building and leases the space to ORTHO under a non-cancelable operating lease that expires in 2017. ORTHO owns the Parkview Surgery One building and leases it to Parkview Ortho Center LLC under a non-cancelable operating lease that expires in 2025. PH has 60% ownership of ORTHO, which owns the Parkview Ortho Center LLC. Rental revenue and expense associated with these leases are eliminated in consolidation, and the related future minimum lease payments have been excluded from the above table.

During 2016, PH entered into a seven-year agreement with a lab testing system vendor which involves a commitment for the purchase of supplies and the use of various lab testing equipment. This agreement will be recorded in 2017 when the system is placed in service. The contract commitment is estimated at approximately $15,300 over the seven-year term of the agreement.

Note 14. Functional Expenses

The Corporation, as an integrated health care delivery system, provides and manages the health care needs of its patients. Aggregate direct expenses for these services as a percentage of total expenses were approximately 91% for each of the years ended December 31, 2016 and 2015.

Note 15. Indiana Medicaid Disproportionate Share

Under Indiana law (IC 12-15-16 (1-3)), health care providers qualifying as State of Indiana Medicaid Acute Disproportionate Share and Medicaid Safety Net Hospitals (DSH providers) are eligible to receive Indiana Medicaid Disproportionate Share (State DSH) payments. The amount of these additional State DSH funds is dependent on regulatory approval by agencies of the federal and state governments and is determined by the level, extent, and cost of uncompensated care (as defined) and various other factors. State DSH payments are paid according to the fiscal year of the state, which ends on June 30 of each year, and are based on the cost of uncompensated care provided by the DSH providers during their respective fiscal year ended during the state fiscal year.

In 2016, PH recognized $985 in income from Indiana Medicaid Disproportionate Share payments, $0 of which pertained to state fiscal year 2016. In 2015, PH recognized $2,638 in income from Indiana Medicaid Disproportionate Share payments, $755 of which pertained to state fiscal year 2015.

At December 31, 2016 and 2015, PH had no State DSH payments receivable recorded.

Note 16. Indiana Hospital Assessment Fee Program

In May 2012, the Indiana Hospital Assessment Fee program (HAF) was approved by the federal Centers for Medicare & Medicaid Services (CMS) through June 30, 2017. Under HAF, Indiana hospitals receive additional federal Medicaid funds for the state's health care system, administered by the Indiana Family and Social Services Administration. HAF includes both a payment to the hospitals from the state and an assessment against the hospitals, which is paid to the state the same year.

Payments to PH recognized for the year ended December 31, 2016, totaled $43,076 and assessments against PH for the same period were $38,090.

Payments to PH recognized for the year ended December 31, 2015, totaled $45,658 and assessments against PH for the same period were $34,446.

HAF payments to PH are included in net patient service care revenue in the consolidated statements of operations and changes in net assets. HAF Assessments against PH are included in operating expense in the consolidated statements of operations and changes in net assets.

Note 17. Subsequent Events

PH has evaluated subsequent events for potential recognition and/or disclosure through March 22, 2017, the date the consolidated financial statements were issued.

Supplementary Information

Parkview Health System, Inc. and Subsidiaries
d/b/a Parkview Health

Details of Consolidated Balance Sheet – Including Obligated Group and Credit Group
December 31, 2016
(In Thousands)

	Obligated Group	Designated Affiliates	Eliminations	Total Credit Group	Other	Eliminations	Consolidated
Assets							
Current assets:							
Cash and cash equivalents	$ 94,831	$ 2,595	$ -	$ 97,426	$ 2,606	$ -	$ 100,032
Short-term investments	306	-	-	306	-	-	306
Patient accounts receivable, net	161,381	10,067	-	171,448	22,658	(10,629)	183,477
Inventories	21,598	603	-	22,201	968	-	23,169
Prepaid expenses and other current assets	49,710	(25,223)	(16,842)	7,645	17,946	(199)	25,392
Estimated third-party payor settlements	2,964	84	-	3,048	912	-	3,960
Total current assets	330,790	(11,874)	(16,842)	302,074	45,090	(10,828)	336,336
Investments:							
Board-designated investments	838,681	-	-	838,681	97,375	-	936,056
Funds held by trustees	26,432	23,537	-	49,969	-	-	49,969
Other investments	-	-	-	-	789	-	789
	865,113	23,537	-	888,650	98,164	-	986,814
Property and equipment:							
Cost	1,653,644	63,346	-	1,716,990	78,861	-	1,795,851
Less accumulated depreciation and amortization	706,836	26,007	-	732,843	37,870	-	770,713
	946,808	37,339	-	984,147	40,991	-	1,025,138
Other assets:							
Interest rate swaps	1,732	-	-	1,732	-	-	1,732
Investments in joint ventures	2,188	-	-	2,188	-	-	2,188
Goodwill and intangible assets, net	97,010	5,011	-	102,021	1,086	-	103,107
Other assets	43,180	-	4,700	47,880	11,228	(22,762)	36,346
	144,110	5,011	4,700	153,821	12,314	(22,762)	143,373
Total assets	$ 2,286,821	$ 54,013	$ (12,142)	$ 2,328,692	$ 196,559	$ (33,590)	$ 2,491,661

Parkview Health System, Inc. and Subsidiaries
d/b/a Parkview Health

Details of Consolidated Balance Sheet – Including Obligated Group and Credit Group (Continued)
December 31, 2016
(In Thousands)

	Obligated Group	Designated Affiliates	Eliminations	Total Credit Group	Other	Eliminations	Consolidated
Liabilities and Net Assets							
Current liabilities:							
Accounts payable and accrued expenses	$ 81,391	$ 4,487	$ -	$ 85,878	$ 16,310	$ (10,828)	$ 91,360
Salaries, wages and related liabilities	97,714	1,021	-	98,735	2,934	-	101,669
Accrued interest	2,650	156	-	2,806	-	-	2,806
Estimated third-party payor settlements	3,872	1,283	-	5,155	59	-	5,214
Current portion of long-term debt	42,906	945	(16,842)	27,009	242	-	27,251
Total current liabilities	228,533	7,892	(16,842)	219,583	19,545	(10,828)	228,300
Noncurrent liabilities:							
Long-term debt, less current portion	542,217	43,005	-	585,222	10,441	-	595,663
Interest rate swaps	73,144	-	-	73,144	-	-	73,144
Accrued pension obligations	90,826	-	-	90,826	-	-	90,826
Other	17,623	5,896	4,700	28,219	6,557	(10,596)	24,180
	723,810	48,901	4,700	777,411	16,998	(10,596)	783,813
Net assets:							
Unrestricted net assets	1,303,321	(10,126)	-	1,293,195	152,188	(12,166)	1,433,217
Noncontrolling interest in subsidiaries	31,157	210	-	31,367	-	-	31,367
Total unrestricted net assets	1,334,478	(9,916)	-	1,324,562	152,188	(12,166)	1,464,584
Temporarily restricted net assets	-	7,136	-	7,136	6,284	-	13,420
Permanently restricted net assets	-	-	-	-	1,544	-	1,544
	1,334,478	(2,780)	-	1,331,698	160,016	(12,166)	1,479,548
Total liabilities and net assets	$ 2,286,821	$ 54,013	$ (12,142)	$ 2,328,692	$ 196,559	$ (33,590)	$ 2,491,661

Parkview Health System, Inc. and Subsidiaries
d/b/a Parkview Health

Details of Consolidated Balance Sheet – Including Obligated Group and Credit Group
December 31, 2015
(In Thousands)

	Obligated Group	Designated Affiliate	Eliminations	Total Credit Group	Other	Eliminations	Consolidated
Assets							
Current assets:							
Cash and cash equivalents	$ 150,166	$ 3	$ -	$ 150,169	$ 4,318	$ -	$ 154,487
Short-term investments	7,961	-	-	7,961	-	-	7,961
Patient accounts receivable, net	151,732	4,320	-	156,052	27,012	(7,964)	175,100
Inventories	19,068	264	-	19,332	1,057	-	20,389
Prepaid expenses and other current assets	56,879	(1,206)	(7,061)	48,612	(14,461)	(3,780)	30,371
Estimated third-party payor settlements	3,204	26	-	3,230	1,678	-	4,908
Total current assets	389,010	3,407	(7,061)	385,356	19,604	(11,744)	393,216
Investments:							
Board-designated investments	662,589	-	-	662,589	90,970	-	753,559
Funds held by trustees	25,446	-	-	25,446	-	-	25,446
Other investments	-	-	-	-	863	-	863
	688,035	-	-	688,035	91,833	-	779,868
Property and equipment:							
Cost	1,596,225	30,996	-	1,627,221	91,420	-	1,718,641
Less accumulated depreciation and amortization	664,827	14,062	-	678,889	41,077	-	719,966
	931,398	16,934	-	948,332	50,343	-	998,675
Other assets:							
Interest rate swaps	4,203	-	-	4,203	-	-	4,203
Investments in joint ventures	2,183	-	-	2,183	-	-	2,183
Goodwill and intangible assets, net	95,869	5,011	-	100,880	841	-	101,721
Other assets	39,550	-	3,887	43,437	42	(22,762)	20,717
	141,805	5,011	3,887	150,703	883	(22,762)	128,824
Total assets	$ 2,150,248	$ 25,352	$ (3,174)	$ 2,172,426	$ 162,663	$ (34,506)	$ 2,300,583

Parkview Health System, Inc. and Subsidiaries
d/b/a Parkview Health

Details of Consolidated Balance Sheet – Including Obligated Group and Credit Group (Continued)
December 31, 2015
(In Thousands)

	Obligated Group	Designated Affiliate	Eliminations	Total Credit Group	Other	Eliminations	Consolidated
Liabilities and Net Assets							
Current liabilities:							
Accounts payable and accrued expenses	$ 66,514	$ 630	$ -	$ 67,144	$ 18,819	$ (11,744)	$ 74,219
Salaries, wages and related liabilities	91,155	490	-	91,645	2,972	-	94,617
Accrued interest	2,587	12	-	2,599	-	-	2,599
Estimated third-party payor settlements	4,012	588	-	4,600	152	-	4,752
Current portion of long-term debt	33,803	859	(7,061)	27,601	397	-	27,998
Total current liabilities	198,071	2,579	(7,061)	193,589	22,340	(11,744)	204,185
Noncurrent liabilities:							
Long-term debt, less current portion	561,889	18,688	-	580,577	10,077	-	590,654
Interest rate swaps	80,128	-	-	80,128	-	-	80,128
Accrued pension obligations	94,080	-	-	94,080	-	-	94,080
Other	16,256	6,596	3,887	26,739	3,934	(10,596)	20,077
	752,353	25,284	3,887	781,524	14,011	(10,596)	784,939
Net assets:							
Unrestricted net assets	1,172,351	(2,617)	-	1,169,734	111,440	(12,166)	1,269,008
Noncontrolling interest in subsidiaries	27,473	-	-	27,473	427	-	27,900
Total unrestricted net assets	1,199,824	(2,617)	-	1,197,207	111,867	(12,166)	1,296,908
Temporarily restricted net assets	-	106	-	106	12,835	-	12,941
Permanently restricted net assets	-	-	-	-	1,610	-	1,610
	1,199,824	(2,511)	-	1,197,313	126,312	(12,166)	1,311,459
Total liabilities and net assets	$ 2,150,248	$ 25,352	$ (3,174)	$ 2,172,426	$ 162,663	$ (34,506)	$ 2,300,583

Parkview Health System, Inc. and Subsidiaries
d/b/a Parkview Health

Details of Consolidated Statement of Operations and Changes in Net Assets –
Including Obligated Group and Credit Group
Year Ended December 31, 2016
(In Thousands)

	Obligated Group	Designated Affiliates	Eliminations	Total Credit Group	Other	Eliminations	Consolidated
Revenues:							
Net patient care service revenue	$ 1,364,886	$ 74,024	$ (38)	$ 1,438,872	$ 212,471	$ (120,031)	$ 1,531,312
Provision for bad debts	(79,942)	(7,451)	-	(87,393)	(23,351)	-	(110,744)
Net patient care service revenue, less provision for bad debts	1,284,944	66,573	(38)	1,351,479	189,120	(120,031)	1,420,568
Capitation revenue	-	-	-	-	98,514	-	98,514
Other revenue	73,115	2,008	(13,825)	61,298	16,186	(32,311)	45,173
	1,358,059	68,581	(13,863)	1,412,777	303,820	(152,342)	1,564,255
Expenses:							
Salaries and benefits	743,095	25,528	-	768,623	71,685	(73,933)	766,375
Supplies	210,084	6,857	(379)	216,562	20,107	(12,754)	223,915
Purchased services	99,068	9,672	(2,552)	106,188	121,178	(58,121)	169,245
Utilities, repairs, and maintenance	52,701	2,475	(341)	54,835	5,487	-	60,322
Depreciation and amortization	84,331	6,541	-	90,872	4,505	-	95,377
Hospital assessment fee	34,228	1,168	-	35,396	2,694	-	38,090
Other	13,606	20,041	(10,591)	23,056	47,898	(7,534)	63,420
	1,237,113	72,282	(13,863)	1,295,532	273,554	(152,342)	1,416,744
Operating income (loss)	120,946	(3,701)	-	117,245	30,266	-	147,511

Parkview Health System, Inc. and Subsidiaries
d/b/a Parkview Health

Details of Consolidated Statement of Operations and Changes in Net Assets –
Including Obligated Group and Credit Group (Continued)
Year Ended December 31, 2016
(In Thousands)

	Obligated Group	Designated Affiliates	Eliminations	Total Credit Group	Other	Eliminations	Consolidated
Nonoperating income (expense):							
Interest, dividends and realized gains (losses) on sales of investments	$ 19,582	$ (5)	$ -	$ 19,577	$ 2,173	$ -	$ 21,750
Unrealized losses on investments, net	30,665	1	-	30,666	3,433	-	34,099
Interest expense	(17,832)	(520)	-	(18,352)	(131)	-	(18,483)
Unrealized losses on interest rate swaps, net	4,456	-	-	4,456	-	-	4,456
Other	(10,238)	12	-	(10,226)	43	-	(10,183)
Excess (deficit) of revenues over expenses	$ 147,579	$ (4,213)	$ -	$ 143,366	$ 35,784	$ -	$ 179,150
Excess (deficit) of revenues over expenses attributable to:							
Noncontrolling interest in subsidiaries	$ 30,764	$ 83	$ -	$ 30,847	$ -	$ -	$ 30,847
Parkview Health System, Inc. and subsidiaries	116,815	(4,296)	-	112,519	35,784	-	148,303
Other changes in net assets attributable to:							
Noncontrolling interest in subsidiaries	(27,080)	(300)	-	(27,380)	-	-	(27,380)
Parkview Health System, Inc. and subsidiaries	14,155	(3,128)	-	11,027	5,292	-	16,319
Increase (decrease) in net assets	134,654	(7,641)	-	127,013	41,076	-	168,089
Net assets (deficit):							
Beginning of year	1,199,824	4,861	-	1,204,685	106,774	-	1,311,459
End of year	$ 1,334,478	$ (2,780)	$ -	$ 1,331,698	$ 147,850	$ -	$ 1,479,548

Parkview Health System, Inc. and Subsidiaries
d/b/a Parkview Health

Details of Consolidated Statement of Operations and Changes in Net Assets –
Including Obligated Group and Credit Group
Year Ended December 31, 2015
(In Thousands)

	Obligated Group	Designated Affiliate	Eliminations	Total Credit Group	Other	Eliminations	Consolidated
Revenues:							
Net patient care service revenue	$ 1,277,852	$ 35,223	$ (33)	$ 1,313,042	$ 227,906	$ (86,449)	$ 1,454,499
Provision for bad debts	(86,436)	(4,435)	-	(90,871)	(26,093)	-	(116,964)
Net patient care service revenue, less provision for bad debts	1,191,416	30,788	(33)	1,222,171	201,813	(86,449)	1,337,535
Capitation revenue	-	-	-	-	57,900	-	57,900
Other revenue	62,264	803	(11,550)	51,517	14,457	(20,041)	45,933
	1,253,680	31,591	(11,583)	1,273,688	274,170	(106,490)	1,441,368
Expenses:							
Salaries and benefits	652,357	12,291	-	664,648	76,104	(63,551)	677,201
Supplies	181,156	2,333	(161)	183,328	19,349	(1,069)	201,608
Purchased services	96,340	4,346	(1,710)	98,976	78,408	(34,539)	142,845
Utilities, repairs, and maintenance	47,447	1,204	(340)	48,311	6,303	-	54,614
Depreciation and amortization	80,899	1,497	-	82,396	7,983	-	90,379
Hospital assessment fee	30,392	643	-	31,035	3,411	-	34,446
Other	19,710	7,438	(9,372)	17,776	52,694	(7,331)	63,139
	1,108,301	29,752	(11,583)	1,126,470	244,252	(106,490)	1,264,232
Operating income	145,379	1,839	-	147,218	29,918	-	177,136

Parkview Health System, Inc. and Subsidiaries
d/b/a Parkview Health

Details of Consolidated Statement of Operations and Changes in Net Assets –
Including Obligated Group and Credit Group (Continued)
Year Ended December 31, 2015
(In Thousands)

	Obligated Group	Designated Affiliate	Eliminations	Total Credit Group	Other	Eliminations	Consolidated
Nonoperating income (expense):							
Interest, dividends and realized gains (losses) on sales of investments	$ 11,386	$ (1)	$ -	$ 11,385	$ 1,445	$ -	$ 12,830
Unrealized losses on investments, net	(28,142)	-	-	(28,142)	(4,360)	-	(32,502)
Interest expense	(17,277)	(135)	-	(17,412)	(113)	-	(17,525)
Unrealized losses on interest rate swaps, net	(224)	-	-	(224)	-	-	(224)
Contribution of unrestricted net assets of Wabash County Hospital	-	-	-	-	37,444	-	37,444
Other	904	-	-	904	(55)	-	849
Excess of revenues over expenses	$ 112,026	$ 1,703	$ -	$ 113,729	$ 64,279	$ -	$ 178,008
Excess of revenues over expenses attributable to:							
Noncontrolling interest in subsidiaries	$ 29,342	$ -	$ -	$ 29,342	$ 70	$ -	$ 29,412
Parkview Health System, Inc. and subsidiaries	82,684	1,703	-	84,387	64,209	-	148,596
Other changes in net assets attributable to:							
Noncontrolling interest in subsidiaries	(27,098)	-	-	(27,098)	356	-	(26,742)
Parkview Health System, Inc. and subsidiaries	69,557	(1,703)	-	67,854	(82,392)	-	(14,538)
Increase in net assets	154,485	-	-	154,485	(17,757)	-	136,728
Net assets (deficit):							
Beginning of year	1,045,339	(2,511)	-	1,042,828	131,903	-	1,174,731
End of year	$ 1,199,824	$ (2,511)	$ -	$ 1,197,313	$ 114,146	$ -	$ 1,311,459

Parkview Health System, Inc. and Subsidiaries
d/b/a Parkview Health

Note to Details of Consolidation
December 31, 2016

Obligated Group and Credit Group

The Obligated Group, as defined in the Amended and Restated Master Trust Indenture between Parkview Health System, Inc.; Parkview Hospital, Inc.; and certain other entities referred to herein as members of the Obligated Group and U.S. Bank National Association (successor to National City Bank of Indiana), as Master Trustee, dated as of November 1, 1998, consists of Parkview Health System, Inc.; Parkview Hospital, Inc.; and any other Obligated Group Affiliate that has fulfilled the requirements for entry into the Obligated Group. Parkview Hospital, Inc. includes Parkview Regional Medical Center and the accounts and activities of Parkview Hospital Randallia, Parkview Behavioral Health and Parkview Home Health and Hospice. Parkview Professional Programs, Inc. is a wholly owned subsidiary of Parkview Hospital, Inc. Included with Parkview Health System, Inc. are the entities of Parkview Physicians Group; Midwest Community Health Associates, Inc.; Parkview Care Partners LLC; New Vision Professional Park, LLC; and the joint ventures of Foundation Surgery Affiliates of Fort Wayne, LLC and Orthopaedic Hospital at Parkview North, LLC and its wholly owned subsidiaries of Parkview Ortho Center, LLC and Parkview Ortho Performance Center, LLC.

On July 20, 2011, the Community Hospital of LaGrange County, Inc. became a designated affiliate of the Obligated Group and is part of, along with Parkview Health System, Inc. and Parkview Hospital, Inc., the Credit Group. The Credit Group for the year ended December 31, 2015, consists of the Obligated Group members (Parkview Health System, Inc. and Parkview Hospital, Inc.) and the Community Hospital of LaGrange County, Inc. Other related entities that are included in the December 31, 2015, consolidated financial statements of Parkview Health System, Inc. and subsidiaries that are not included in the Obligated Group, but are included in the grouping labeled as Other, are as follows: Huntington Memorial Hospital, Inc.; Whitley Memorial Hospital, Inc.; Community Hospital of Noble County, Inc.; Parkview Wabash Hospital, Inc.; Managed Care Services, L.L.C.; Parkview Occupational Health Center, Inc.; Parkview Foundation, Inc.; Whitley Memorial Hospital Foundation, Inc.; The Parkview Huntington Hospital Foundation, Inc.; Community Hospital of Noble County Foundation, Inc.; Wabash County Hospital Foundation Inc. and the joint venture Wabash MRI LLC.

On August 17, 2016, Parkview Wabash Hospital, Inc. became a designated affiliate of the Obligated Group and is part of, along with Parkview Health System, Inc., Parkview Hospital, Inc. and the Community Hospital of LaGrange County, Inc., the Credit Group. The Credit Group for the year ended December 31, 2016, consists of the Obligated Group members (Parkview Health System, Inc. and Parkview Hospital, Inc.) and the designated affiliates (the Community Hospital of LaGrange County, Inc. and Parkview Wabash Hospital, Inc.). Included with Parkview Wabash Hospital, Inc. is the joint venture of Wabash MRI LLC. Other related entities that are included in the December 31, 2016, consolidated financial statements of Parkview Health System, Inc. and subsidiaries that are not included in the Obligated Group, but are included in the grouping labeled as Other, are as follows: Huntington Memorial Hospital, Inc.; Whitley Memorial Hospital, Inc.; Community Hospital of Noble County, Inc.; Managed Care Services, L.L.C.; Parkview Occupational Health Center, Inc.; Parkview Foundation, Inc.; Whitley Memorial Hospital Foundation, Inc.; The Parkview Huntington Hospital Foundation, Inc.; Community Hospital of Noble County Foundation, Inc.; and Wabash County Hospital Foundation Inc.

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APPENDIX C

SUMMARY OF MASTER DOCUMENTS AND DEFINITIONS

APPENDIX C

Page

SUMMARY OF MASTER DOCUMENTS AND DEFINITIONS

The following descriptions are summaries of certain provisions of the Master Indenture, the Loan Agreement and the Indenture. Such summaries do not purport to be comprehensive or definitive, and all references herein to the Master Indenture, the Loan Agreement and the Indenture are qualified in their entirety by reference to each such document, copies of which are available for review prior to the issuance and delivery of the Bonds at the office of J.P. Morgan Securities LLC and thereafter at the principal corporate trust office of the Trustee. All references to the Bonds are qualified in their entirety by reference to the definitive forms thereof and the information with respect thereto included in the Indenture.

DEFINITIONS OF CERTAIN TERMS

The following are definitions of certain terms used in the Master Indenture, the Loan Agreement and the Indenture.

"Act" means collectively, Indiana Code 4-4-10.9 and 11 and Indiana Code 5-1-16, as heretofore and hereafter amended or supplemented.

"Additional Indebtedness" means Indebtedness incurred by the Members subsequent to the issuance of the first Master Note under the Master Indenture.

"Adjusted Contributions" means, for any fiscal year of a Person, the lesser of: (i) the Contributions actually received by such Person for such fiscal year or (ii) the sum total of Contributions actually received by such Person during such fiscal year and during the preceding four fiscal years of such Person divided by five.

"Amended and Restated Master Indenture" means the Amended and Restated Master Trust Indenture dated as of November 1, 1998 among Parkview Health, Parkview Hospital and the Master Trustee.

"Authority" means the Indiana Finance Authority, a public body politic and corporate, not a state agency but an independent public instrumentality, organized under the laws of the State of Indiana, and any successor to its functions under the Indenture.

"Authority Request", "Authority Order" or *"Authority Consent"* means, respectively, a written request, order or consent of the Authority, signed by the Chairman of the Authority, the Public Finance Director of the State of Indiana or other officer of the Authority designated pursuant to an Authority Resolution, and delivered to the Trustee.

"Authority Resolution" means a resolution, ordinance or other appropriate enactment by the Authority certified by an appropriate officer thereof to have been duly adopted by the Authority and to be in full force and effect on the date of such certification, and delivered to the Trustee.

"Balloon Indebtedness" means Long-Term Indebtedness, 25% or more of the original principal of which matures during any consecutive twelve-month period, if such principal amount is not required to be amortized below such percentage by mandatory redemption or prepayment prior to such twelve-month period. Balloon Indebtedness does not include Indebtedness which otherwise would be classified under the Master Indenture as Put Indebtedness.

"Beneficial Owner" means the Person in whose name a Bond is recorded as beneficial owner of such Bond by the Securities Depository or a Participant or an Indirect Participant on the records of such Securities Depository, Participant or Indirect Participant, as the case may be, or such Person's subrogee, so long as the Book Entry System is in effect with respect to the Bonds.

"Bond Counsel" means any firm of nationally recognized bond counsel experienced in matters relating to the tax-exempt financing of healthcare facilities, acceptable to the Authority and to Parkview Health.

"Bond Fund" means the Bond Fund created in the Indenture.

"Bondholder" "holder" or *"owner of the Bonds"* when used in the Indenture, means the registered holder of a Bond and, when used in the Master Indenture, means the registered owner of any Related Bond.

"Bonds" means the Authority's $110,630,000 in aggregate principal amount of Hospital Refunding Revenue Bonds, Series 2017A (Parkview Health) issued under the Indenture.

"Bonds to Be Refunded" means the portion of Series 2009A Bonds being refunded with proceeds of the Bonds.

"Book Entry System" means a book entry system established and operated for the recordation of Beneficial Owners of the Bonds pursuant to the Indenture.

"Capitalized Interest" means amounts irrevocably deposited in escrow in connection with the issuance of Funded Indebtedness or Related Bonds to pay interest on such Funded Indebtedness or Related Bonds and interest earned on such amounts.

"Capitalized Lease" means any lease of real or personal property which, in accordance with GAAP, is required to be capitalized on the balance sheet of the lessee.

"Capitalized Rentals" means the amount at which the aggregate Net Rentals due and to become due would be reflected as a liability on a balance sheet of such Person.

"Code" means the Internal Revenue Code of 1986, as amended, or any successor statute thereto, together with the regulations promulgated thereunder.

"Collateral Document" or *"Collateral Documents"* means any written instrument other than the Loan Agreement, the Master Indenture, the Series 2017A Supplemental Indenture, the Indenture or the Series 2017A Note, whereby any property or interest or rights in property of any kind is granted, pledged, conveyed, assigned, or transferred to the Authority or Bond Trustee, or both, as security for payment of the Bonds or performance by Parkview Health of its obligations under the Series 2017A Note or the Master Documents.

"Commitment Indebtedness" means the obligation of any Member to repay amounts disbursed pursuant to a commitment from a financial institution to refinance or purchase when due, when tendered or when required to be purchased (a) other indebtedness of such Member or (b) Indebtedness of a Person who is not a Member, which Indebtedness is guaranteed by a Guaranty of such Member or secured by or payable from amounts paid on Indebtedness of such Member, in either case which Indebtedness or Guaranty of such Member was incurred in accordance with the provisions of Master Indenture relating to permitted additional indebtedness, and the obligation of any Member to pay interest payable on amounts

disbursed for such purposes, plus any fees, costs or expenses payable to such financial institution for, under or in connection with such commitment, in the event of disbursement pursuant to such commitment or in connection with enforcement thereof, including without limitation any penalties payable in the event of such enforcement.

"Completion Funded Indebtedness" means any Funded Indebtedness for borrowed money: (a) incurred for the purpose of financing the completion of the acquisition, construction, remodeling, renovation or equipping of Facilities with respect to which Funded Indebtedness for borrowed money has been incurred in accordance with the provisions of the Master Indenture; and (b) with a principal amount not in excess of the amount required to provide a completed and equipped Facility of substantially the same type and scope contemplated at the time such prior Funded Indebtedness was originally incurred, to provide for Capitalized Interest during the period of construction, to provide any reserve fund relating to such Completion Funded Indebtedness and to pay the costs and expenses of issuing such Completion Funded Indebtedness.

"Consultant" means a professional consulting firm acceptable to the Master Trustee, recognized as having the skill and experience necessary to render the particular report required, which firm shall have no interest, direct or indirect, in any Member and shall not have a partner, member, director, officer or employee who is a partner, member, director, officer or employee of any Member.

"Contributions" means the aggregate amount of all contributions, grants, gifts and bequests actually received in cash or marketable securities by any Person in the applicable fiscal year of such Person which are not restricted in any way which would prevent their application to the payment of debt service on Indebtedness.

"Corporation" means Parkview Health System, Inc., an Indiana nonprofit corporation.

"Coverage Test" means the test that shall be met if there is delivered to the Master Trustee a written report of the Obligated Group Representative stating that the Historical Debt Service Coverage Ratio of the Credit Group for the most recent Fiscal Year preceding the date of delivery of the report for which combined financial statements reported upon by independent certified public accountants are available, taking into account the proposed transaction, if any, was not less than 1.10:1. See "SUMMARY OF CERTAIN PROVISIONS OF SUPPLEMENTAL NO. 8" herein for a summary of amendments to the definition of Coverage Test.

"Credit Group" means Parkview Health, Parkview Hospital, any other Members of the Obligated Group and any Designated Affiliates.

"Crossover Date" means with respect to Crossover Refunding Indebtedness, the date on which the principal portion of the Crossover Refunded Indebtedness is paid or redeemed, or on which it is anticipated that such principal portion will be paid or redeemed, from the proceeds of such Crossover Refunding Indebtedness.

"Crossover Refunded Indebtedness" means Indebtedness of the Person refunded by Crossover Refunding Indebtedness.

"Crossover Refunding Indebtedness" means Indebtedness of the Person issued for the purpose of refunding other Indebtedness of such Person if the proceeds of such Crossover Refunding Indebtedness are irrevocably deposited in escrow to secure the payment on the applicable Crossover Date of the Crossover Refunded Indebtedness in earnings on such escrow deposit are required to be applied to pay

interest or principal on either or both of such Crossover Refunding Indebtedness or such Crossover Refunded Indebtedness until the Crossover Date.

"Debt Service Requirements" means, with respect to the period of time for which calculated, the aggregate of the payments required to be made in respect of principal (whether at maturity, as a result of mandatory prepayment or otherwise) and interest on outstanding Funded Indebtedness (or in the case of Capitalized Rentals with respect to Capitalized Leases, the aggregate of the Net Rentals required to be made on such Capitalized Leases), excluding, however, (a) interest to the extent that Capitalized Interest is available to pay such interest, (b) principal or interest to the extent that amounts are on deposit in an irrevocable escrow and such amounts (including, where appropriate, the earnings or other increment to accrue thereon) are required to be applied and are sufficient to pay such principal or interest on the scheduled due date.

"Designated Affiliate" or *"Designated Affiliates"* means any Person that has been designated as such pursuant to the Master Indenture.

"Escrow Obligations" means, (i) with respect to any series of Related Bonds, the obligations permitted to be used to refund or advance refund such series of Related Bonds under the Related Bond Indenture, and (ii) in all other cases, (a) United States Government Obligations, or (b) obligations of any agency or instrumentality of the United States Government which are guaranteed by the full faith and credit of the United States of America, or (c) certificates of deposit which are fully insured by the Federal Deposit Insurance Corporation, Federal Savings and Loan Insurance Corporation or similar corporation chartered by the United States of America, or if issued by a bank or trust company if such certificates shall be secured by a pledge of any United States Government Obligations have an aggregate market value, exclusive of accrued interest, equal at least to the principal amount of the certificates so secured, or (d)(1) evidences of a direct ownership in future interest or principal payments on obligations issued or guaranteed by the United States of America, which obligations are held in a custody account by a custodian satisfactory to the Master Trustee, pursuant to the terms of a custody agreement, and (2) obligations issued by any state of the United States of America or any political subdivision, public instrumentality or public authority of any state, which obligations are fully secured by and payable solely from direct obligations of, or obligations, the principal of and interest on which are fully guaranteed by, the United States of America, which security is held pursuant to an agreement in form and substance acceptable to the Master Trustee.

"Event of Default" when used with respect to the Master Indenture has the meaning described herein under the heading "SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE –Defaults and Remedies," and when used with respect to the Indenture has the meaning described herein under the heading " SUMMARY OF CERTAIN PROVISIONS OF THE INDENTURE – Events of Default and Remedies."

"Expense Fund" means the Expense Fund created under the Indenture.

"Expenses" means, for any period, the aggregate of all expenses calculated under GAAP, including without limitation any taxes, incurred by the Person or group of Persons involved during such period, minus interest on Funded Indebtedness, depreciation and amortization and extraordinary expenses (including without limitation losses on the sale of assets other than in the ordinary course of business and losses on the extinguishment of debt) and, if such calculation is being made with respect to the Obligated Group, excluding any such expenses attributable to transactions between the respective members of the Obligated Group or the Credit Group.

"Exposure on Guaranteed Debt" means, with respect to the period of time for which calculated, an amount equal to the sum of 20% of the maximum annual debt service requirement (calculated in the

same manner as the Maximum Annual Debt Service Requirement) on each series of Indebtedness of a Primary Obligor which is guaranteed; provided, however, that if a guarantor has been required, by reason of its Guaranty, to make any payment in respect of the Indebtedness which is guaranteed within the immediately preceding twenty-four (24) months, the Exposure on Guaranteed Debt means an amount equal to 100% of the maximum annual debt service requirement (calculated in the same manner as Maximum Annual Debt Service Requirement) on such Indebtedness of the Primary Obligor.

"Facilities" means all land, leasehold interests and buildings and all fixtures and equipment (as defined in the Uniform Commercial Code or equivalent statute in effect in the state where such fixtures or equipment are located).

"Fiscal Year" means any period beginning on January 1 of any calendar year and ending on December 31 of such year, or any other twelve-month period selected by Parkview Health as its Fiscal Year. When any Member or Designated Affiliate maintains a fiscal year different than that of Parkview Health, a Fiscal Year of the Credit Group shall be deemed to include the fiscal year of such other Member or Designated Affiliate ending on any date within one year prior to the last day of the Fiscal Year of Parkview Health.

"Fitch" means Fitch Ratings, Inc., its successors and assigns, or upon the discontinuance of such service, such other nationally recognized rating service as shall be determined by the Obligated Group Representative by notice to the Trustee.

"Funded Indebtedness" means with respect to any Person (i) all Long-Term Indebtedness of such Person; and (ii) Capitalized Rentals under Capitalized Leases entered into by the Person.

"GAAP" means generally accepted accounting principles as from time to time in effect.

"Government Obligations" means direct obligations of, or obligations the principal of and interest on which are unconditionally guaranteed by, the United States of America, U.S. Treasury STRIPS, REFCORP STRIPS (stripped by the Federal Reserve Bank of New York) and any stripped securities assessed or rated A- by S&P or A3 by Moody's, or better, at the time of purchase.

"Guaranty" means all obligations of a Person guaranteeing or, in effect, guaranteeing any Indebtedness, dividend or other obligation of any Primary Obligor in any manner, whether directly or indirectly, including but not limited to obligations incurred through an agreement, contingent or otherwise, by such Person to assure the owner of such Indebtedness against loss in respect thereof.

"Historical Debt Service Coverage Ratio" means, for any period of time, the ratio consisting of a numerator equal to the amount determined by dividing Income Available for Debt Service for that period by the Debt Service Requirements for such period and a denominator of one; *provided*, however, that in calculating the Debt Service Requirements for such period, the principal amount of any Indebtedness included in such calculation which is paid during such period shall be excluded to the extent such principal amount is paid from a source other than Revenues of the Credit Group; and *further provided* that, when such calculation is being made with respect to the Credit Group, Income Available for Debt Service and Debt Service Requirements shall be determined only with respect to those Persons who are members thereof at the close of such period. See "SUMMARY OF CERTAIN PROVISIONS OF SUPPLEMENTAL NO. 8" herein for a summary of amendments to the definition of Historical Debt Service Coverage Ratio.

"Historical Pro Forma Debt Service Coverage Ratio" means, for any period of time, the ratio consisting of a numerator equal to the amount determined by dividing Income Available for Debt Service

for that period by the Maximum Annual Debt Service Requirement for the Funded Indebtedness then outstanding (other than any other Funded Indebtedness being refunded with the Funded Indebtedness then proposed to be issued) and the Funded Indebtedness then proposed to be issued and a denominator of one; provided that, when such calculation is being made with respect to the Credit Group, Income Available for Debt Service and Maximum Annual Debt Service Requirement shall be determined only with respect to those Persons who are Members of the Credit Group at the time of such calculation. See "SUMMARY OF CERTAIN PROVISIONS OF SUPPLEMENTAL NO. 8" herein for a summary of amendments to the definition of Historical Pro Forma Debt Service Coverage Ratio.

"*Income Available for Debt Service*" means, for any period, the excess of Revenues over Expenses of the Person or group of Persons involved.

"Indebtedness" means, for any Person, (a) all Guaranties by such Person, (b) all liabilities (exclusive of reserves such as those established for deferred taxes) recorded as such on the audited financial statements of such Person as of the end of the then most recent fiscal year for which financial statements reported upon by independent certified public accountants are available, and (c) all obligations for the payment of money incurred or assumed by such Person (i) due and payable in all events or (ii) if incurred or assumed primarily to assure the repayment of money borrowed or credit extended, due and payable upon the occurrence of a condition precedent or upon the performance of work, possession of Property as lessee, rendering of services by others or otherwise, and shall include, without limitation, Non-Recourse Indebtedness; *provided* that Indebtedness shall not include Indebtedness of one member of the Credit Group to another member of the Credit Group or any Guaranty by any member of the Credit Group of Indebtedness of any other member of the Credit Group.

"Indenture" means the Trust Indenture, dated as of August 1, 2017, between the Authority and the Trustee, as such may be amended or supplemented from time to time in accordance with the provisions thereof.

"Independent Counsel" means an attorney duly admitted to practice law before the highest court of any state and, without limitation, may include independent legal counsel for any Related Issuer, any Member, any Affiliate, the Master Trustee or any Related Bond Trustee.

"Indirect Participant" means a broker-dealer, bank or other financial institution for which the Securities Depository holds Bonds as a securities depository through a Participant.

"Insurance Consultant" means a person or firm who is not an employee or officer of any Member, any Affiliate or any Related Issuer, appointed by the Obligated Group Representative, qualified to survey risks and to recommend insurance coverage for hospital or health care facilities and services of the type involved, and having a favorable reputation for skill and experience in such surveys and such recommendations.

"Interest Account" means the Interest Account of the Bond Fund created pursuant to the Indenture.

"Interest Payment Date" means each May 1 and November 1, commencing November 1, 2017.

"Interest Rate Agreement" means an interest rate exchange, hedge or similar agreement, expressly identified in an Officer's Certificate of the Obligated Group Representative delivered to the Master Trustee 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 swap, 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.

"Investment Securities" means:

(a) direct obligations of the United States of America, including obligations the principal and interest of which are guaranteed by the full faith and credit of the US Government; and trust receipts evidencing a direct ownership interest in such obligations;

(b) obligations issued or guaranteed by any United States Government Agency or Instrumentality;

(c) (i) obligations issued by any state of the United States of America, or any political subdivision or instrumentality thereof, rated by at least two Rating Services in one of the three highest Rating Categories, or (ii) such obligations that are fully secured by and payable solely from an escrow fund held by a trustee consisting of cash or the Investment Securities described in (a) above;

(d) (i) debt obligations of any US corporation or trust, which obligations are rated by at least two Rating Services in one of the three highest Rating Categories, or (ii) commercial paper of same rated by at least two Rating Services in the highest Rating Category;

(e) certificates of deposit or time deposits of any bank, trust company or savings and loan which deposits are fully insured by a federally sponsored deposit insurance program;

(f) bankers acceptances of any bank which bank or its parent holding company's debt conforms to the rating requirements of (d) above;

(g) repurchase agreements, entered in conformance with prevailing industry standard guidelines, of obligations listed in (a) or (b) above, delivered versus payment to the trustee and continuously collateralized at 102% or greater, with counterparties having debt rated in conformance with the rating requirements of (d) above;

(h) investment agreements of any corporation which agreements or the corporation's or its parent holding company's long term debt is rated by at least two Rating Services in one of the three highest Rating Categories;

(i) shares of a money market fund or commingled trust which fund or trust's investments are restricted to these Investment Securities;

(j) investments in a money market fund registered under the Investment Company Act of 1940, as amended, whose shares are registered under the Securities Act of 1933 rated "AAAm" or AAAm-G" or "AAm" by S&P, and if rated by Moody's, "Aaa" or "Aa1" or "Aa2"; and

(k) certificates of deposit issued by commercial banks, savings and loans associations or mutual savings banks which are secured by the Investment Securities described in clauses (a) and (b) above, which are held by the Trustee or a custodian for the Trustee; provided the Trustee has received an opinion of counsel that it has a perfected first lien on the obligations serving as collateral and such collateral is free from all third party liens.

"Irrevocable Deposit" means with respect to any Indebtedness or portion thereof an irrevocable deposit in trust with a corporate trustee of cash (or Escrow Obligations the principal of and interest on which will be) sufficient to pay when due the principal, premium, and interest of any Indebtedness or such portion which would otherwise be considered Outstanding.

"Lien" means any mortgage, pledge, security interest in, lien, charge or encumbrance on any Property of a Member or a Designated Affiliate which secures any obligation to any Person (other than another member of the Credit Group) and any Capitalized Lease under which any Member or a Designated Affiliate as lessee if the lessor is not another member of the Credit Group.

"Loan Agreement" means the Loan Agreement dated as of August 1, 2017, between the Authority and Parkview Health, as the same may be from time to time amended or supplemented.

"Long-Term Indebtedness" means Indebtedness having a stated maturity greater than one year or renewable at the option of the debtor for a period greater than one year from the date of original issuance.

"Master Documents" means the Master Indenture, all Supplemental Master Indentures and the Loan Agreement.

"Master Indenture" means the Amended and Restated Master Indenture, dated as of November 1, 1998, among the Obligated Group and the Master Trustee, as heretofore supplemented and amended, as supplemented by the Series 2017A Supplemental Indenture.

"Master Note Holder" means the registered owner of any Master Note.

"Master Note" or *"Master Notes"* means all Master Notes issued under the Master Indenture.

"Master Trustee" means U.S. Bank National Association, as successor trustee or any other permitted successor as trustee under the provisions of the Master Indenture.

"Maximum Annual Debt Service Requirement" means the largest total Debt Service Requirements for all Indebtedness outstanding for the current or any succeeding Fiscal Year; provided that in applying the provisions of the Master Indenture relating to permitted additional indebtedness and the calculation of debt service the current year shall be deemed to include the Fiscal Year with respect to which Historical Debt Service Coverage is being calculated and provided further that in calculating Maximum Annual Debt Service Requirement for the purposes of applying such provisions, the principal amount of any Indebtedness included in such calculation which is being paid during the year with respect to which Historical Debt Service Coverage is being calculated shall be excluded to the extent such principal amount is paid from the proceeds of other Indebtedness incurred in accordance with the provisions of the Master Indenture or from amounts deposited to provide for such payment pursuant to an amortization schedule established and maintained in accordance with the provisions of the Master Indenture relating to permitted additional indebtedness and the calculation of debt service, which amounts were deposited in Fiscal Years prior to the Fiscal Year in which such principal was paid; provided further that principal and interest payment on Indebtedness due on the first day or the first business day of a month shall be deemed payable during the preceding month if they are required to be fully deposited with the trustee for such Indebtedness during such preceding month.

"Member" or *"Member of the Obligated Group"* means (a) Parkview Health; (b) Parkview Hospital; and (c) any other Person who is then designated as a Member of the Obligated Group.

"Moody's" means Moody's Investors Service, its successors and assigns, or upon the discontinuance of such service, such other nationally recognized rating service as shall be determined by the Obligated Group Representative by notice to the Trustee.

"Net Rentals" means all fixed rents payable under a lease of real or personal Property, including any sums payable upon the scheduled termination thereof, but excluding any amounts payable for maintenance, repairs, insurance, taxes and similar charges. Net Rentals for any future period under any so-called "percentage lease" shall be computed on the basis of the amount reasonably estimated to be payable thereunder for such period, but in any event not less than the amount paid or payable thereunder during the immediately preceding period of the same duration; *provided* that the amount estimated to be payable under any such percentage lease shall in all cases recognize any change in the applicable percentage called for by the terms of such lease.

"Non-Recourse Indebtedness" means any Indebtedness incurred for the acquisition of Property, Plant and Equipment, liability for which is limited to such Property, Plant and Equipment with no recourse, directly or indirectly, to any other Property of any Member of the Obligated Group.

"Obligated Group" means all Persons who at the time are Members.

"Obligated Group Representative" means, under the Master Indenture, Parkview Health or any other Member designated to the Master Trustee by a Written Request signed by all Members.

"Officer's Certificate" means, in regard to the Authority, a certificate signed by the Chairman of the Authority or the Public Finance Director of the State of Indiana or other officer of the Authority as specified in an Authority Resolution, and delivered to the Trustee, and means, pursuant to the Master Indenture, a certificate signed, in the case of a corporation by the President or any Vice-President of such corporation or, in the case of a certificate delivered by any other Person, the chief executive or chief financial officer of such other Person.

"One-Month LIBOR Rate" means, as of any date of determination, the offered rate for deposit in U.S. dollars for a one-month period which appears on the Telerate page 3750 at approximately 11:00 a.m., London time, on such date, or if such date is not a date on which dealings in U.S. dollars are transacted in the London Interbank Market, then on the next preceding day on which such dealings were transacted in such market.

"Outstanding" or *"outstanding"* pursuant to the Master Indenture, means all Indebtedness which has been issued except (i) Indebtedness which is no longer deemed outstanding under its terms and with respect to which the Obligor is no longer liable, (ii) Indebtedness for which an Irrevocable Deposit has been made, and (iii) for the purpose of any waivers, consents, notices or other actions under the Master Indenture, Related Bonds held by any Member or an Affiliate.

"Outstanding" when used with reference to Bonds means, as of the date of determination, all Bonds theretofore issued and delivered under the Indenture, except:

(i) Bonds theretofore cancelled by the Trustee or delivered to the Trustee cancelled or for cancellation;

(ii) Bonds and portions of Bonds for whose payment or redemption moneys or Government Obligations shall have been theretofore deposited with the Trustee in trust for the Holders of such Bonds, provided, however, that if such Bonds are to be redeemed, notice of such redemption shall have been duly given pursuant to the Indenture or

irrevocable instructions to call such Bonds for redemption at a stated Redemption Date shall have been given to the Trustee; and

(iii) Bonds in exchange for or in lieu of which other Bonds shall have been issued and delivered pursuant to the Indenture;

provided, however, that in determining whether the Holders of the requisite principal amount of Outstanding Bonds have given any request, demand, authorization, direction, notice, consent or waiver under the Indenture, Bonds owned by the Authority or Parkview Health shall be disregarded and deemed not to be Outstanding, except that in determining whether the Trustee shall be protected in relying upon any such request, demand, authorization, direction, notice, consent, or waiver, only Bonds which the Trustee knows to be so owned shall be disregarded.

"Outstanding Master Notes" or *"Master Notes Outstanding"* means all Master Notes which have been duly authenticated and delivered under the Master Indenture, except:

(a) Master Notes cancelled after purchase in the open market or after payment;

(b) Master Notes for the payment or redemption of which cash or Escrow Obligations shall have been deposited with the Master Trustee or any Related Bond Trustee (whether upon or prior to the maturity or redemption date thereof) in accordance with the Master Indenture; *provided* that if such Master Notes are to be prepaid or redeemed prior to the maturity thereof, notice shall have been given or waived or arrangements satisfactory to the Master Trustee shall have been made;

(c) Master Notes in lieu of which others have been authenticated under the Master Indenture; and

(d) For the purpose of any waivers, consents, notices or other actions by the holders of Master Notes, Master Notes held by any Member or any Affiliate.

"Parkview Health" means Parkview Health System, Inc., an Indiana nonprofit corporation.

"Parkview Hospital" means Parkview Hospital, Inc., an Indiana nonprofit corporation.

"Participant" means a broker-dealer, bank or other financial institution for which the Securities Depository holds Bonds as a securities depository.

"Permitted Encumbrances" means the Master Indenture, any Related Loan Document, any Related Bond Indenture and, as of any particular time:

(a) Liens arising by reason of good faith deposits with a Person in connection with tenders, leases of real estate, bids or contracts (other than contracts for the payment of money), deposits by a Person to secure public or statutory obligations, or to secure, or in lieu of, surety, stay or appeal bonds, and deposits as security for the payment of taxes or assessments or other similar charges; 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 as a condition to the transaction of any business or the exercise of any privilege or license, or to enable a Person to maintain self-insurance or to participate in any funds established to cover any insurance risks or in connection with workmen's compensation, unemployment insurance, pensions or profit sharing

plans or other social security plans or programs, or to share in the privileges or benefits required for corporations participating in such arrangements;

(b) any Lien on Property if such Lien equally and ratably secures all of the Master Notes and only the Master Notes;

(c) leases of any Member or any Designated Affiliate as lessor relating to Property which is customarily the subject of such leases, such as office space for physicians and educational institutions, food service facilities, gift shops and radiology or other hospital-based specialty services, pharmacy and similar departments, leases, licenses or similar rights to use Property existing as of November 1, 1998 and any renewals and extensions thereof, and any leases, licenses or similar rights to use Property whereunder a Member or Designated Affiliate is lessee, licensee or the equivalent thereof upon fair and reasonable terms no less favorable to the lessor or licensor than would obtain in a comparable arm's-length transaction;

(d) Liens for taxes and special assessments which are not then delinquent or if then delinquent are being contested in accordance with the provisions of the Master Indenture;

(e) utility, access and other easements and rights-of-way, restrictions, encumbrances and exceptions which do not materially interfere with or materially impair the operation of the Property of the Members or Designated Affiliates affected thereby (or, if such Property is not being then operated, the operation for which it was designed or last modified);

(f) any mechanic's, laborer's, material man’s, supplier's or vendor's Lien or right in respect thereof if payment is not yet due under the contract in question or if such Lien is being contested in accordance with the provisions of the Master Indenture;

(g) such minor defects, irregularities of title and encroachments on adjoining property as normally exist with respect to Property similar in character to the Property of the Members or Designated Affiliates involved and which do not materially adversely affect the value of, or materially impair, the Property affected thereby for the purpose for which it was acquired or is held by the owner thereof;

(h) zoning laws and similar restrictions which are not violated by the Property or the use thereof of the Credit Group affected thereby;

(i) statutory rights under Section 291, Title 42 of the United States Code, as a result of Hill-Burton grants, and similar rights under other federal or state statutes;

(j) any interest of any state, any municipality and the public in and to tunnels, bridges and passageways over, under or upon a public way;

(k) Liens on or in Property given, bequeathed or devised to the owner thereof existing at the time of such gift, bequest or devise, provided that (i) such Liens attach solely to that Property, and (ii) the Indebtedness secured by such Liens is not assumed by any Member or any Designated Affiliate;

(l) Liens resulting from any judgment or award that is not yet final or is being contested, provided that stay of execution pending such contest has in good faith been obtained;

(m) Liens on moneys deposited by patients or others with a Person as security for or as prepayment of the cost of patient care or any rights of residents of life care or similar facilities to endowment or similar funds deposited by or on behalf of such residents;

(n) Liens on Property due to rights of third party payers for recoupment of excess payments;

(o) any security interest in any fund established pursuant to the terms of any Related Supplemental Indenture or any Related Bond Indenture in favor of the Master Trustee, the Related Bond Trustee, the Related Issuer or the holder of the Indebtedness issued pursuant to such document;

(p) any Lien secured by any Related Bond;

(q) any Lien with respect to Property which Lien either secures the purchase price of such Property or is a Lien to which such Property is subject at the time of its acquisition by the Member or Designated Affiliate;

(r) (with the consent of any issuer of a letter of credit supporting any series of Related Bonds if required by the reimbursement agreement with such letter of credit issuer), Liens on accounts receivable arising as a result of the sale of such accounts receivable with or without recourse, *provided* that the principal amount of Indebtedness secured by any such Lien does not exceed the aggregate sales price of such accounts receivable received by the Member or Designated Affiliate selling the same;

(s) any Lien on any Property of any Member or Designated Affiliate granted in favor of or securing Indebtedness to any other Member or Designated Affiliate;

(t) such Liens, covenants, conditions and restrictions, if any, which do not secure indebtedness and which are other than those of the type referred to above, and which (i) in the case of Property of any Member or any Designated Affiliate on November 1, 1998, do not and will not, so far as can reasonably be foreseen, materially adversely affect the value of the Property currently affected thereby or materially impair the same, and (ii) in the case of any other Property, do not materially impair or materially interfere with the operation or usefulness thereof for the purpose for which such Property was acquired or is held by a Member or Designated Affiliate;

(u) Liens on any Property of a Member or of a Designated Affiliate at November l, 1998 or existing at the time any Person becomes a Member or a Designated Affiliate; *provided* that no such Lien (or the amount of Indebtedness secured thereby) may be increased, extended, renewed or modified to apply to any Property of the Member or any Designated Affiliate not subject to such Lien on such date unless such Lien as so increased, extended, renewed or modified is otherwise permitted under the Master Indenture;

(v) Liens on Property of a Person existing at the time such Person is merged into or consolidated with a Member or a Designated Affiliate, or at the time of a sale, lease or other disposition of the Properties of a Person as an entirety or substantially as an entirety to a Member or a Designated Affiliate which becomes part of a Property that secured Indebtedness that is assumed by a Member or a Designated Affiliate as a result of any such merger, consolidation or acquisition; *provided*, that no such Lien may be increased, extended, renewed, or modified after such date to apply to any Property of a Member or a Designated Affiliate not subject to such Lien

on such date unless such Lien as so increased, extended, renewed or modified is otherwise permitted under the Master Indenture; and

(w) Liens on any Property of a Member or a Designated Affiliate securing any Indebtedness if at the time of incurrence of such Indebtedness and after giving effect to all Liens permitted under this subparagraph, the aggregate value of Property subject to such Liens pursuant to this subparagraph does not exceed 25% of the value of the total assets of the Credit Group, as such value is shown on the most recent financial reports required to be delivered under the Master Indenture.

"Person" or *"Persons"* under the Master Indenture means any natural person, firm, joint venture, limited liability company, association, partnership, business trust, corporation, public body, agency or political subdivision thereof or any other similar entity.

"Pledged Revenues" means all gross revenues, rents, profits, receipts, benefits, royalties, money and income of any Member of the Obligated Group arising from services provided by Obligated Group Members or arising in any manner with respect to, incident to or on account of the Obligated Group Members operations, including, without limitation, (i) the Obligated Group Members' rights under agreements with insurance companies, Medicare, Medicaid, governmental units and prepaid health organizations, including rights to Medicare and Medicaid loss recapture under applicable regulations and (ii) gifts, grants, bequests, donations, contributions and pledges to any Obligated Group Member and (iii) insurance proceeds or any award, or payment in lieu of an award, resulting from condemnation proceedings and all rights to receive the foregoing, whether now owned or hereafter acquired by any Obligated Group Member and regardless of whether generated in the form of accounts, accounts receivable, contract rights, chattel paper, documents, general intangibles, instruments, investment property, proceeds of insurance and all proceeds of the foregoing, whether cash or noncash; excluding, however, gifts, grants, bequests, donations, contributions and pledges to any Obligated Group Member heretofore or hereafter made, and the income and gains derived there from, which are specifically restricted by the donor or grantor to a particular purpose which is inconsistent with its use for payments required under the Master Indenture or on the Indebtedness except that gifts, grants, bequests, donations, contributions and pledges which may be applied at the discretion of an Obligated Group Member to the payments due under the Master Indenture on the Indebtedness for any period shall not be excluded for purposes of determining Pledged Revenues of the Member of the Obligated Group for such period.

"Primary Obligor" means the Person who is primarily obligated on an obligation which is guaranteed by another Person.

"Principal Payment Date" means a date upon which the principal of any Bonds shall become due by maturity.

"Projected Debt Service Coverage Ratio" means, for any future period, the ratio consisting of a numerator equal to the amount determined by dividing the projected Income Available for Debt Service for that period by the Maximum Annual Debt Service Requirement for the Funded Indebtedness expected to be outstanding during such period and a denominator of one.

"Projected Rate" means, as designated at the time of each calculation by the Obligated Group Representative either of the following at the option of the Obligated Group Representative: (i) (A) if the interest on the Indebtedness (or the Related Bonds) with respect to which the Projected Rate is being calculated is entitled to the exemption from federal income tax afforded by Section 103 of the Code or any successor thereto, the average of the rates determined pursuant to the SIFMA Index published for the twelve consecutive months before the date of the calculation in question and (B) if the interest on the

Indebtedness (or the Related Bonds) with respect to which the Projected Rate is being calculated is not entitled to the exemption from federal income tax afforded by Section 103 of the Code or any successor thereto, the average One Month LIBOR Rate published for the twelve consecutive months before the date of the calculation in question; or (ii) the projected yield up par of an obligation as set forth in the report of a Consultant (which Consultant and report including, without limitation, the scope, form, substance and other aspects thereof are acceptable to the Master Trustee**).** Such Consultant's report shall state that in determining the Projected Rate the Consultant reviewed the yield evaluations at par of not less than three obligations (or such lesser number as the Consultant shall deem appropriate, but in no event less than one) selected by the Consultant which obligations are reasonable comparators to utilize in developing such Projected Rate, taking into account the exemption of interest on such obligations from income tax under Section 103 of the Code or any successor section (or lack of such exemption) and the term and amortization schedule of such obligations.

"Property" means interests in and to property whether real or personal, tangible or intangible.

"Property, Plant and Equipment" means all Property of each Member or Designated Affiliate which is classified as property, plant and equipment under GAAP.

"Put Date" means (i) any date on which an owner of Put Indebtedness may elect to have such Put Indebtedness paid, purchased or redeemed by or on behalf of the underlying obligor prior to its stated maturity date or (ii) any date on which Put Indebtedness is required to be paid, purchased or redeemed from the owner by or on behalf of the underlying obligor (other than at the option of the owner) prior to its stated maturity date, other than pursuant to any mandatory sinking fund or other similar fund or other than by reason of acceleration upon the occurrence of an event of default.

"Put Indebtedness" means Indebtedness which is (i) payable or required to be purchased or redeemed by or on behalf of the underlying obligor at the option of the owner thereof, prior to its stated maturity date or (ii) payable or required to be purchased or redeemed from the owner by or on behalf of the underlying obligor (other than at the option of the owner) prior to its stated maturity date, other than pursuant to any mandatory sinking fund or other similar fund or other than by reason of acceleration upon the occurrence of an event of default.

"Rating Categories" means one or more of the generic rating categories of a nationally recognized rating service without regard to any refinement or gradation of such rating category by numerical or other modifier.

"Rating Service" means each nationally recognized securities rating service which at the time has a credit rating assigned to the Bonds at the request of Parkview Health, which shall initially be S&P and Moody's.

"Rebate Fund" means the Rebate Fund created pursuant to the Indenture.

"Redemption Date" means, when used with respect to any Bond to be redeemed, the date on which it is to be redeemed pursuant to the Indenture.

"Refunding Fund" means the Refunding Fund created pursuant to the Indenture.

"Related Bond" or "*Related Bonds*" means revenue bonds or similar obligations issued by any state of the United States or any municipal corporation or other political subdivision formed under the laws thereof or any constituted authority, agency or instrumentality of any of the foregoing, the proceeds

of which are loaned or otherwise made available to a Member in consideration, whether in whole or in part, of the execution, authentication and delivery of a Master Note.

"Related Bond Indenture" means any indenture, bond resolution or similar instrument pursuant to which any series of Related Bonds is issued.

"Related Bond Trustee" means the trustee under any Related Bond Indenture and any successor trustee thereunder or, if no trustee is appointed under a Related Bond Indenture, the Related Issuer.

"Related Issuer" means the issuer of any series of Related Bonds.

"Related Loan Document" means any document pursuant to which proceeds of Related Bonds are made available to a Member.

"Related Supplemental Indenture" means any indenture supplementing the Master Indenture.

"Revenues" means, for any period: (I) in the case of any Person providing health care services, the sum of (a) gross patient service revenues less contractual allowances and provisions for uncollectible accounts, free care and discounted care, plus (b) other operating revenues, plus (c) non-operating revenues (other than Contributions, income derived from the sale of assets not in the ordinary course of business, any gain or loss from the extinguishment of debt or other extraordinary item, earnings which constitute Capitalized Interest or earnings on amounts which are irrevocably deposited in escrow to pay the principal of Indebtedness), plus (d) Adjusted Contributions, all as determined in accordance with GAAP; and (II) in the case of any other Person, gross revenues less sale discounts and sale returns and allowances, as determined in accordance with GAAP, but excluding in any event (a) any gain or loss resulting from the extinguishment of Indebtedness, (b) any gain or loss resulting from the sale, exchange or other disposition of assets not in the ordinary course of business and any unusual charges for valuation adjustments relating to fixed assets, (c) any gain or loss resulting from any discontinued operations, (d) any gain or loss resulting from pension terminations, settlements or curtailments, (e) any unusual charges for employee severance, (f) other extraordinary items as defined by GAAP, (g) any unrealized gains or losses for general investments, (h) any unrealized changes in the value of derivative instruments, or (i) any non cash impairment charges. If such calculation is being made with respect to the Obligated Group or the Credit Group, such calculation shall also be made in such a manner so as to exclude any revenues attributable to transactions between members of the Obligated Group or the Credit Group. See "SUMMARY OF CERTAIN PROVISIONS OF SUPPLEMENTAL NO. 8" herein for a summary of amendments to the definition of Revenues.

"S&P" means S & P Global Ratings, a Standard & Poor's Financial Services LLC business, its successors and assigns, or upon the discontinuance of such service, such other nationally recognized rating service as shall be determined by the Obligated Group Representative in writing to the Trustee.

"Securities Depository" means The Depository Trust Company and any substitute for or successor to such securities depository pursuant to the terms of the Indenture that shall maintain a Book Entry System with respect to the Bonds.

"Series 2009A Bonds" means the Indiana Finance Authority Hospital Revenue Bonds, Series 2009A (Parkview Health System Obligated Group).

"Series 2017A Note" means the Series 2017A Master Note issued under the Master Indenture, as previously supplemented and amended, and as further supplemented by the Series 2017A Supplemental Indenture.

"Series 2017A Supplemental Indenture" means the Series 2017A Supplemental Master Indenture, dated as of August 1, 2017, between Parkview Health and the Master Trustee pursuant to which the Series 2017A Note is issued.

"Short-Term" when used in connection with Indebtedness, means having an original maturity less than or equal to one year and not renewable at the option of the debtor for a term greater than one year from the date of original issuance.

"SIFMA Index" means, on any date, a rate determined on the basis of the seven-day high grade market index of tax-exempt variable rate demand obligations, as produced by Municipal Market Data and published or made available by the Securities Industry & Financial Markets Association (formerly the Bond Market Association) ("SIFMA") or any Person acting in cooperation with or under the sponsorship of SIFMA and acceptable to the Master Trustee and effective from such date.

"Sinking Fund Account" means the Sinking Fund Account of the Bond Fund created pursuant to the Indenture.

"Supplemental No. 8" means Supplemental and Amendatory Master Trust Indenture No. 8, dated as of August 1, 2017, between Parkview Health and the Master Trustee.

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

"Trustee" means U.S. Bank National Association, Indianapolis, Indiana, and any permitted successor as trustee under the Indenture.

"Trust Estate" means the property and other rights assigned by the Authority to the Trustee in the granting clauses of the Indenture.

"Trust Funds" means the funds and accounts created in the Indenture, except the Rebate Fund and the accounts thereof.

"Trust Moneys" means all moneys received by the Trustee (except for amounts on deposit in the Rebate Fund and the investment income earned thereon), upon the release of property from the lien of the Master Documents, any Collateral Documents or the Indenture, or as elsewhere in the Indenture provided to be held and applied under the Indenture, or required to be paid to the Trustee and whose disposition is not elsewhere in the Indenture otherwise specifically provided for, including, but not limited to, the investment income of all moneys (except amounts held in the Rebate Fund) held by the Trustee under the Indenture, or as payments made on the Series 2017A Note.

"United States Government Obligations" means direct obligations of, or obligations the principal of and interest on which are fully guaranteed by, the United States of America.

"Unrestricted Net Assets" means, at the time of calculation, the part of net assets of a nonprofit organization that is neither permanently restricted nor temporarily restricted by donor-imposed stipulations.

"Written Request" means with reference to a Related Issuer, a request in writing signed by the Chairman, Vice-Chairman, Mayor, Clerk, President, Vice President, Secretary or Assistant Secretary of the Related Issuer or any other officer designated by the Related Issuer and, with reference to any Member, means a request in writing signed by the President or a Vice President of Parkview Health or any other officers designated by Parkview Health.

SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE

PLEDGED REVENUES

All Master Notes issued under the Master Indenture are secured by the Pledged Revenues. Any Permitted Encumbrance properly granted under the Master Indenture and any claim arising therefrom or related thereto shall be senior in priority and prior to the lien of the Master Trustee in the Pledged Revenues if so designated by the Member creating such Permitted Encumbrance.

THE MASTER NOTES; PAYMENT OF MASTER NOTES; DESIGNATED AFFILIATES

Each Member will duly and punctually pay the principal of, premium, if any, and interest on each Master Note executed by it at the place, on the dates, and in the manner provided in the Master Indenture and in said Master Notes when and as the same become payable, whether at maturity, upon call for redemption, by acceleration of maturity or otherwise, and any other payments due under each Master Note, including payments of the purchase price of any Related Bonds tendered or deemed tendered for purchase pursuant to the terms of the Related Bond Indenture. Each Member unconditionally and irrevocably, jointly and severally guarantees and promises to pay any and all payments on all Master Notes when due. If for any reason any payment required pursuant to the terms of any Master Note has not been timely paid by the issuer thereof, all other Members shall be obligated under the Master Indenture to make such payment. These agreements on the part of each Member shall be absolute and unconditional until such Member withdraws from the Obligated Group, in which event they shall terminate only with respect to the withdrawing Members or until satisfaction and discharge of the Master Indenture.

The Obligated Group Representative shall cause its Designated Affiliates to pay, loan or otherwise transfer to the Obligated Group Representative such moneys as are necessary, in the aggregate, to pay the principal of, premium, if any, and interest on all outstanding Master Notes and to make any other payments, including payments of the purchase price of any Master Notes tendered or deemed tendered for purchase pursuant to the terms of a Related Bond Indenture, which are required by the terms of the Master Notes, on the dates, at the times, at the places and in the manner provided in the Master Notes, the related Supplemental Master Indentures and the Master Indenture, when and as the same become due and payable, whether at maturity, upon call for prepayment, by acceleration of maturity or otherwise.

The Obligated Group Representative may designate any Person as a Designated Affiliate, and such Person shall thereafter be deemed a Designated Affiliate until such time as the Obligated Group Representative shall declare that such Person will no longer be a Designated Affiliate; *provided, however*, that the Obligated Group Representative may not declare that a Person shall no longer be a Designated Affiliate if an Event of Default, or an event which, with the passage of time or giving of notice or both, would constitute an Event of Default, shall have occurred and be continuing at the time of such declaration or shall directly result from any such declaration. With respect to each such Person which is (and so long as such Person is) designated as a Designated Affiliate, the Obligated Group Representative shall either (i) maintain, directly or indirectly, control of each Designated Affiliate, including the power to direct the management, policies, disposition of assets and actions of such Designated Affiliate to the extent required to cause such Designated Affiliate to comply with the terms and conditions of the Master Indenture, whether through the ownership of voting securities, partnership interests, membership, reserved powers, the power to appoint members, trustees or directors or otherwise, or (ii) execute and have in effect such contracts or other agreements that the Obligated Group Representative in its sole judgment deems sufficient for it to cause such Designated Affiliate to comply with the terms and conditions of the Master Indenture.

The Obligated Group Representative shall cause its Designated Affiliates to comply with the terms and conditions of the Master Indenture which are applicable to the Designated Affiliates and the Related Loan Documents, if any, to which the Designated Affiliates are a party.

Notwithstanding anything in the Master Indenture to the contrary, no Person shall cease to be a Designated Affiliate if any outstanding Related Bonds have been issued for the benefit of such Person until there is delivered to the Master Trustee an opinion of nationally recognized municipal bond counsel to the effect that, under then existing law, the cessation by such Person of such status will not adversely affect the validity of any Related Bond or any exemption from federal or state income taxation of interest payable thereon to which such Related Bond would otherwise be entitled.

The Obligated Group Representative shall at all times maintain an accurate and complete list of (i) all Persons that are Members of the Obligated Group and (ii) all Persons designated as Designated Affiliates, and shall, at such times as the Obligated Group Representative revises such list, provide the Master Trustee with such revised list. Currently the only Designated Affiliate is Community Hospital of LaGrange County, Inc.

ENTRANCE INTO THE OBLIGATED GROUP

Any Person may become a Member of the Obligated Group if:

(a) all Members consent in writing;

(b) a Related Supplemental Indenture is executed by such Person in which such Person agrees to become a Member and to be jointly and severally liable with the other Members for the performance of all covenants contained in the Master Indenture and in the Master Notes;

(c) the Master Trustee receives an opinion of counsel to such Person that nothing in its Corporate Charter or Bylaws or in any instrument or agreement to which it or its Property is bound restricts its ability to perform its obligations under the Master Indenture;

(d) the Master Trustee receives an opinion of counsel to such Person to the effect that such Person has the corporate power and authority to execute and deliver the Related Supplemental Indenture and to perform its obligations under such instrument and to the effect that the Master Indenture, as supplemented by the Related Supplemental Indenture, constitutes the valid and binding obligation of such Person, enforceable in accordance with its terms, except as limited by bankruptcy laws, insolvency laws and other similar laws affecting creditors' rights generally and further subject to the exception that the provisions of the Master Indenture pursuant to which such Person guarantees the payment of any and all amounts due under the Master Notes of all Members may not be enforceable if payments or such guaranties: (i) are required with respect to payments of any Master Note which was issued for a purpose which is not consistent with the charitable purpose of such Person or which are issued for the benefit of any entity other than a not-for-profit corporation which 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; (ii) are required to be made from any moneys or assets of such Person which are donor restricted or which are subject to a direct or express trust which does not permit the use of such moneys or assets for such payments; (iii) would result in a cessation or discontinuance of any material portion of the health care or related services previously provided by such Person; or (iv) are required to be made pursuant to any loan violating applicable usury laws; and

(e) the Master Trustee receives (A) an Officer's Certificate of the Obligated Group Representative which demonstrates that, immediately upon such Person becoming a Member, the Obligated Group would not, as a result of such transaction, be in default in the performance or observance of the covenants or conditions to be performed or observed by it under the Master Indenture and the Credit Group could meet the Coverage Test; (B) an opinion of Independent Counsel to the effect that the addition of such Person as a Member will not adversely affect the status as a Tax-Exempt Organization of any Member which otherwise has such status; and (C) with respect to any tax exempt Related Bonds then outstanding, an opinion of nationally recognized municipal bond counsel to the effect that the consummation of such transaction would not adversely affect the validity of or the exemption from federal or state income taxation of interest payable on any such Related Bond.

Upon compliance with the foregoing conditions, such Person shall become a Member of the Obligated Group and shall be jointly and severally liable for the performance of all covenants contained in the Master Indenture and in the Master Notes. Upon entering the Obligated Group, the new Member shall execute such financing statements or take such other actions as the Master Trustee shall request to perfect the security interest created.

CESSATION OF STATUS AS A MEMBER OF THE OBLIGATED GROUP

No Member may withdraw from the Obligated Group unless:

(a) the Master Trustee shall have received written consents of all Members;

(b) the Member proposing to withdraw is not a party to any Related Loan Document with respect to Related Bonds which remain outstanding and there are no Outstanding Master Notes executed by it unless the remaining Members assume the obligations on any such Outstanding Master Notes;

(c) prior to the cessation of such status, there is delivered to the Master Trustee an opinion of nationally recognized municipal bond counsel to the effect that the cessation by the Member of its status as a Member will not adversely affect the validity of any Related Bond or the exemption from federal or state income taxation of interest payable on any Related Bond otherwise entitled to such exemption;

(d) taking such withdrawal into account, the Credit Group could meet the Coverage Test;

(e) prior to the cessation of such status there is delivered to the Master Trustee an opinion of Independent Counsel to the effect that the cessation by such Member of such status will not adversely affect the status as a Tax-Exempt Organization of any other Member which otherwise has such status; and

(f) prior to and immediately after such cessation no Event of Default exists under the Master Indenture.

LIENS ON PROPERTY

Each Member agrees that it will keep, and the Obligated Group Representative agrees that it will cause its Designated Affiliates to keep, its Property free and clear of all Liens which are not Permitted Encumbrances.

PERMITTED ADDITIONAL INDEBTEDNESS

So long as any Master Notes are Outstanding, a Member will not incur any Additional Indebtedness if an Event of Default has occurred and is continuing. Further, any Additional Indebtedness incurred following the date of issuance of the Bonds must be incurred under one of the following subparagraphs:

(A) Funded Indebtedness, if prior to incurrence thereof or, if such Funded Indebtedness was incurred in accordance with another subparagraph set forth below and any Member wishes to have such Indebtedness classified as having been issued as described under this subparagraph (A), prior to such classification, there is delivered to the Master Trustee:

(i) An Officer's Certificate of the Obligated Group Representative acceptable to the Master Trustee stating that the principal amount of all Long-Term Indebtedness of the Credit Group, together with the principal amount of the Long Term Indebtedness proposed to be issued is not more than 65% of the sum of the Unrestricted Net Assets of the of the Credit Group and the aggregate principal amount of the outstanding and proposed Long Term Indebtedness; or

(ii) an Officer's Certificate of the Obligated Group Representative acceptable to the Master Trustee stating that the Historical Pro Forma Debt Service Coverage Ratio of the Credit Group for each of the most recent Fiscal Year preceding the date of delivery of the report for which combined financial statements reported upon by independent certified public accountants are available was not less than 1.25:1, or

(iii) (a) An Officer's Certificate of the Obligated Group Representative acceptable to the Master Trustee stating that the Historical Debt Service Coverage Ratio of the Credit Group for the Fiscal Year next preceding the incurrence of such Funded Indebtedness for which combined financial statements reported upon by independent certified public accountants are available was not less than 1.10:1; and (b) (1) a written Consultant's report (which report, including without limitation the scope, form, substance and other aspects thereof, is acceptable to the Master' Trustee) to the effect that the Projected Debt Service Coverage Ratio of the Credit Group for each of the next two succeeding Fiscal Years or, if such Indebtedness is being incurred in connection with the financing of Facilities, the two Fiscal Years succeeding the projected completion date of such Facilities, is not less than 1.10:1; or (2) an Officer's Certificate from the Obligated Group Representative in a form acceptable to the Master Trustee to the effect that the Projected Debt Service Coverage Ratio of the Credit Group for each of the next two succeeding Fiscal Years or, if such Indebtedness is being incurred in connection with the financing of Facilities, the two Fiscal Years succeeding the projected completion date of such Facilities, is not less than 1.25:1, provided that either of such reports shall include forecast balance sheets, statements of revenues and expenses and statements of changes in financial position for each of such two Fiscal Years and a statement of the relevant assumptions upon which such forecasted statements are based, which financial statements must indicate that sufficient revenues and cash flow could be generated to pay the operating expenses of the Credit Group's proposed and existing Facilities and the debt service on the Credit Group's other existing Indebtedness during such two Fiscal Years; provided that the requirements of the foregoing subparagraph (A)(iii)(a) or (b) as the case may be, shall be deemed satisfied if (x) there is delivered to the Master Trustee the report of a Consultant, (which report, including without limitation the scope, form, substance and other aspects thereof, is acceptable to the Master Trustee and which contains the

information required by the proviso to subparagraph (A)(iii)(b) in the case of projections) which contains an opinion of such Consultant that applicable laws or regulations have prevented or will prevent the Credit Group from generating the amount of Income Available for Debt Service required to be generated by subparagraph (A)(iii)(a) or (b), as the case may be, as a prerequisite to the issuance of Funded Indebtedness, and, if requested by the Master Trustee, such report is accompanied by a concurring opinion of Independent Counsel (which Counsel and opinion, including without limitation the scope, form, substance and other aspects thereof, are acceptable to the Master Trustee) as to any conclusions of law supporting the opinion of such Consultant, (y) the report of the Consultant indicates that the rates charged or to be charged by the Credit Group are or will be such that, in the opinion of such Consultant, the Credit Group has generated or will generate the maximum amount of Revenues reasonably practicable given such laws or regulations, and (z) the Historical Debt Service Coverage Ratio of the Credit Group and the Projected Debt Service Coverage Ratio of the Credit Group referred to in the applicable subparagraph are at least 1.00:1. See "SUMMARY OF CERTAIN PROVISIONS OF SUPPLEMENTAL NO. 8" herein for a summary of amendments to the covenants relating to this subparagraph (A).

(B) Completion Funded Indebtedness if there is delivered to the Master Trustee: (i) an Officer's Certificate of the Member for-whose benefit such Indebtedness is being issued stating that at the time the original Funded Indebtedness for the Facilities to be completed was incurred, such Member had reason to believe that the proceeds of such Funded Indebtedness together with other moneys then expected to be available would provide sufficient moneys for the completion of such Facilities, (ii) a statement of an Independent Architect or an expert acceptable to the Master Trustee setting forth the amount estimated to be needed to complete the Facilities, and (iii) an Officer's Certificate of such Member stating that the proceeds of such Completion Funded Indebtedness to be applied to the completion of the Facilities, together with a reasonable estimate of investment income to be earned on such proceeds and available to pay such costs, the amount of moneys, if any, committed to such completion from available cash or marketable securities and reasonably estimated earnings thereon, enumerated bank loans (including letters or lines of credit) and federal or state grants reasonably expected to be available, will be in an amount not less than the amount set forth in the statement of an Independent Architect or other expert, as the case may be, referred to in (ii).

(C) Funded Indebtedness for the purpose of refunding (whether in advance or otherwise, including without limitation refunding through the issuance of Cross-over Refunding Indebtedness) any outstanding Funded Indebtedness if prior to the incurrence thereof an Officer's Certificate of a Member is delivered to the Master Trustee stating that, taking into account the issuance of the proposed Funded Indebtedness and the application of the proceeds thereof and any other funds available to be applied to such refunding, the Maximum Annual Debt Service Requirement of the Credit Group will not be increased by more than 15%.

(D) Short-Term Indebtedness (other than Short-Term Indebtedness incurred in accordance with subparagraph (E) described below) in a total principal amount which at the time incurred does not, together with the principal amount of all other such Short Term Indebtedness of the Credit Group then outstanding as described under this subparagraph (D) and the principal payable on all Funded Indebtedness during the next succeeding 12 months, excluding such principal to the extent that amounts are on deposit in an irrevocable escrow and such amounts (including, where appropriate, the earnings or other increments to accrue thereon) are required to be applied to pay such principal and such amounts so required to be applied are sufficient to pay such principal, exceed 25% of the Revenues of the Credit Group for the most recent Fiscal Year

for which combined financial statements reported upon by independent certified public accountants are available; provided, however, that for a period of 20 consecutive calendar days in each Fiscal Year the total amount of such Short-Term Indebtedness of the Credit Group outstanding as described under this subparagraph (D) shall be not more than 5% of the Revenues of the Credit Group during such Fiscal Year plus such additional amount as the Obligated Group Representative certifies in an Officer's Certificate is (a) attributable to Short-Term Indebtedness incurred to offset a temporary delay in the receipt of funds due from third party payors and (b) in the minimum amount reasonably practicable taking into account such delay

(E) Short-Term Indebtedness if:

(i) There is in effect at the time the Short-Term Indebtedness provided for as described in this subparagraph (E) is incurred a binding commitment (including without limitation letters or lines of credit or insurance) which may be subject only to commercially reasonable contingencies, by a financial institution generally regarded as responsible, which commitment and institution are acceptable to the Master Trustee, to provide financing sufficient to pay such Short-Term Indebtedness at its maturity; and

(ii) The conditions described in subparagraph (A) are met with respect to such Short-Term Indebtedness when it is assumed that such Short-Term Indebtedness is Funded Indebtedness maturing over 30 years from the date of issuance of the Short-Term Indebtedness, bears interest on the unpaid principal balance at the Projected Rate and is payable on a level annual debt service basis over a 30-year period.

(F) Non-Recourse Indebtedness.

(G) Balloon Indebtedness if:

(i) (a) there is in effect at the time such Balloon Indebtedness is incurred a binding commitment (including without limitation letters or lines of credit or insurance) which may be subject only to commercially reasonable contingencies by a financial institution generally regarded as responsible, which commitment and institution are acceptable to the Master Trustee, to provide financing sufficient to pay the principal amount of such Balloon Indebtedness coming due in each consecutive 12 month period in which 25% or more of the original principal amount of such Balloon Indebtedness comes due; and (b) the conditions set forth in subparagraph (A) are met with respect to such Balloon Indebtedness when the assumptions set forth in subparagraph (E)(ii) above are made with respect to the portion of such Balloon Indebtedness becoming due during each such 12 month period; or

(ii) (a) a Member establishes in an Officer's Certificate filed with the Master Trustee an amortization schedule for such Balloon Indebtedness, which amortization schedule shall provide for payments of principal and interest for each Fiscal Year that are not less than the amounts required to make any actual payments required to be made in such Fiscal Year by the terms of such Balloon Indebtedness; (b) such Member agrees in such Officer's Certificate to deposit for each Fiscal Year with a bank or trust company (pursuant to an agreement between such Member and such bank or trust company, which agreement shall be satisfactory in form and substance to the Master Trustee) the amount of principal shown on such amortization schedule net of any amount of principal actually paid on such Balloon Indebtedness during such Fiscal Year (other than from amounts on deposit with such bank or trust company) which deposit shall be made prior to any such

required actual payment during such Fiscal Year if the amounts so on deposit are intended to be the source of such actual payments; and (c) the conditions described in subparagraph (A) above are met with respect to such Balloon Indebtedness when it is assumed that such Balloon Indebtedness is actually payable in accordance with such amortization schedule.

(H) Put Indebtedness if the conditions set forth in subparagraph (A) above are met, with respect to such Put Indebtedness when it is assumed that such Put Indebtedness bears interest at the Projected Rate and is payable on a level annual debt service basis over a 30-year period commencing with the next succeeding Put Date.

(I) Guaranties by any Member of the payment by another Person of a sum certain; provided that the conditions described under this heading "PERMITTED ADDITIONAL INDEBTEDNESS" are satisfied if it is assumed that the Indebtedness guaranteed is Funded Indebtedness of such Member; provided, however, that such obligation shall be considered Funded Indebtedness of any Member only to the extent of the Member's Exposure on Guaranteed Debt; provided further that the Income Available for Debt Service for the Credit Group shall not be deemed to include any Revenues of the Primary Obligor and that the debt service payable with respect to the Indebtedness guaranteed shall be calculated in accordance with the assumptions contained in the Master Indenture.

(J) Liabilities for contributions to self-insurance or shared or pooled-risk insurance programs required or permitted to be maintained under the Master Indenture.

(K) Commitment Indebtedness.

(L) Indebtedness consisting of accounts payable incurred in the ordinary course of business or other Indebtedness not incurred or assumed primarily to assure the repayment of money borrowed or credit extended which Indebtedness is incurred in the ordinary course of business.

(M) Indebtedness the principal amount of which at the time incurred, together with (i) the aggregate principal amount of all other Indebtedness then outstanding which was issued pursuant to the provisions of described in this subparagraph (M) and which has not been subsequently reclassified as having been issued as described under subparagraphs (A), (E), (G) or (H), and (ii) the aggregate principal amount of all Indebtedness then outstanding as described under subparagraph (D) above, does not exceed 25% of the Revenues of the Credit Group for the latest preceding Fiscal Year for which combined financial statements reported upon by independent certified public accountants are available.

(N) Indebtedness incurred in connection with a sale of accounts receivable with or without recourse by any Member consisting of an obligation to repurchase all or a portion of such accounts receivable upon certain conditions, provided that the principal amount of such Indebtedness permitted hereby shall not exceed the aggregate amount of such accounts receivable so sold by such Member.

It is agreed and understood by the parties to the Master Indenture that various types of Indebtedness may be incurred as described under any of the above-referenced subparagraphs with respect to which the tests set forth in such subparagraph are met and need not be incurred under only a subparagraph specifically referring to such type of Indebtedness (e.g., Balloon Indebtedness and Put

Indebtedness may be incurred as described under subparagraph (A) above if the tests therein are satisfied).

Each Member covenants that Indebtedness of the type permitted to be incurred as described under subparagraph (L) above will not be allowed to become overdue for a period in excess of that which is ordinary for similar institutions without being contested in good faith and by appropriate proceedings.

Each Member covenants that prior to, or as soon as reasonably practicable after, the incurrence of Indebtedness by such Member for money borrowed or credit extended, or the equivalent thereof, after the date of issuance of the Bonds, it will deliver to the Master Trustee an Officer's Certificate which identifies the Indebtedness incurred, identifies the subparagraph set forth above pursuant to which such Indebtedness was incurred, demonstrates compliance with the provisions of such subparagraph and attaches a copy of the instrument evidencing such Indebtedness; provided, however, that this requirement shall not apply to Indebtedness incurred as described pursuant to subparagraph (J) or (L) set forth above.

CALCULATION OF DEBT SERVICE AND DEBT SERVICE COVERAGE

The various calculations of the amount of Indebtedness of a Person, the amortization schedule of such Indebtedness and the debt service payable with respect to such Indebtedness required under certain provisions of the Master Indenture shall be made in a manner consistent with that adopted in the Master Indenture. In the case of Balloon or Put Indebtedness issued pursuant to the provisions of the Master Indenture described above under the heading "PERMITTED ADDITIONAL INDEBTEDNESS – subparagraphs (B), (G), (H) or (M)", unless such Indebtedness is reclassified pursuant to the Master Indenture as having been issued pursuant to another subparagraph of the Master Indenture described above under the heading "PERMITTED ADDITIONAL INDEBTEDNESS", the amortization schedule of such Indebtedness and the debt service payable with respect to such Indebtedness for future periods shall be calculated on the assumption that such Indebtedness is being issued simultaneously with such calculation. With respect to Put Indebtedness, if the option of the holder to require that such Indebtedness be paid, purchased or redeemed prior to its stated maturity date, or if the requirement that such Indebtedness be paid, purchased or redeemed prior to its stated maturity date (other than at the option of such holder and other than pursuant to any mandatory sinking fund or any similar, fund), has expired or lapsed as of the date of calculation, such Put Indebtedness shall be deemed payable in accordance with its terms.

In determining the amount of debt service payable on Indebtedness in the course of the various calculations required under certain provisions of the Master Indenture, if the terms of the Indebtedness being considered are such that interest thereon for any future period of time is expressed to be calculated at a varying rate per annum, a formula rate or a fixed rate per annum based on a varying index, then for the purpose of making such determination of debt service, interest on such Indebtedness for such period (the "Determination Period") shall be computed by assuming that the rate of interest applicable to the Determination Period is equal to the average of (i) the rate of interest (calculated in the manner in which the rate of interest for the Determination Period is expressed to be calculated) which was in effect on the last date of each of the twelve consecutive calendar months immediately preceding the month in which such calculation is made or (ii) if the index or other basis for calculating such interest was not in existence for twelve consecutive calendar months, the rate of interest (calculated in the manner in which the rate of interest for the Determination Period is expressed to be calculated) which was in effect on the last date of each calendar month in which such index or other basis was in existence; provided that if the index or other basis for calculating such interest was not in existence for at least three full calendar months next preceding the date of calculation, the rate of interest for such portion of such period shall be deemed to be the rate of interest borne by such Indebtedness when issued.

Master Notes issued to secure Indebtedness permitted to be incurred under the Master Indenture as described above under the heading "PERMITTED ADDITIONAL INDEBTEDNESS" shall not be treated as Additional Indebtedness.

No debt service shall be deemed payable with respect to Commitment Indebtedness until such time as funding occurs under the commitment which gave rise to such Commitment Indebtedness. From and after such funding, the amount of such debt service shall be calculated in accordance with the actual amount required to be repaid on such Commitment Indebtedness and the actual interest rate and amortization schedule applicable thereto. No Additional Indebtedness shall be deemed to arise when any funding occurs under any such commitment or any such commitment is renewed upon terms which provide for substantially the same terms of repayment of amounts disbursed pursuant to such commitment as obtained prior to such renewal. In addition, no Additional Indebtedness shall be deemed to arise when Indebtedness which bears interest at a variable rate of interest is converted to Indebtedness which bears interest at a fixed rate or the method of computing the variable rate on such Indebtedness is changed or the terms upon which Indebtedness, if Put Indebtedness, may be or is required to be tendered for purchase are changed, if such conversion or change is in accordance with the provisions applicable to such variable rate Indebtedness or Put Indebtedness in effect immediately prior to such conversion or change.

Anything in the Master Indenture to the contrary notwithstanding, any portion of any Indebtedness of any member of the Credit Group for which an Interest Rate Agreement has been obtained by such member of the Credit Group shall be deemed to bear interest for the period of time that such Interest Rate Agreement is in effect at a net rate which takes into account the interest payments made by such member of the Credit Group on such Indebtedness and the payments made or received by such member of the Credit Group on such Interest Rate Agreement; provided that the long-term credit rating of the provider of such Interest Rate Agreement (or any guarantor thereof) is in one of the two highest rating categories of any Rating Agency (without regard to any refinements of gradation of rating category by numerical modifier or otherwise) or is at least as high as that of the Credit Group. In addition, so long as any Indebtedness is deemed to bear interest at a rate taking into account an Interest Rate Agreement, any payments made by a member of the Credit Group on such Interest Rate Agreement shall be excluded from expenses and any payments received by an Issuer on such Interest Rate Agreement shall be excluded from revenues, in each case, for all purposes of the Master Indenture.

Balloon Indebtedness incurred as provided under subparagraph (B) or (M) described under the heading "PERMITTED ADDITIONAL INDEBTEDNESS" set forth above, unless reclassified pursuant to the section of the Master Indenture regarding calculation of debt service, shall be deemed to be payable in accordance with the assumptions set forth in subparagraph (G)(i)(b) described under the heading "PERMITTED ADDITIONAL INDEBTEDNESS" set forth above. Put Indebtedness incurred as provided under subparagraph (B) or (M) described above under the heading "PERMITTED ADDITIONAL INDEBTEDNESS" set forth above, unless reclassified pursuant to the section of the Master Indenture regarding calculation of debt service, shall be deemed to be payable in accordance with the assumptions set forth in subparagraph (H)(ii) described under the heading "PERMITTED ADDITIONAL INDEBTEDNESS" set forth above.

For the purposes of the various calculations required under the Master Indenture, the Capitalized Rentals under a Capitalized Lease at the time of such calculation shall be deemed to be the principal payable thereon.

Each Member may elect to have Indebtedness issued pursuant to one provision of the Master Indenture described above under the heading "PERMITTED ADDITIONAL INDEBTEDNESS" set forth above, including without limitation subparagraph (M) thereof, reclassified as having been incurred under another provision of the Master Indenture described under the heading "PERMITTED ADDITIONAL

INDEBTEDNESS" set forth above, by demonstrating compliance with such other provision on the assumption that such Indebtedness, is being reissued on the date of delivery of the materials required to be delivered under such other provision including the certification of any applicable Projected Rate. From and after such demonstration, such Indebtedness shall be deemed to have been incurred under the provision with respect to which such compliance has been demonstrated until any subsequent reclassification of such Indebtedness.

RATES AND CHARGES

To the extent permitted by law, each Member agrees to operate its Facilities and to charge such fees and rates for its Facilities and services as to provide income from its operations together with other available funds sufficient to pay promptly all payments on its Indebtedness, all expenses of operation, maintenance and repair of the Property of the Member and all other payments required to be made by it under the Master Indenture.

If the Coverage Test is not met for any Fiscal Year, the Members of the Obligated Group shall, at their expense, retain a Consultant to make recommendations with respect to the rates, fees and charges of the Credit Group and the Credit Group's methods of operation and other factors affecting its financial condition in order to meet the Coverage Test.

A copy of the Consultant's report and recommendations, if any, shall be filed with each of the Members and the Master Trustee. The Members shall, and the Obligated Group Representative shall cause each of its Designated Affiliates to, follow each recommendation of the Consultant to the extent deemed feasible by the Obligated Group Representative. No default shall be deemed to occur under the provisions summarized under this heading if such recommendations are followed, notwithstanding that the Coverage Test is not met in a subsequent year, *provided* the Historical Debt Service Coverage Ratio of the Credit Group for the subsequent year in which the Coverage Test was not met was greater than or equal to 1.0:1. In determining whether such Historical Debt Service Coverage Ratio was greater than or equal to 1.0:1 as provided in the preceding sentence (and only for such purpose), the Revenues of the Credit Group shall include an additional amount equal to 10% of the sum of the cash and marketable securities of the Credit Group as reported on the financial statements which are the basis for the calculation of such Historical Debt Service Coverage Ratio, but such additional inclusion shall only be made for the first subsequent year in which such Coverage Test is not met. The provisions described in this paragraph shall not be construed to prohibit any Member or Designated Affiliate which is a Tax-Exempt Organization from serving indigent patients or from serving any other class or classes of patients without charge or at reduced rates to the extent necessary to preserve such status as a Tax-Exempt Organization.

The foregoing provisions notwithstanding, the Credit Group shall not be required to comply with the provisions summarized under this heading if: (A) there is filed with the Master Trustee a written opinion of a Consultant to the effect that applicable laws or regulations have prevented or have contributed significantly to preventing the Credit Group from meeting the Coverage Test and is accompanied by a concurring opinion of Independent Counsel as to any conclusions of law supporting the opinion of such Consultant; and (B) the Historical Debt Service Coverage Ratio was at least 1:1. The Obligated Group shall not be required to cause the Consultant's opinion to be prepared more frequently than once every two Fiscal Years if at the end of the first of such two Fiscal Years it provides to the Master Trustee an opinion of Independent Counsel to the effect that the applicable laws and regulations underlying the Consultant's opinion delivered in the previous year have not changed in any material way. See "SUMMARY OF CERTAIN PROVISIONS OF SUPPLEMENTAL NO. 8" herein for a summary of amendments to the covenants relating to Rates and Charges.

FINANCIAL STATEMENTS

The Members covenant and agree that they will keep or cause to be kept proper books of record and account in which full, true and correct entries will be made of all dealings or transactions of, or in relation to, the business and affairs of the Credit Group in accordance with GAAP. The Obligated Group Representative shall cause its Designated Affiliates to keep or cause to be kept proper books of records and account in which full, true and correct entries will be made of all dealings or transactions of, or in relation to, the business and affairs of such Designated Affiliate in accordance with GAAP. See "SUMMARY OF CERTAIN PROVISIONS OF SUPPLEMENTAL NO. 8" herein for a summary of amendments to the covenants relating to Financial Statements.

The Obligated Group Representative covenants and agrees to furnish to the Master Trustee, any Related Issuer or Related Bond Trustee:

(a) As soon as practicable, but in no event more than five months after the last day of each Fiscal Year beginning with the Fiscal Year ending December 31, 1998, a financial report for each Member for such Fiscal Year certified by a firm of nationally recognized independent certified public accountants approved by the Obligated Group Representative prepared on a combined or consolidated basis to include the results of operations of all Persons required to be consolidated or combined with such Member in accordance with GAAP and containing an audited combined balance sheet as of the end of such Fiscal Year and an audited combined statement of cash flows for such Fiscal Year, together with an accompanying unaudited balance sheet, statement of operations and changes in net assets prepared on a combined basis to reflect only the operations of the Members and Designated Affiliates which have been required to be included in such report, showing in each case in comparative form the financial figures for the preceding Fiscal Year, and the statement that such accountants have obtained no knowledge of any default by such Member in the fulfillment of any of the terms, covenants, provisions, or conditions of the Master Indenture relating to accounting matters included in the Master Indenture, or if such accountant shall have obtained knowledge of any such default or defaults, they shall disclose in such statements the default or defaults and the date thereof (but such accountant shall not be liable directly or indirectly to anyone for failure to obtain knowledge of any default).

(b) If the reports referred to in subparagraph (a) above do not include the results of operations of any Designated Affiliate, as soon as practicable, but in no event more than five months after the last day of each Fiscal Year beginning with the Fiscal Year ending December 31, 1998, a financial report for such Designated Affiliate for such Fiscal Year certified by a firm of nationally recognized independent certified public accountants approved by the Obligated Group Representative, prepared on a combined or consolidated basis to include the results of operations of all Persons required to be consolidated or combined with such Designated Affiliate in accordance with GAAP, and containing an audited combined balance sheet as of the end of such Fiscal Year and an audited combined statement of changes in operations and changes in the net assets for such Fiscal Year and an audited combined statement of cash flows for such Fiscal Year, together with an accompanying unaudited balance sheet, statement of operations and changes in net assets prepared on a combined basis to reflect only the operations of the Designated Affiliates which have been required to be included in such report, showing in each case in comparative form the financial figures for the preceding Fiscal Year, and the statement that such accountants have obtained no knowledge of any default by such Designated Affiliate in the fulfillment of any of the terms, covenants, provisions or conditions of the Master Indenture relating to accounting matters included in the Master Indenture, or if such accountant shall have obtained knowledge of any such default or defaults, they shall disclose in such statements the default or defaults and the

dates such thereof (but such accountants shall not be liable directly or indirectly to anyone for failure to obtain knowledge of any default).

(c) As soon as practicable, but in no event more than six months after the last day of each Fiscal Year beginning with the Fiscal Year ending December 31, 1998, a balance sheet, statement of operations and changes in net assets including all the Members and Designated Affiliates prepared based on the accompanying unaudited combined schedules delivered with the audited financial statements described in subparagraphs (a) and (b) above (such balance sheet, statement of operations and changes in net assets being referred to herein as the "*Credit Group Financial Statements"),* together with a certificate of the chief financial officer of the Obligated Group Representative stating that the Credit Group Financial Statements were prepared on a basis consistent with that used for the Members and the Designated Affiliates and that the Credit Group Financial Statements reflect the results of the operations of only the Members and the Designated Affiliates and all Members and Designated Affiliates are included.

(d) At the time of the delivery of the Credit Group Financial Statements, a certificate of the chief financial officer of the Obligated Group Representative, stating that the Obligated Group Representative has made a review of the activities of each Member and Designated Affiliate during the preceding Fiscal Year for the purpose of determining whether or not the Members and Designated Affiliates have complied with all of the terms, provisions and conditions of the Master Indenture and that each Member and Designated Affiliate has kept, observed, performed and fulfilled each and every covenant, provision and condition of the Master Indenture on its part to be performed and is not in default in the performance or observance of any of the terms, covenants, provisions or conditions thereof, or if any Member or Designated Affiliate shall be in default such certificate shall specify all such defaults and the nature thereof.

If all financial statements referred to under this heading are filed with a Nationally Recognized Municipal Securities Information Repository (in accordance with Securities and Exchange Commission Rule 15c2-12), the Obligated Group shall not be required to also provide such statements to the Master Trustee, the Related Issuers and the Related Bond Trustees unless such parties request in writing copies of such statements from the Obligated Group Representative.

Upon the written request of the Master Trustee, each Member shall, and the Obligated Group Representative shall cause each of its Designated Affiliates to, at any and all times permit the Master Trustee by its representatives to inspect the properties, books of account, records, reports and other papers of the Member or Designated Affiliate, except donor records, patient records, personnel records, and any other confidential records, and to take copies and extracts therefrom and will afford and procure a reasonable opportunity to make any such inspection. Each Member shall, and the Obligated Group Representative shall cause each of its Designated Affiliates to, furnish to the Master Trustee any and all information as the Master Trustee may reasonably request, with respect to the performance by the Members or Designated Affiliates of their respective covenants in the Master Indenture. See "SUMMARY OF CERTAIN PROVISIONS OF SUPPLEMENTAL NO. 8" herein for a summary of amendments to the covenant relating to Financial Statements.

INSURANCE

Each Member covenants to maintain, or cause to be maintained (and the Obligated Group Representative shall cause its Designated Affiliates to maintain or cause to be maintained), insurance with respect to its Property, the operation thereof and its business, or may self insure, against such casualties, contingencies and risks in amounts not less than is customary in the case of corporations engaged in the same or similar activities and similarly situated and as, in the judgment of such Member, is adequate to

protect its Property, operations and businesses. Each Member shall biannually review the insurance it maintains as to its customariness and adequacy. In addition, each Member shall at least once every Fiscal Year cause a certificate of an Insurance Consultant to be delivered to the Master Trustee which indicates that the insurance then being maintained by such Member is customary in the case of entities engaged in the same or similar activities and similarly situated, is reasonably adequate to protect such Member's Property and operations and meets the minimum requirements of applicable state law. The Obligated Group Representative shall cause its Designated Affiliates to comply with the provisions described in this paragraph. See "SUMMARY OF CERTAIN PROVISIONS OF SUPPLEMENTAL NO. 8" herein for a summary of amendments to the covenant relating to Insurance.

MERGER, CONSOLIDATION, SALE OR CONVEYANCE

Excepting transactions solely among Members, each Member agrees that it will not merge into, or consolidate with, any corporation, allow any corporation to merge into it or sell or convey all or substantially all of its Property to any Person unless:

(a) the survivor is or becomes a Member;

(b) no Event of Default has occurred and is continuing;

(c) the Coverage Test is met; and

(d) if all amounts due or to become due on all Related Bonds have not been fully paid or provided for, there shall be delivered to the Master Trustee an opinion of nationally recognized municipal bond counsel acceptable to the Master Trustee to the effect that the consummation of such merger, consolidation, sale or conveyance, would not adversely affect the validity of or the exemption from federal income taxation of interest payable on such Related Bonds.

The Master Trustee may rely upon an opinion of Independent Counsel as conclusive evidence that any such consolidation, merger, sale or conveyance, and any such assumption, complies with the provisions described in this Section.

Except as may be expressly provided in any supplemental Master Indenture, the ability of any of the Designated Affiliates to merge into, or consolidate with, one or more corporations, or allow one or more corporations to merge into it, or sell or convey all or substantially all of its Property to any Person is not limited by the provisions of the Master Indenture. Notwithstanding anything to the contrary therein, no such Designated Affiliate shall engage in any merger or consolidation or any sale or conveyance of substantially all of its assets if any Related Bonds then outstanding have been issued for its benefit unless there is delivered to the Master Trustee an opinion of nationally recognized municipal bond counsel to the effect that, under then existing law, such action will not adversely affect the validity of any Related Bond or any exemption from federal or state income taxation of interest payable thereon to which such Related Bond would otherwise be entitled.

OTHER COVENANTS OF THE MEMBERS

Each Member covenants to, among other things, (a) pay all taxes, assessments and charges and comply with all present and future laws, rules, orders and regulations; *provided* that under certain circumstances such Member has the right and privilege to contest any of the foregoing; (b) maintain its Property in good condition, repair and working order, and from time to time make all necessary and proper repairs and replacements thereto as it judges necessary; (c) procure and maintain all necessary

licenses and permits and maintain the status of its health care Facilities as a provider of services eligible for participation in those reimbursement programs which the Member determines is appropriate, except to the extent the Member shall determine in good faith that maintenance of such status is not in its best interest and that lack of such status will not materially impair the ability of the Obligated Group to pay its Indebtedness when due; and (d) file certain financial information periodically with the Master Trustee.

DEFAULTS AND REMEDIES

The following events are "Events of Default" under the Master Indenture:

(a) the failure to pay when due the principal of, premium, if any, or interest on any Master Note, whether at maturity, by acceleration or otherwise (or the failure to pay when due any advance deposit with respect to payments on any Master Note required pursuant to the terms of any loan or other financing agreement); or

(b) failure of the Obligated Group to perform any other covenant, condition or provision contained in the Master Indenture and to remedy such default within 30 days after written notice thereof from the Master Trustee to each Member unless it cannot be remedied within the 30-day period and the Master Trustee agrees in writing to an extension of time (which agreement shall not be unreasonably withheld) and the Obligated Group institutes corrective action within the period agreed upon and diligently pursues such action until the default is remedied; or

(c) if any representation or warranty made by any Member of the Obligated Group in any statement or certificate furnished in connection with the sale of any Master Note or Related Bonds or pursuant to the Master Indenture is untrue when made in any material respect and shall not be made good within 30 days after written notice thereof to each Member by the Master Trustee; or

(d) if default shall occur in the payment of the principal of or interest on any Indebtedness of any Member for borrowed money, or if default shall occur under any mortgage, agreement or other instrument under or pursuant to which Indebtedness of a Member is issued with the result that such Indebtedness becomes due and payable prior to its expressed maturity; or

(e) any judgment, writ or warrant of attachment or of any similar process shall be entered or filed against any Member or Designated Affiliate or its Property and remains unvacated, unpaid, unbonded or unstayed for 90 days; *provided*, *however*, that no such event shall constitute an Event of Default within the meaning of this paragraph unless the amount of such judgment, writ, warrant of attachment or similar process, together with the amount of all other such judgments, writs, warrants or similar processes so unvacated, unpaid, unbonded, unstayed or uncontested, exceeds 1% of the Unrestricted Net Assets of the Credit Group as shown on or derived from the then latest available audited financial statements of the Credit Group; or

(f) if any Member admits insolvency or bankruptcy or its inability to pay its debts as they mature, or makes an assignment for the benefit of creditors or applies for or consents to the appointment of a trustee or receiver for it or for a major part of its Property; or if a trustee or receiver is appointed for any Member or for a major part of its Property and is not discharged within 30 days; or if bankruptcy, reorganization, arrangement, insolvency or liquidation or other proceedings for relief under any bankruptcy or similar law for the relief of debtors are instituted by or against any Member and if instituted against such Member are not dismissed within 30 days; *provided*, *however*, that no event described in this paragraph shall constitute an Event of

Default if, within 15 days after the Obligated Group Representative has received written notice from the Master Trustee that such event has occurred, there shall have been deposited with the Master Trustee either (i) sufficient moneys to provide for the payment in full of all outstanding Indebtedness of such Member other than its Master Notes or (ii) if acceptable to the Master Trustee in its sole discretion, and then only under such terms and conditions as it shall prescribe, one or more Master Notes executed by another Member in substitution for all such outstanding Indebtedness of the defaulting Member.

Upon the occurrence and continuance of an Event of Default, the Master Trustee may, and if requested by the holders of not less than 25% in aggregate principal amount of all Master Notes then Outstanding, the Master Trustee shall, by notice in writing to each Member declare the principal of all Master Notes to be due and payable immediately, and upon any such declaration the same, with interest thereon to the date of declaration, shall be immediately due and payable.

The principal of all Outstanding Master Notes shall also become immediately due and payable, with interest thereon to the date of declaration, upon any declaration of acceleration by a Related Trustee of the principal of any Related Bond *ipso facto* and without the necessity of any action by the Master Trustee.

The foregoing provisions, however, are subject to the condition that if, at any time after the principal of all Master Notes shall have been 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 Obligated Group shall pay or shall deposit with the Master Trustee a sum sufficient to pay all matured installments of interest upon all such Master Notes and principal and premium, if any, of all such Master Notes that shall have become due otherwise than by acceleration (with interest on overdue installments of interest, to the extent permitted by law, and on such principal and premium, if any, at the rate borne by such Master Notes to the date of such payment or deposit) and the expenses of the Master Trustee, and any and all Events of Default, shall have been remedied the holders of 51% in aggregate principal amount of all Master Notes then Outstanding by written notice to each Member and to the Master Trustee, may 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.

See "SUMMARY OF CERTAIN PROVISIONS OF SUPPLEMENTAL NO. 8" herein for a summary of amendments to subparagraph (e) under this heading.

SUPPLEMENTAL MASTER INDENTURES

The Members and the Master Trustee may enter into an indenture supplemental to the Master Indenture without the consent of the Master Note Holders for one or more of the following purposes: (a) to evidence the admission or withdrawal of a Member; (b) to add to the covenants of the Obligated Group such further covenants, restrictions or conditions as the Master Trustee shall consider to be for the protection of the holders of Master Notes; (c) to cure any ambiguity or to correct or supplement any provision contained in the Master Indenture which may be defective or inconsistent with any other provision contained in the Master Indenture, or to make such other provisions in regard to matters or questions arising under the Master Indenture as shall not be inconsistent with the Master Indenture and shall not adversely affect the interests of the holders of Master Notes; (d) to modify or supplement the Master Indenture in such manner as may be necessary or appropriate to qualify the Master Indenture under the Trust Indenture Act of 1939, or under any similar federal or state statute hereafter enacted; (e) to provide for the issuance of a new series of Master Notes; and (f) to amend the Master Indenture in any

other respect which, in the judgment of the Master Trustee, is not to the detriment of the holders of the Master Notes.

With the consent of the holders of not less than 51% in aggregate principal amount of Master Notes then Outstanding, the Obligated Group and the Master Trustee may enter into indentures supplemental to the Master Indenture for any purpose; *provided*, *however*, that no such supplemental indenture shall (i) effect a change in the times, amounts or currency of payment of any Master Note or a reduction in the principal amount or redemption price of any Master Note or the rate of interest thereon, (ii) reduce the aforesaid percentage of Master Notes, the holders of which are required to consent to any such supplemental indenture, or (iii) permit the preference or priority of any Master Note over another, without the consent of the holders of all Master Notes then Outstanding.

CREDIT ENHANCEMENT PROVIDERS DEEMED BONDHOLDERS FOR PURPOSES OF CONSENTS AND SUPPLEMENTS.

With respect to any series of Related Bonds which is backed by a credit enhancement device which insures, guarantees or otherwise supports the payment of all of the principal, premium and interest on such series of Related Bonds, the issuer of such credit enhancement device shall be deemed to be the holder of all of such series of Related Bonds for purposes of giving consents to supplements of or amendments to the Master Indenture.

SUMMARY OF CERTAIN PROVISIONS OF SUPPLEMENTAL NO. 8

Supplemental No. 8 contains certain prospective amendments of the Master Indenture relating to accounting principles, certain financial covenants, insurance requirements and reporting of financial statements. **By their purchase of the Bonds, the original purchasers thereof will be deemed to have consented to such amendments by their acceptance of the Bonds**. Such consent will bind future Holders of the Bonds. Pursuant to the provisions of the Master Indenture relating to amendments thereof, the amendment described in this paragraph will be effective upon the receipt of consent of the holders of at least 51% in aggregate principal amount of the Master Notes which are outstanding under the Master Indenture. Once effective, Parkview Health will provide a notice of the effective date of the amendment to EMMA. The amendments provided for in Supplemental No. 8 may therefore not yet be effective upon the issuance of the Bonds.

Specifically, Supplemental No. 8, once effective, will add the following two definitions to the Master Indenture:

> *"System"* means the affiliated group of Persons comprised of all the System Affiliates.
>
> *"System Affiliate"* means each Member of the Obligated Group, each Affiliate of the Corporation or any other Member of the Obligated Group, each Designated Group Affiliate and each other Person with whom a Member or Designated Group Affiliate has in place a contract or other agreement whereby such Person is obligated to make payments in respect of Master Notes.

Supplemental No. 8, once effective, will amend and restate the following definitions in the Master Indenture as follows:

> *"Coverage Test"* shall be met if there is delivered to the Master Trustee a written report of the Obligated Group Representative stating that the Historical Debt Service Coverage Ratio of the System for the most recent Fiscal Year preceding the date of delivery of the report for which combined financial statements reported upon by independent certified

public accountants are available, taking into account the proposed transaction, if any, was not less than 1.10:1.

"Historical Debt Service Coverage Ratio" means, for any period of time, the ratio consisting of a numerator equal to the amount determined by dividing Income Available for Debt Service for that that period by the Debt Service Requirements for such period and a denominator of one; provided, however, that in calculating the Debt Service Requirements for such period, the principal amount of any such Indebtedness included in such calculation which is paid during such period shall be excluded to the extent such principal amount is paid from a source other than Revenues of the System; and further provided that, when such calculation is being made with respect to the Credit Group, Income Available for Debt Service and Debt Service Requirements shall be determined only with respect to those Persons who make up the System at the close of such period.

"Historical Pro Forma Debt Service Coverage Ratio" means, for any period of time, the ratio consisting of a numerator equal to the amount determined by dividing Income Available for Debt Service for that period by the Maximum Annual Debt Service Requirement for the Funded Indebtedness then outstanding (other than any other Funded Indebtedness being refunded with the Funded Indebtedness then proposed to be issued) and the Funded Indebtedness then proposed to be issued and a denominator of one; provided that, when such calculation is being made with respect to the Credit Group, Income Available for Debt Service and Maximum Annual Debt Service Requirement shall be determined only with respect to those Persons who make up the System at the time of such calculation.

"Revenues" means, for any period: (I) in the case of any Person providing health care services, the sum of (a) gross patient service revenues less contractual allowances and provisions for uncollectible accounts, free care and discounted care, plus (b) other operating revenues, plus (c) non-operating revenues (other than Contributions, income derived from the sale of assets not in the ordinary course of business, any gain or loss from the extinguishment of debt or other extraordinary item, earnings which constitute Capitalized Interest or earnings on amounts which are irrevocably deposited in escrow to pay the principal of Indebtedness), plus (d) Adjusted Contributions, all as determined in accordance with GAAP; and (II) in the case of any other Person, gross revenues less sale discounts and sale returns and allowances, as determined in accordance with GAAP; provided the following are excluded in either case (a) any gain or loss resulting from the extinguishment of Indebtedness, (b) any gain or loss resulting from the sale, exchange or other disposition of assets not in the ordinary course of business and any unusual charges for valuation adjustments relating to fixed assets, (c) any gain or loss resulting from any discontinued operations, (d) any gain or loss resulting from pension terminations, settlements or curtailments, (e) any unusual charges for employee severance, (f) other extraordinary items as defined by GAAP, (g) any unrealized gains or losses for general investments, (h) any unrealized changes in the value of derivative instruments or (i) any non cash impairment charges.

Supplemental No. 8, once effective, will amend and restate provisions in the Master Indenture regarding accounting principles to provide that all accounting terms not specifically defined in the Master Indenture shall be construed in accordance with GAAP consistently applied, except as otherwise stated herein. For avoidance of doubt, subsidiaries that are consolidated with the financial results of a Member of the Obligated Group or a Designated Affiliate shall be included for all purposes with respect to financial covenants and financial reporting herein. If any change in accounting principles from those used

in the preparation of the financial statements of the System as of December 31, 2016 results from the promulgation of rules, regulations, pronouncements and opinions by or required by the Financial Accounting Standards Board, American Institute of Certified Public Accountants or other authoritative bodies that determine GAAP (or successors thereto or agencies with similar functions) and such change results in a change in the accounting terms used in the Master Indenture, at the option of the Obligated Group Representative, the accounting terms used herein shall be modified to reflect such change in accounting principles so that the criteria for evaluating the compliance of the System with all financial covenants and tests contained in the Master Indenture shall be the same after such change as if no such change in the accounting principles from those used in the preparation of the financial statements of the System, as of December 31, 2016 had been made. If any such modification of the accounting terms used in the Master Indenture shall occur and the Obligated Group Representative elects to have the accounting terms used in the Master Indenture modified as provided in the preceding sentence, the Obligated Group Representative shall file an Officer's Certificate with the Master Trustee, which shall contain a certification to the effect that (i) such modifications are occasioned by such a change in accounting principles, and (ii) such modifications will not have a materially adverse effect on the Master Note holders or result in materially different criteria for evaluating the compliance of the System with all financial covenants and tests contained in the Master Indenture.

Supplemental No. 8, once effective, will amend and restate provisions in the Master Indenture to provide for the Obligated Group to utilize financial and other information with respect to the System in the aggregate when computing or calculating Debt Service Requirements, Historical Debt Service Coverage Ratio, Historical Pro Forma Annual Debt Service Coverage Ratio, Income Available for Debt Service, Maximum Annual Debt Service Requirement, Projected Debt Service Coverage Ratio, Revenues and Unrestricted Net Assets.

Supplemental No. 8, once effective, will amend and restate the covenant regarding the delivery of financial information summarized under the heading "SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE – Financial Statements" of the Master Indenture with the following:

> Each Member of the Obligated Group covenants that it will, and will cause each System Affiliate to, keep or cause to be kept proper books of records and accounts in which full, true and correct entries will be made of all dealings or transactions of or in relation to the business and affairs in accordance with GAAP consistently applied except as may be disclosed in the notes to the audited financial statements referred to in subparagraph (a) below, and the Obligated Group Representative will furnish to the Master Trustee:
>
> (a) As soon as practicable after they are available, but in no event more than 150 days after the last day of each Fiscal Year, a financial report of the System for such Fiscal Year certified by a firm of nationally recognized independent certified public accountants selected by the Obligated Group Representative prepared on a combined or consolidated, or combining or consolidating, basis in accordance with GAAP, covering the operations of the System, as the case may be, for such Fiscal Year and containing an audited consolidated statement of financial position of the System, as of the end of such Fiscal Year and an audited consolidated and an unaudited consolidating statement of operations of the System, for such Fiscal Year, showing in each case in comparative form the financial figures for the preceding Fiscal Year. Such financial report shall be accompanied by consolidating schedules with corresponding figures for the Credit Group presented in one of the following formats: (i) for each member of the Credit Group individually, or (ii) for the members of the Credit Group in the aggregate, or (iii) for the Members of Obligated Group and the Designated Affiliates in the aggregate; provided, any change in the presentation of such consolidating schedules over the presentation

accompanying the financial report for the Fiscal Year prior shall be described in an Officer's Certificate filed with the Master Trustee containing a certification to the effect that such presentation is consistent with the requirements of this paragraph.

(b) At the time of delivery of the financial report referred to in subparagraph (a) above, an Officer's Certificate of the Obligated Group Representative stating that the Obligated Group Representative has made a review of the activities of each member of the Credit Group and each System Affiliate during the preceding Fiscal Year for the purpose of determining whether or not the members of the Credit Group and System Affiliates have complied with all of the terms, provisions and conditions of the Master Indenture and that each member of the Credit Group and System Affiliate has kept, observed, performed and fulfilled each and every covenant, provision and condition of the Master Indenture on its part to be performed and is not in default in the performance or observance of any of the terms, covenants, provisions or conditions hereof, and if an event of default shall have occurred and be continuing such Officer's Certificate shall specify all such events of default and the nature thereof.

Upon the written request of the Master Trustee, each Member shall, and the Obligated Group Representative shall cause each of its Designated Affiliates to, at any and all times permit the Master Trustee by its representatives to inspect the properties, books of account, records, reports and other papers of the Member or Designated Affiliate, except donor records, patient records, personnel records, and any other confidential records, and to take copies and extracts therefrom and will afford and procure a reasonable opportunity to make any such inspection. Each Member shall, and the Obligated Group Representative shall cause each of its Designated Affiliates to, furnish to the Master Trustee any and all information as the Master Trustee may reasonably request, with respect to the performance by the Members or Designated Affiliates of their respective covenants in the Master Indenture.

The Obligated Group Representative also agrees that within 10 days after its receipt thereof, it will file with the Master Trustee a copy of each Consultant's report or counsel's opinion required to be prepared under the terms of the Master Indenture.

Supplemental No. 8, once effective, will amend and restate the covenant regarding insurance requirements summarized under the heading "SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE – Insurance" of the Master Indenture with the following:

Each Member of the Obligated Group shall maintain or cause to be maintained (and the Obligated Group Representative shall cause its Designated Affiliates to maintain or cause to be maintained) at its sole cost and expense, with financially sound and reputable insurers (which may include System Affiliates or other captive insurers), such public liability insurance, third party property damage insurance, business interruption insurance and casualty insurance with respect to liabilities, losses or damage in respect of the assets, properties and businesses of the Obligated Group as may customarily be carried or maintained under similar circumstances by healthcare service providers of established reputation engaged in similar businesses (or, in the case of a Member of the Obligated Group that is not a healthcare services provider, customarily carried or maintained under similar circumstances by entities of established reputation engaged in similar businesses), in each case in such amounts (giving effect to self-insurance), with such deductibles, covering such risks and otherwise on such terms and conditions as are customary for corporations similarly situated in the industry and as are determined to be

consistent with reasonably prudent business practices, which determination can be based upon the advice of an independent insurance consultant.

Supplemental No. 8, once effective, will amend and restate the covenant regarding rates and charges summarized under the heading "SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE – Rates and Charges" of the Master Indenture with the following:

> To the extent permitted by law, each Member agrees to operate its Facilities and to charge such fees and rates for its Facilities and services as to provide income from its operations together with other available funds sufficient to pay promptly all payments on its Indebtedness, all expenses of operation, maintenance and repair of the Property of the Member and all other payments required to be made by it under the Master Indenture.
>
> If the Coverage Test is not met for any Fiscal Year, the Members of the Obligated Group shall, at their expense, retain a Consultant to make recommendations with respect to the rates, fees and charges of the System and the System's methods of operation and other factors affecting its financial condition in order to meet the Coverage Test.
>
> A copy of the Consultant's report and recommendations, if any, shall be filed with each of the Members and the Master Trustee. The Members shall, and the Obligated Group Representative shall cause each of its Designated Affiliates to, follow each recommendation of the Consultant to the extent deemed feasible by the Obligated Group Representative. No default shall be deemed to occur under the provisions summarized under this heading if such recommendations are followed, notwithstanding that the Coverage Test is not met in a subsequent year, *provided* the Historical Debt Service Coverage Ratio of the System for the subsequent year in which the Coverage Test was not met was greater than or equal to 1.0:1. In determining whether such Historical Debt Service Coverage Ratio was greater than or equal to 1.0:1 as provided in the preceding sentence (and only for such purpose), the Revenues of the System shall include an additional amount equal to 10% of the sum of the cash and marketable securities of the System as reported on the financial statements which are the basis for the calculation of such Historical Debt Service Coverage Ratio, but such additional inclusion shall only be made for the first subsequent year in which such Coverage Test is not met. The provisions described in this paragraph shall not be construed to prohibit any Member or Designated Affiliate which is a Tax-Exempt Organization from serving indigent patients or from serving any other class or classes of patients without charge or at reduced rates to the extent necessary to preserve such status as a Tax-Exempt Organization.
>
> The foregoing provisions notwithstanding, the Credit Group shall not be required to comply with the provisions summarized under this heading if: (A) there is filed with the Master Trustee a written opinion of a Consultant to the effect that applicable laws or regulations have prevented or have contributed significantly to preventing the Credit Group from meeting the Coverage Test and is accompanied by a concurring opinion of Independent Counsel as to any conclusions of law supporting the opinion of such Consultant; and (B) the Historical Debt Service Coverage Ratio of the System was at least 1:1. The Obligated Group shall not be required to cause the Consultant's opinion to be prepared more frequently than once every two Fiscal Years if at the end of the first of such two Fiscal Years it provides to the Master Trustee an opinion of Independent Counsel to the effect that the applicable laws and regulations underlying the Consultant's opinion delivered in the previous year have not changed in any material way.

Supplemental No. 8, once effective, will amend and restate the covenant regarding additional indebtedness summarized in subparagraphs (A)(i), (A)(ii) and (A)(iii) under the heading "SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE – Permitted Additional Indebtedness" of the Master Indenture with the following:

(i) An Officer's Certificate of the Obligated Group Representative acceptable to the Master Trustee stating that the principal amount of all Long-Term Indebtedness of the Credit Group, together with the principal amount of the Long Term Indebtedness proposed to be issued is not more than 65% of the sum of the Unrestricted Net Assets of the System and the aggregate principal amount of the outstanding and proposed Long Term Indebtedness; or

(ii) an Officer's Certificate of the Obligated Group Representative acceptable to the Master Trustee stating that the Historical Pro Forma Debt Service Coverage Ratio of the System for each of the most recent Fiscal Year preceding the date of delivery of the report for which combined financial statements reported upon by independent certified public accountants are available was not less than 1.25:1, or

(iii) (a) An Officer's Certificate of the Obligated Group Representative acceptable to the Master Trustee stating that the Historical Debt Service Coverage Ratio of the System for the Fiscal Year next preceding the incurrence of such Funded Indebtedness for which combined financial statements reported upon by independent certified public accountants are available was not less than 1.10:1; and (b) (1) a written Consultant's report (which report, including without limitation the scope, form, substance and other aspects thereof, is acceptable to the Master' Trustee) to the effect that the Projected Debt Service Coverage Ratio of the System for each of the next two succeeding Fiscal Years or, if such Indebtedness is being incurred in connection with the financing of Facilities, the two Fiscal Years succeeding the projected completion date of such Facilities, is not less than 1.10:1; or (2) an Officer's Certificate from the Obligated Group Representative in a form acceptable to the Master Trustee to the effect that the Projected Debt Service Coverage Ratio of the System for each of the next two succeeding Fiscal Years or, if such Indebtedness is being incurred in connection with the financing of Facilities, the two Fiscal Years succeeding the projected completion date of such Facilities, is not less than 1.25:1, provided that either of such reports shall include forecast balance sheets, statements of revenues and expenses and statements of changes in financial position for each of such two Fiscal Years and a statement of the relevant assumptions upon which such forecasted statements are based, which financial statements must indicate that sufficient revenues and cash flow could be generated to pay the operating expenses of the Credit Group's proposed and existing Facilities and the debt service on the Credit Group's other existing Indebtedness during such two Fiscal Years; provided that the requirements of the foregoing subparagraph (A)(iii)(a) or (b) as the case may be, shall be deemed satisfied if (x) there is delivered to the Master Trustee the report of a Consultant, (which report, including without limitation the scope, form, substance and other aspects thereof, is acceptable to the Master Trustee and which contains the information required by the proviso to subparagraph (A)(iii)(b) in the case of projections) which contains an opinion of such Consultant that applicable laws or regulations have prevented or will prevent the System from generating the amount of Income Available for Debt Service required to be generated by subparagraph (A)(iii)(a) or (b), as the case may be, as a prerequisite to the issuance of Funded Indebtedness, and, if requested by the Master Trustee, such report is accompanied by a concurring opinion of Independent Counsel (which Counsel and opinion, including without limitation the scope, form,

substance and other aspects thereof, are acceptable to the Master Trustee) as to any conclusions of law supporting the opinion of such Consultant, (y) the report of the Consultant indicates that the rates charged or to be charged by the System are or will be such that, in the opinion of such Consultant, the System has generated or will generate the maximum amount of Revenues reasonably practicable given such laws or regulations, and (z) the Historical Debt Service Coverage Ratio of the System and the Projected Debt Service Coverage Ratio of the System referred to in the applicable subparagraph are at least 1.00:1.

Supplemental No. 8, once effective, will amend and restate an event of default summarized in subparagraph (e) under the heading "SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE – Events of Default" of the Master Indenture with the following:

(e) any judgment, writ or warrant of attachment or of any similar process shall be entered or filed against any Member or Designated Affiliate or its Property and remains unvacated, unpaid, unbonded or unstayed for 90 days; *provided*, *however*, that no such event shall constitute an Event of Default within the meaning of this paragraph unless the amount of such judgment, writ, warrant of attachment or similar process, together with the amount of all other such judgments, writs, warrants or similar processes so unvacated, unpaid, unbonded, unstayed or uncontested, exceeds 1% of the Unrestricted Net Assets of the System as shown on or derived from the then latest available audited financial statements of the System; or

SUMMARY OF CERTAIN PROVISIONS OF THE SERIES 2017A SUPPLEMENTAL INDENTURE

The Series 2017A Note is issued pursuant to the Series 2017A Supplemental Indenture. The Series 2017A Supplemental Indenture provides that the Series 2017A Note will be subject to payment prior to maturity to the extent that the Bonds are subject to redemption prior to maturity.

SUMMARY OF CERTAIN PROVISIONS OF THE LOAN AGREEMENT

The following is a summary of certain provisions of the Loan Agreement. This summary does not purport to be complete and is qualified by express reference to the full text thereof.

LOAN OF BOND PROCEEDS

Under the Loan Agreement, the Authority will loan to Parkview Health the proceeds of the Bonds for the purpose of (i) refunding the Bonds to Be Refunded and (ii) paying costs of issuance of such Bonds.

In order to provide for the repayment of such loan, Parkview Health will execute and deliver to the Trustee, as assignee of the Authority, its Series 2017A Note, which Series 2017A Note will be issued and secured under the Master Indenture. The Bonds shall be secured by a pledge by the Authority to the Trustee of the Trust Estate, including the payments to be paid by Parkview Health pursuant to the Series 2017A Note.

LOAN TERM

Parkview Health's obligations under the Loan Agreement shall commence on the date of the execution and delivery of the Loan Agreement and shall terminate after payment in full of the loan and all other amounts due under the Loan Agreement, the Indenture or the Series 2017A Note; provided,

however, that the covenants and obligations provided in the Loan Agreement shall survive the termination of the Loan Agreement and the payment in full of the amounts due under the Loan Agreement and the Series 2017A Note.

COVENANTS

The Loan Agreement contains covenants of Parkview Health related to its tax-exempt status, to indemnification of the Authority and the Trustee, and to the application of the proceeds of the sale of the Bonds.

OBLIGATIONS UNCONDITIONAL

Parkview Health's obligations under the Loan Agreement and the Series 2017A Note are absolute, irrevocable and unconditional and shall not be subject to any defense (other than payment) or any right of set-off, counterclaim or recoupment arising out of any breach of the Authority, the Trustee or the Master Trustee of any obligation owed to Parkview Health, or out of any indebtedness or liability at any time owing to Parkview Health by the Authority, the Master Trustee or the Trustee, including, without limiting the generality of the foregoing, failure of title to Parkview Health's property or any part thereof, any acts or circumstances that may constitute failure of consideration, destruction of or damage to Parkview Health's property, commercial frustration of purpose, any change in the tax or other laws of the United States of America or of the State of Indiana or any political subdivision thereof and, further, that the payments of principal of and premium, if any, and interest on the Series 2017A Note shall continue to be payable as specified in the Loan Agreement.

PREPAYMENT OF LOAN AND SERIES 2017A NOTE

The amounts, principal payments, interest rates, prepayment provisions and other terms of the Series 2017A Note shall conform to the terms and provisions of the Bonds. At all times payments due under the Series 2017A Note shall be equal to and payable at the same times as the principal of, premium, if any, and interest on the Bonds.

SUMMARY OF CERTAIN PROVISIONS OF THE INDENTURE

The following summarizes certain provisions of the Indenture between the Authority and the Trustee.

PLEDGE AND ASSIGNMENT

Under the Indenture the Authority pledges and assigns to the Trustee, for the benefit of the holders from time to time of the Bonds (i) all of its right, title and interest in, to and under the Loan Agreement (except for certain rights of the Authority for indemnification and administration expenses under the Loan Agreement), the Series 2017A Supplemental Indenture and the Series 2017A Note, including, but not limited to, all payments of principal of, premium, if any, and interest, if any thereon, and (ii) all property of any kind subjected to the lien of the Indenture or assigned to the Trustee pursuant to the provisions of the Indenture, including the proceeds of the Bonds and all cash and securities held by the Trustee in the Trust Funds (except for the Rebate Fund) created or established under the Indenture and all earnings thereon.

FUNDS AND ACCOUNTS

There are established in the Indenture the following funds and accounts: a Bond Fund (including an Interest Account and a Sinking Fund Account), an Expense Fund, a Rebate Fund and a Refunding Fund.

From the payments to be made on the Series 2017A Note, the Trustee is required to deposit said amounts as follows: (a) first, into the Interest Account, the deposits of the payments of interest due on the Series 2017A Note; and (b) second, into the Sinking Fund Account, the balance of any such payment or other money received. On or before each Interest Payment Date, the Trustee is required to make payments of interest on the Bonds from the Interest Account; and on or before each Principal Payment Date the Trustee is required to pay principal on the Bonds by reason of maturity from the Sinking Fund Account. If on any Interest Payment Date there are not sufficient amounts on deposit in the Interest Account to pay the total amount of interest coming due on such Interest Payment Date, the Trustee will transfer any moneys then on deposit in the Sinking Fund Account in an amount equal to such deficiency to the Interest Account.

Moneys in the Expense Fund will be used for the payment of expenses for any recording, trustee's and depositary's fees and expenses, accounting and legal fees, financing costs, printing costs, rating service fees, and other fees and expenses incurred or to be incurred by or on behalf of the Authority or Parkview Health in connection with the issuance and sale of the Bonds.

Certain amounts may be held from time to time in the Rebate Fund to comply with the arbitrage and rebate requirements under the Code.

On the date of delivery of the Bonds, the Trustee shall transfer the amount in the Refunding Fund to the trustee for the Bonds to Be Refunded to provide for the payment of the Bonds to Be Refunded as described herein under the heading "Plan of Finance".

The Trustee shall invest all Trust Moneys on hand from time to time as specified in a written request of Parkview Health in Investment Securities.

EVENTS OF DEFAULT AND REMEDIES

An Event of Default includes: (1) default in the payment of any interest upon any Bond when it becomes due and payable; or (2) default in the payment of the principal of (or premium, if any, on) any Bond when the same becomes due and payable; or (3) default in the performance or breach of any covenant or warranty of the Authority contained in the Indenture (other than a default described in (1) or (2) above or (4) below), and continuance of such default or breach for a period of thirty (30) days after there has been given, by registered or certified mail, to the Authority and Parkview Health by the Trustee or to the Authority, Parkview Health and the Trustee by the holder of holders of at least twenty-five percent (25%) in aggregate principal amount of the Bonds then Outstanding, a written notice specifying such default or breach and requiring it to be remedied; or (4) a default under the Loan Agreement; or (5) an event of default under the Master Indenture.

Upon the occurrence and continuance of an Event of Default, and upon the acceleration of the Series 2017A Note under the Master Indenture, the maturity of the Bonds shall, without further action, be accelerated; provided that if after the Series 2017A Note and the Bonds have been accelerated, the acceleration of the maturity of the Series 2017A Note shall be annulled in accordance with the Master Indenture, then the acceleration of the maturity of the Bonds shall automatically be annulled and the Trustee shall promptly give (i) written notice of such annulment to the Authority, Parkview Health and

the Master Trustee in accordance with the provisions of the Indenture, and (ii) notice to the Bondholders by mailing in the same manner as a notice of redemption under the Indenture; provided, however, that no such waiver, rescission and annulment shall extend to or affect any subsequent Event of Default or impair any right or remedy consequent thereon.

Upon the happening and continuance of any Event of Default while any such failure is continuing, the Trustee, upon the written request of the holders of at least twenty-five percent (25%) in aggregate principal amount of the Bonds then Outstanding and receipt of indemnity to its satisfaction, shall take any one or more or the following steps:

(a) by mandamus or other suit, action or proceeding at law or in equity enforce all rights of the Bondholders, and require the Authority or Parkview Health or each of them to carry out any agreements with or for the benefit of the Bondholders and to perform its or their duties under the Act, the Master Indenture, the Loan Agreement and the Indenture;

(b) by action or suit in equity require the Authority to account as if it were the trustee of an express trust for the Bondholders; or

(c) by action or suit in equity enjoin any acts or things which may be unlawful or in violation of the rights of the Bondholders.

Anything in the Indenture to the contrary notwithstanding, the holders of a majority in aggregate principal amount of the Bonds then Outstanding under the Indenture shall have the right, by an instrument in writing executed and delivered to the Trustee, to direct the method and place of conducting all remedial proceedings to be taken by the Trustee under the Indenture.

No holder of any of the Bonds shall have any right to institute any suit, action or proceeding in equity or at law for the execution of any trust under the Indenture, or the pursuit of any remedy under the Indenture or on the Bonds, unless: (i) such holder previously shall have given to the Trustee written notice of an Event of Default as provided in the Indenture; (ii) the holders of not less than twenty-five percent (25%) in aggregate principal amount of the Bonds then Outstanding shall have made written request of the Trustee to execute such trust or trusts or pursue such remedy or remedies, after the right to exercise such powers or rights of action, as the case may be, shall have accrued, and shall have afforded the Trustee a reasonable opportunity either to proceed to exercise the powers, or to institute such action, suit or proceeding in its or their name; (iii) there also shall have been offered to the Trustee security and indemnity satisfactory to it against the costs, expenses and liabilities to be incurred therein or thereby; and (iv) the Trustee shall not have complied with such request within a reasonable time.

No remedy conferred upon or reserved to the Trustee or to the holders of the Bonds is intended to be exclusive of any other remedy or remedies, and each and every remedy shall be cumulative, and shall be in addition to every other remedy given under the Indenture or at the time of issuance of the Bonds or thereafter existing at law or in equity or by statute.

APPLICATION OF MONEYS

All moneys received under the provisions described above, after payment of the costs and expenses of the proceedings resulting in the collection of such moneys and of the expenses, liabilities and advances incurred or made by the Trustee, shall be deposited in the Bond Fund and all moneys so deposited in the Bond Fund during the continuance of an Event of Default (other than moneys for the payment of Bonds which have matured or otherwise become payable prior to such Event of Default) shall (after payment of the fees and expenses of the Trustee) be applied as follows:

(a) Unless the principal of all the Bonds shall have become or shall have been declared due and payable, all such moneys shall be applied:

First -- To the payment to the persons entitled thereto of all installments of interest then due on the Bonds, in the order of the maturity of the installments of such interest and, if the amounts available shall not be sufficient to pay in full any particular installment then to the payment ratably, according to the amounts due on such installment, to the persons entitled thereto, without any discrimination or privilege; and

Second -- To the payment to the persons entitled thereto of the unpaid principal of and premium, if any, on any of the Bonds which shall have become due (other than Bonds which have matured or otherwise become payable prior to such Event of Default and moneys for the payment of which are held in the Bond Fund or otherwise held by the Trustee), with interest on such principal at the rate or rates borne by such Bonds from the respective dates upon which the same became due and, if the amount available shall not be sufficient to pay in full the principal amount, premium, if any, and interest due on any particular date, then to the payment ratably, according to the principal amount due on such date, to the persons entitled thereto, without any discrimination or privilege.

(b) If the principal of all the Bonds shall have become or shall have been declared due and payable, all such moneys shall be applied to the payment of the principal, premium, if any, then due and unpaid upon the Bonds, with interest on overdue principal, premium, if any, and interest without discrimination or privilege of principal or premium, if any, over interest or of interest over principal and premium, if any, or of any installment of any Bond over any other Bond, ratably, according to the amounts due respectively for principal, premium, if any, and interest, to the persons entitled thereto without any discrimination or privilege.

(c) If the principal of all the Bonds shall have been declared due and payable, and if such declaration shall thereafter have been rescinded and annulled under the provisions described above, then, subject to the provisions of paragraph (b) above which shall be applicable in the event that the principal of all the Bonds shall later become due or be declared due and payable, the moneys shall be applied in accordance with the provisions of paragraph (a) above.

The Trustee will be the holder of the Series 2017A Note under the Master Indenture and, as such, it has only those rights and remedies specified in the Master Indenture for a holder of Notes upon a default by Parkview Health thereunder, except that to the extent action may be taken by a specified percentage of holders under the Master Indenture, the holders of a corresponding percentage of Bonds will be deemed to be holders for such purpose.

AMENDMENTS AND SUPPLEMENTS

Without the consent of the holders of any Bonds, the Authority, when authorized by an Authority Resolution, and the Trustee, at any time and from time to time, may enter into one or more supplemental indentures, in form satisfactory to the Trustee, for any one of the following purposes:

(a) To correct or amplify the description of the Trust Estate, or better to assure, convey and confirm unto the Trustee any property subject or required to be subjected to the lien of the Indenture, or to subject to the lien of the Indenture additional property, or to subject to the lien and pledge of the Indenture additional revenues, properties or collateral; or

(b) To add to the conditions, limitations and restrictions on the authorized amount, terms or purposes of issue, authentication and delivery of Bonds other conditions, limitations and restrictions thereafter to be observed; or

(c) To add to the covenants of the Authority, for the benefit of the holders of the Bonds, or to surrender any right or power conferred upon the Authority in the Indenture; or

(d) To cure any ambiguity, to correct or supplement any provision in the Indenture which may be inconsistent with any other provision of the Indenture, or to make any other provisions with respect to matters or questions arising under the Indenture which shall not be inconsistent with the provisions of the Indenture, provided such action shall not adversely affect the interests of the holders of the Bonds then Outstanding; or

(e) To modify or supplement the Indenture in such manner as may be necessary or appropriate to qualify the Indenture under the Trust Indenture Act of 1939, as amended from time to time; or

(f) To provide for a Book Entry System.

With the consent of the holders of not less than a majority in principal amount of the Bonds Outstanding which are affected by such supplemental Indenture and notice to a Rating Service, by act of said holders delivered to the Authority, Parkview Health and the Trustee, the Authority, when authorized by an Authority Resolution, and the Trustee may enter into a supplemental indenture or supplemental indentures for the purpose of adding any provisions to or changing in any manner or eliminating any of the provisions of the Indenture or of modifying in any manner the rights of the holders of the Bonds under the Indenture, provided, however, that no such supplemental indenture shall, without the consent of the holder of each Outstanding Bond affected thereby,

(a) change the maturity of the principal of, or any installment of interest on, any Bond, or reduce the principal amount thereof or the interest thereon or any premium payable upon the redemption thereof, or change the coin or currency in which, any Bond or the premium or interest thereon is payable, or impair the right to institute suit for the enforcement of any such payment on or after the stated maturity thereof (or, in the case of redemption, on or after the Redemption Date), or

(b) reduce the percentage in principal amount of the Outstanding Bonds, the consent of whose holders is required for any such supplemental indenture, or the consent of whose holders is required for any waiver (of compliance with certain provisions of the Indenture or certain defaults thereunder and their consequences) provided for in the Indenture, or

(c) modify any of the provisions of the Indenture relating to amendment of the Loan Agreement or the Indenture, except to increase any such percentage or to provide that certain other provisions of the Indenture cannot be modified or waived without the consent of the holder of each Bond affected thereby.

Under the Master Indenture, for certain purposes the holder of each Bond is considered a holder of a corresponding amount of the Series 2017A Note and may consent to amendments to the Master Indenture or to Supplemental Master Indentures as provided herein under the heading "SUMMARY OF CERTAIN PROVISIONS OF THE MASTER INDENTURE - Supplemental Master Indentures."

DEFEASANCE

Whenever the conditions specified in either clause (1) or clause (2) of the following subparagraph A, and the conditions specified in the following subparagraphs B and C shall exist, namely:

(A) either

(1) Bonds theretofore authenticated and delivered have been cancelled by the Trustee or delivered to the Trustee for cancellation, excluding, however,

(a) Bonds for whose payment money has been deposited in trust or segregated and held in trust by the Trustee and thereafter repaid to Parkview Health or discharged from such trust, as provided in the Indenture, and

(b) Bonds alleged to have been destroyed, lost or stolen which have been replaced or paid as provided in the Indenture, and (i) which, prior to the satisfaction and discharge of the Indenture, have not been presented to the Trustee with a claim of ownership and enforceability by the holder thereof, or (ii) whose enforceability by the holder thereof, has been determined adversely to the holder by a court of competent jurisdiction or other competent tribunal;

or

(2) the Authority or Parkview Health has deposited or caused to be deposited with the Trustee, in trust, cash and/or Government Obligations which do not permit the redemption thereof at the option of the issuer, the principal of, premium, if any, and interest on which when due (or upon the redemption thereof at the option of the holder), will, without reinvestment, provide cash which, together with the cash, if any, deposited with the Trustee at the same time, shall be sufficient to pay and discharge the entire indebtedness on Bonds, not theretofore cancelled by the Trustee or delivered to the Trustee for cancellation, for interest, principal and premium, if any, which have become due and payable, or to the maturity or Redemption Date, as the case may be, and has made arrangements satisfactory to the Trustee for the giving of notice of redemption, if any, by the Trustee in the name, and at the expense, of Parkview Health in the same manner as is provided in the Indenture;

(B) the Authority or Parkview Health has paid, caused to be paid or made arrangements satisfactory to the Trustee for the payment of all other sums payable under the Indenture including fees and expenses of the Trustee and any rebate to the United States of America required under the Code and the Indenture; and

(C) the Authority or Parkview Health has delivered to the Trustee a Borrower's Certificate and an opinion of Bond Counsel each stating that all conditions herein provided for relating to the satisfaction and discharge of the Indenture have been complied with;

then, upon Authority Request or Borrower Request authorized by an Authority Resolution or a resolution of Parkview Health, the Indenture and the lien, rights and interests thereby granted shall cease, determine and become null and void, and the Trustee and each co-trustee and separate trustee, if any, then acting as such thereunder shall, at the expense of Parkview Health, execute and deliver such instruments of satisfaction as may be necessary, and forthwith the estate, right, title and interest of the Trustee in and to all of the Trust Estate and in and to all rights under the Master Documents, the Loan Agreement, the Series 2017A Note, and any Collateral Documents, (except the moneys and/or Government Obligations

deposited as required above) shall thereupon be discharged and satisfied, and the Trustee shall in such case transfer, deliver and pay the same to Parkview Health or upon a Borrower order.

In the absence of Authority Request or a request by Parkview Health authorized by a resolution of the Authority or Parkview Health, the payment of all Bonds Outstanding shall not render the Indenture inoperative.

REPLACEMENT OF SERIES 2017A NOTE WITH OBLIGATION ISSUED UNDER A SEPARATE MASTER INDENTURE

The Series 2017A Note shall be surrendered by the Trustee and delivered to the Master Trustee for cancellation upon receipt by the Trustee and the Authority of the following:

(i) a Request of the Obligated Group Representative requesting such surrender and delivery and stating that the Members of the Obligated Group have become members of an obligated group under a replacement master indenture (other than the Master Indenture) (or the Members of the Obligated Group are obligated, by their respective articles of incorporation, bylaws or by contract or otherwise, to make payments to an entity that is a member of such an obligated group in amounts sufficient to enable the entity to make payments with respect to obligations issued under such replacement master indenture) and that an obligation is being issued to the Trustee under such replacement master indenture (the "Replacement Master Indenture");

(ii) a properly executed obligation (the "Replacement Obligation") issued under the Replacement Master Indenture and registered in the name of the Trustee with the same tenor and effect as the Series 2017A Note (in a principal amount equal to the then Outstanding principal amount of Bonds), duly authenticated by the master trustee under the Replacement Master Indenture;

(iii) an Opinion of Counsel selected by the Obligated Group and not objected to by the Authority, addressed to the Trustee and the Authority, to the effect that the Replacement Obligation has been validly issued under the Replacement Master Indenture and constitutes a valid and binding obligation of the Obligated Group (or the entity to which the Obligated Group is obligated to make the payments referred in paragraph (i) above) and each other member of the obligated group (if any) which is jointly and severally liable under the Replacement Master Indenture, subject to such qualifications as are acceptable to the Trustee;

(iv) a copy of the Replacement Master Indenture, certified as a true and accurate copy by the master trustee under the Replacement Master Indenture;

(v) written confirmation from each Rating Service then rating the Bonds that the replacement of the Series 2017A Note will not, by itself, result in a reduction in the then-current ratings on the Bonds; and

(vi) an opinion of Bond Counsel addressed to the Authority and the Trustee to the effect that the replacement of the Series 2017A Note is authorized or permitted by the Indenture and the Act and will not result in the inclusion of interest on the Bonds in gross income for federal income tax purposes.

Upon satisfaction of such conditions, all references in the Indenture and the Loan Agreement to the Series 2017A Note shall be deemed to be references to the Replacement Obligation, all references to the Master Indenture shall be deemed to be references to the Replacement Master Indenture, all references to the Master Trustee shall be deemed to be references to the master trustee under the Replacement Master Indenture, all references to the Obligated Group and the Members of the Obligated Group shall be

deemed to be references to the obligated group and the members of the obligated group under the Replacement Master Indenture and all references to the Series 2017A Supplemental Indenture shall be deemed to be references to the supplemental master indenture pursuant to which the Replacement Obligation is issued

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APPENDIX D

FORM OF OPINION OF BOND COUNSEL

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August 10, 2017

Indiana Finance Authority
Indianapolis, Indiana

Parkview Health System, Inc.
Fort Wayne, Indiana

U.S. Bank National Association,
as Bond Trustee and Master Trustee
Indianapolis, Indiana

Re: Indiana Finance Authority Hospital Refunding Revenue Bonds, Series 2017A (Parkview Health) issued in the aggregate principal amount of $110,630,000 (the "Bonds") pursuant to the Trust Indenture dated as of August 1, 2017 (the "Bond Indenture"), between the Indiana Finance Authority (the "Authority") and U.S. Bank National Association, as trustee (the "Bond Trustee"), which Bond Indenture contains an assignment of the Authority's rights under the Loan Agreement, dated as of August 1, 2017 (the "Loan Agreement"), between the Authority and Parkview Health System, Inc. (the "Borrower"), and the Series 2017A Master Note of the Borrower (the "Note") issued pursuant to the Amended and Restated Master Trust Indenture, dated as of November 1, 1998 as supplemented and amended (the "Master Indenture"), among the Borrower, Parkview Hospital, Inc. and U.S. Bank National Association, as successor master trustee (the "Master Trustee"), as further supplemented by a Series 2017A Supplemental Master Indenture, dated as of August 1, 2017 (the "Supplemental Master Indenture").

Ladies and Gentlemen:

We have examined a certified transcript of proceedings relating to (a) the creation and organization of the Authority; (b) the authorization, issuance and sale of the Bonds; (c) the authorization and execution of the Bond Indenture, the Loan Agreement, the Master Indenture, the Supplemental Master Indenture, and the Note; (d) an opinion of Rothberg Logan & Warsco, LLP, Fort Wayne, Indiana, general counsel for the Borrower; (e) executed counterparts of the Loan Agreement, the Bond Indenture and the Supplemental Master Indenture; (f) a certificate of officers of the Authority, of even date herewith, regarding the execution of the Bonds and showing no litigation pending or threatened; (g) certificates of officers of the Bond Trustee regarding the execution of the Bond Indenture, authentication of the Bonds, and showing payment for and delivery of the Bonds; (h) letters from the Internal Revenue Service evidencing that the Members of the Obligated Group and the Designated Affiliates, as such terms are defined in the Master Indenture (collectively, the "Credit Group") and certain other affiliates are

exempt from taxation as organizations described in Section 501(c)(3) of the Internal Revenue Code of 1986, as in effect on the date hereof (the "Code"); (i) the executed Note; (j) certificates and other agreements of the Borrower and certain other affiliates, of even date herewith; and (k) an executed Internal Revenue Service Form 8038.

We have also examined Indiana Code 4-4-10.9 and -11 and Indiana Code 5-1-16, as amended, and such other provisions of the constitution and laws of the State of Indiana (the "State") as we have deemed relevant and necessary as a basis for the opinions set forth herein. As to questions of fact material to our opinion, we have relied upon representations and covenants of the Borrower and the Authority contained in the Loan Agreement and the Bond Indenture and in the certified transcript of proceedings and other certificates of officers furnished to us, including the tax covenants and representations of the Authority and the Borrower (the "Tax Covenants"), without undertaking to verify the same by independent investigation.

Based on the foregoing and our review of such other information, papers and documents as we believe necessary or advisable, we are of the opinion that:

1. The Loan Agreement has been duly authorized, executed and delivered by the Authority, and, assuming due authorization, execution and delivery thereof by the Borrower, is a valid and binding agreement of the Authority enforceable against the Authority in accordance with its terms.

2. The Bond Indenture has been duly authorized, executed and delivered by the Authority, and, assuming due authorization, execution and delivery thereof by the Bond Trustee, is a valid and binding agreement of the Authority enforceable against the Authority in accordance with its terms.

3. The Bonds have been duly authorized, executed and issued and are valid and binding limited obligations of the Authority enforceable in accordance with their terms.

4. Under existing laws, regulations, judicial decisions and rulings, the interest on the Bonds is exempt from income taxation in the State. This opinion relates only to the tax exemption of interest on the Bonds from State income taxes.

5. Under federal statutes, decisions, regulations and rulings existing on this date, the interest on the Bonds is excludable from gross income for purposes of federal income taxation pursuant to Section 103 of the Code, is not an item of tax preference for purposes of the federal alternative minimum tax imposed on individuals and corporations, but is taken into account in determining adjusted current earnings for the purpose of computing the federal alternative minimum tax imposed on certain corporations. This opinion is conditioned on continuing

compliance by the Obligated Group and certain other affiliates and the Authority with the Tax Covenants. Failure to comply with the Tax Covenants could cause interest on the Bonds to lose the exclusion from gross income for purposes of federal income taxation retroactive to the date of issuance of the Bonds.

In rendering the opinion set forth in paragraph 5 above, we have relied upon a report of Causey Demgen & Moore P.C., independent certified public accountants, as to the accuracy of (i) the mathematical computations concerning the adequacy of the maturing principal amounts of and interest earned on direct obligations of the United States of America, together with other escrowed money, deposited on the date hereof with U.S. Bank National Association, as prior trustee and escrow trustee (the "Escrow Trustee"), pursuant to an Escrow Deposit Agreement dated as of August 1, 2017, between the Borrower and the Escrow Trustee, to pay the principal of and interest on a portion of the Indiana Finance Authority Hospital Revenue Bonds, Series 2009A (Parkview Health System Obligated Group) (the "Refunded Bonds") from the date of delivery of the Bonds to the earliest date on which the Refunded Bonds may be called for redemption and all fees and expenses for the redemption, and (ii) the mathematical accuracy of the computation of the yield on the Bonds and the yield on the direct obligations of the United States of America.

It is to be understood that the rights of the owners of the Bonds, the Authority, the Bond Trustee and the Credit Group and the enforceability of the Bonds, the Bond Indenture and the Loan Agreement may be subject to bankruptcy, insolvency, reorganization, moratorium and other similar laws affecting creditors' rights heretofore and hereafter enacted to the extent constitutionally applicable and that their enforcement may be subject to the exercise of judicial discretion in accordance with general principles of equity. It is to be understood that the rights of the owners of the Bonds, the Authority, the Bond Trustee and the Credit Group and the enforceability of the Bonds, the Bond Indenture and the Loan Agreement may be subject to the valid exercise of the constitutional powers of the State and the United States of America.

Very truly yours,

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APPENDIX E

FORM OF CONTINUING DISCLOSURE AGREEMENT

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CONTINUING DISCLOSURE AGREEMENT

This Continuing Disclosure Agreement, dated August 10, 2017 (the "Disclosure Agreement"), is executed and delivered by Parkview Health System, Inc., an Indiana nonprofit corporation (the "Corporation"), acting as obligated group representative, for itself and on behalf of the members of an obligated group (collectively, the "Obligated Group" and individually, an "Obligated Group Member", "Member of the Obligated Group" or "Member"), in connection with the issuance of $110,630,000 Indiana Finance Authority Hospital Refunding Revenue Bonds, Series 2017A (Parkview Health) (the "Bonds"). The Bonds are being issued pursuant to that certain Trust Indenture, dated as of August 1, 2017 (the "Indenture"), between the Indiana Finance Authority (the "Authority") and U.S. Bank National Association, as bond trustee (the "Bond Trustee"). The proceeds of the Bonds are being loaned to the Corporation pursuant to that certain Loan Agreement dated as of August 1, 2017 (the "Loan Agreement") between the Authority and the Corporation. The obligations of the Corporation under the Loan Agreement are secured by payments required to be made by the Obligated Group on the Series 2017A Master Note (the "Master Note") issued by the Corporation pursuant to the Amended and Restated Master Trust Indenture dated as of November 1, 1998 (the "Master Indenture") among the Corporation, Parkview Hospital, Inc. and U.S. Bank National Association, as master trustee (in such capacity, the "Master Trustee") and a Series 2017A Supplemental Master Indenture, dated as of August 1, 2017, between the Corporation and Master Trustee. The Corporation and each other Member of the Obligated Group will be jointly and severally obligated to make payments on the Master Note according to the terms thereof when due.

Section 1. Purpose of the Disclosure Agreement. This Disclosure Agreement is being executed and delivered by the Corporation for the benefit of the Owners and Beneficial Owners of the Bonds and in order to assist the Underwriter (defined below) in complying with the Rule (defined below). The Corporation is an "obligated person" within the meaning of the Rule. The Corporation acknowledges that the Authority has undertaken no responsibility with respect to any reports, notices or disclosures provided or required under this Disclosure Agreement, and has no liability to any person, including any Owner or Beneficial Owner of the Bonds, with respect to any such reports, notices or disclosures.

Section 2. Definitions. In addition to the definitions set forth in the Indenture, which apply to any capitalized term used in this Disclosure Agreement unless otherwise defined in this Section 2, the following capitalized terms shall have the following meanings:

"Annual Report" shall mean any Annual Report provided by the Corporation pursuant to, and as described in, Sections 3 and 4 of this Disclosure Agreement.

"Audited Financial Statements" shall mean a financial report of the System for such Fiscal Year certified by a firm of nationally recognized independent certified public accountants selected by the Corporation prepared on a combined or consolidated, or combining or consolidating, basis in accordance with generally accepted accounting principles, covering the operations of the System, as the case may be, for such Fiscal Year and containing an audited consolidated statement of financial position of the System, as of the end of such Fiscal Year and an audited consolidated and an unaudited consolidating statement of operations of the System, for such Fiscal Year, showing in each case in comparative form the financial figures for the

preceding Fiscal Year. Such financial report shall be accompanied by consolidating schedules with corresponding figures for the Credit Group presented in one of the following formats: (i) for each member of the Credit Group individually, or (ii) for the members of the Credit Group in the aggregate, or (iii) for the Members of Obligated Group and the Designated Affiliates in the aggregate. Any change in the presentation of such consolidating schedules over the presentation accompanying the financial report for the Fiscal Year prior shall be described in an officer's certificate of the Corporation which shall contain certification to the effect that such presentation is consistent with the requirements of this paragraph. For avoidance of doubt, subsidiaries that are consolidated with the financial results of a Member of the Obligated Group or a Designated Affiliate shall be included for all purposes with respect to reporting.

"Beneficial Owner" shall mean any Person or entity that has or shares the power, directly or indirectly, to make investment decisions concerning ownership of any Bonds (including Persons holding Bonds through nominees, depositories or other intermediaries); provided, however, that a person shall not be deemed to be a beneficial owner of a Bond solely as a result of a right held by such person to acquire the Bond in the future.

"Corporation" shall mean the Corporation as defined in the introductory paragraph to this Disclosure Agreement and any entity that succeeds to the role of Obligated Group Representative under the Master Indenture.

"Dissemination Agent" shall mean any Person or entity designated in writing by the Corporation as the dissemination agent and which has filed with the Bond Trustee a written acceptance of such designation. As of the date hereof, the Corporation has designated Digital Assurance Certification, L.L.C. as the Dissemination Agent.

"Fiscal Year" shall mean the fiscal year of the Corporation.

"Listed Events" shall mean any of the events listed in Section 5 of this Disclosure Agreement.

"MSRB" shall mean the Municipal Securities Rulemaking Board or any other entity designated or authorized by the Securities and Exchange Commission to receive continuing disclosure filings pursuant to the Rule. Until otherwise designated by the MSRB or the Securities and Exchange Commission, filings with the MSRB are to be made through the Electronic Municipal Market Access (EMMA) website of the MSRB, currently located at http://emma.msrb.org.

"Official Statement" shall mean the official statement relating to the Bonds, dated July 18, 2017, which has been filed with the MSRB under CUSIP 45471APP1, 45471APQ9, 45471APR7, 45471APS5, 45471APT3, 45471APU0, 45471APV8, 45471APW6, 45471APX4, 45471APY2, 45471APZ9, 45471AQA3, and 45471AQB1.

"Rule" shall mean Rule 15c2-12 adopted by the Securities and Exchange Commission under the Securities Exchange Act of 1934, as the same may be amended from time to time.

"State" shall mean the State of Indiana.

"System" shall have the meaning assigned to it in the Master Indenture.

"Underwriter" shall mean J.P. Morgan Securities LLC, the original underwriter of the Bonds, which is required to comply with the Rule in connection with the offering of the Bonds.

Section 3. Provision of Annual Reports.

(a) The Corporation shall, or shall cause the Dissemination Agent to, not later than one hundred fifty (150) days after the end of the Fiscal Year, commencing with the Fiscal Year ending December 31, 2017, provide an Annual Report to the MSRB which is consistent with the requirements of Section 4 of this Disclosure Agreement. In each case, the Annual Report may be submitted as a single document or as separate documents comprising a package, and may cross-reference other information as provided in Section 4 of this Disclosure Agreement; provided that the audited financial statements of the Members may be submitted separately from the balance of the Annual Report and later than the date required above for the filing of the Annual Report if they are not available by that date. If the Fiscal Year changes, the Corporation shall promptly provide, or cause the Dissemination Agent to provide, written notice of such change in the same manner as for a Listed Event under Section 5(b).

(b) If the Corporation is unable to provide any Annual Report to the MSRB by the date required in subsection (a), the Corporation shall provide, or cause the Dissemination Agent to provide, notice of such failure (in substantially the form attached as EXHIBIT A) to the MSRB electronically within fifteen (15) Business Days of the required date of such Annual Report. If the Corporation files such notice directly, it shall send a written notice to the Dissemination Agent that the failure notice has been filed.

(c) Upon receipt of the Annual Report and subsequent filing with the MSRB, the Dissemination Agent shall file a report with the Corporation and the Bond Trustee certifying that the Annual Report has been provided pursuant to this Disclosure Agreement and stating the date it was provided to the MSRB.

The Dissemination Agent shall have no duty or obligation to review such Annual Report.

Any filing under this Disclosure Agreement may be made solely by transmitting such filing to the MSRB, or as otherwise permitted or required under the Rule.

Section 4. Content of Annual Reports. The Annual Report shall contain or include by reference the following:

(a) The Audited Financial Statements for the preceding Fiscal Year, prepared in accordance with generally accepted accounting principles as promulgated from time to time by the Financial Accounting Standards Board. If the Audited Financial Statements are not available by the time the Annual Report is required to be filed pursuant to Section 3(a), the Annual Report shall contain unaudited financial statements in a format similar to the financial statements contained in the Official Statement, and the audited financial statements shall be filed in the same manner as the Annual Report when they become available.

(b) A list of the Obligated Group Members and the Designated Affiliates.

(c) Information and data of the type set forth in APPENDIX A to the Official Statement under the captions:

1. "OPERATING STATISTICS";

2. "FINANCIAL INFORMATION − Ratios – Debt Ratios" (excluding pro-forma);

3. "FINANCIAL INFORMATION − Ratios – Historic Liquidity"; and

4. "FINANCIAL INFORMATION – Third Party Payments."

In addition to the information described in paragraphs (a)-(c) above, (i) if any part of the information described in Paragraph (c) can no longer be generated because the operations to which it is related have been materially changed or discontinued, the Corporation will include a statement to that effect as part of the Annual Report for the year if the change or discontinuation occurs, and (ii) the Annual Report for the year in which any amendment or waiver of a provision of this Disclosure Agreement occurs shall describe and explain the amendment or waiver, the reason for it and its impact on the type of information being provided, and if the amendment relates to the accounting principles to be followed in preparing financial statements, the Annual Report for the year in which the change is made shall present a comparison (in narrative form and also, if feasible, in quantitative form) between the financial statements prepared on the basis of the new accounting principles and those prepared on the basis of the former accounting principles.

Section 5. Reporting of Listed Events.

The Corporation shall file, or cause the Dissemination Agent to file, notice of the occurrence of any of the following events (the "Listed Events") with respect to the Bonds, in a timely manner not in excess of ten (10) business days after the occurrence of such Listed Event:

(a) principal and interest payment delinquencies;

(b) non-payment-related defaults, if material;

(c) unscheduled draws on debt service reserves reflecting financial difficulties;

(d) unscheduled draws on credit enhancement reflecting financial difficulties;

(e) substitution of credit or liquidity providers, or their failure to perform;

(f) 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 Bonds, or other listed events affecting the tax status of the Bonds;

(g) modifications to rights of holders of the Bonds, if material;

(h) Bond calls, if material;

(i) Bond defeasances;

(j) release, substitution, or sale of property securing repayment of the Bonds, if material;

(k) rating changes;

(l) tender offers;

(m) bankruptcy, insolvency, receivership or similar event of an Obligated Group Member;

(n) consummation of a merger, consolidation, or acquisition involving an Obligated Group member or sale of all or substantially all of the assets of such Obligated Group member, other than in the ordinary course of business, or the entry into or termination of a definitive agreement relating to the foregoing, other than pursuant to its terms, if material; and

(o) appointment of a successor or additional trustee or the change of name of a trustee, if material.

For any of the Listed Events that require the evaluation of a materiality standard, the Corporation shall make such determination in accordance with securities laws in effect at the time of such Listed Event.

Section 6. Quarterly Reports. As soon as available and in any event within forty-five (45) days after the end of each of the first three fiscal quarters and seventy-five (75) days after the end of the fourth fiscal quarter of each Fiscal Year, beginning with the quarter ending September 30, 2017, the Corporation shall provide, or shall cause the Dissemination Agent to provide to the MSRB, a quarterly report which shall consist of the unaudited financial information for the System for such fiscal quarter, including a consolidated balance sheet, a consolidated statement of operations and changes in net assets, and a consolidated statement of cash flows; presented on a basis substantially consistent with the Audited Financial Statements.

Section 7. Termination of Reporting Obligation. The Corporation's obligations under this Disclosure Agreement shall terminate upon the legal defeasance, prior redemption or payment in full of all of the Bonds. If the Corporation's obligations under the Loan Agreement are assumed in full by some other entity, such Person shall be responsible for compliance with this Disclosure Agreement in the same manner as if it were the Corporation, and the Corporation shall have no further responsibility hereunder. If such termination or substitution occurs prior to the final maturity of the Bonds, the Corporation shall give notice of such termination or substitution in the same manner as for a Listed Event under Section 5.

Section 8. Dissemination Agent. The Corporation may, from time to time, appoint or engage a Dissemination Agent to assist it in carrying out its obligations under this Disclosure Agreement, and may discharge any such Dissemination Agent, with or without appointing a successor Dissemination Agent. The Dissemination Agent shall not be responsible in any manner for the content of any notice or report prepared by the Corporation pursuant to this Disclosure Agreement. The Dissemination Agent may resign by providing thirty (30) days

written notice to the Corporation and the Counterparty. The Dissemination Agent shall have no duty to prepare any information report nor shall the Dissemination Agent be responsible for filing any report not provided to it by the Corporation in a timely manner and in a form suitable for filing. The initial Dissemination Agent shall be Digital Assurance Certification, L.L.C.

Section 9. Amendment; Waiver. Notwithstanding any other provision of this Disclosure Agreement, the Corporation may amend this Disclosure Agreement and any provision of this Disclosure Agreement may be waived, provided that the following conditions are satisfied:

(a) If the amendment or waiver relates to the provisions of Sections 3(a), 4, or 5, it may only be made in connection with a change in circumstances that arises from a change in legal requirements, change in law or change in the identity, nature or status of an obligated person with respect to the Bonds or the type of business conducted;

(b) The undertaking, as amended or taking into account such waiver, would, in the opinion of nationally recognized bond counsel, have complied with the requirements of the Rule at the time of the original issuance of the Bonds, after taking into account any amendments or interpretations of the Rule, as well as any change in circumstances; and

(c) The amendment or waiver either (i) is approved by the Owners of the Bonds in the same manner as provided in the Indenture for amendments to the Indenture with the consent of Owners, or (ii) does not, in the opinion of nationally recognized bond counsel, materially impair the interests of the Owners or Beneficial Owners of the Bonds.

In the event of any amendment or waiver of a provision of this Disclosure Agreement, the Corporation shall describe such amendment in the next Annual Report, and shall include, as applicable, a narrative explanation of the reason for the amendment or waiver and its impact on the type (or, in the case of a change of accounting principles, on the presentation) of financial information or operating data being presented by the Corporation. In addition, if the amendment relates to the accounting principles to be followed in preparing financial statements, (i) notice of such change shall be given in the same manner as for a Listed Event under Section 5, and (ii) the Annual Report for the year in which the change is made should present a comparison (in narrative form and also, if feasible, in quantitative form) between the financial statements as prepared on the basis of the new accounting principles and those prepared on the basis of the former accounting principles.

Section 10. Additional Information. Nothing in this Disclosure Agreement shall be deemed to prevent the Corporation from disseminating any other information, using the means of dissemination set forth in this Disclosure Agreement or any other means of communication, or including any other information in any Annual Report or notice of occurrence of a Listed Event, in addition to that which is required by this Disclosure Agreement. If the Corporation chooses to include any information in any Annual Report or notice of occurrence of a Listed Event, in addition to that which is specifically required by this Disclosure Agreement, the Corporation shall have no obligation under this Disclosure Agreement to update such information or include it in any future Annual Report or notice of occurrence of a Listed Event.

Section 11. Default. In the event of a failure of the Corporation to comply with any provision of this Disclosure Agreement, the Bond Trustee may (and, at the request of the Underwriters or the Owners of at least twenty-five percent (25%) aggregate principal amount of Outstanding Bonds, but only to the extent funds in an amount satisfactory to the Bond Trustee have been provided to it or it has been otherwise indemnified to its satisfaction from any cost, liability, expense or additional charges of the Bond Trustee whatsoever, including, without limitation, fees and expenses of its attorneys, shall), or any Owner or Beneficial Owner of the Bonds may take such actions as may be necessary and appropriate, including seeking mandate or specific performance by court order, to cause the Corporation or the Dissemination Agent, as the case may be, to comply with its obligations under this Disclosure Agreement. A default under this Disclosure Agreement shall not be deemed an Event of Default under the Indenture, and the sole remedy under this Disclosure Agreement in the event of any failure of the Corporation or the Dissemination Agent to comply with this Disclosure Agreement shall be an action to compel performance.

Section 12. Duties, Immunities and Liabilities of Dissemination Agent. The Dissemination Agent shall have only such duties as are specifically set forth in this Disclosure Agreement, and the Corporation agrees to indemnify and save the Dissemination Agent, its officers, directors, employees and agents, harmless for, from and against any loss, expense and liabilities which it may incur arising out of or in the exercise or performance of its powers and duties hereunder, including the costs and expenses (including attorneys' fees and expenses) of defending against any claim of liability, but excluding liabilities due to the Dissemination Agent's negligence or willful misconduct. The obligations of the Corporation under this Section shall survive resignation or removal of the Dissemination Agent and payment of the Bonds. The Dissemination Agent shall be paid compensation by the Corporation for its services provided hereunder in accordance with it schedule of fees as amended from time to time and all expenses, legal fees and advances made or incurred by the Dissemination Agent in the performance of its duties hereunder. The Dissemination Agent shall have no duty or obligation to review any information provided to them hereunder and are only responsible for the obligations set forth herein.

Section 13. Beneficiaries. This Disclosure Agreement shall inure solely to the benefit of the Authority, the Corporation, the Bond Trustee, the Dissemination Agent, the Underwriter and Owners and Beneficial Owners from time to time of the Bonds, and shall create no rights in any other person or entity.

Section 14. Governing Law. This Disclosure Agreement shall be governed by and construed in accordance with the laws of the State.

Section 15. Entire Agreement. This Disclosure Agreement contains the entire agreement of the Corporation with respect to the subject matter hereof and supersedes all prior arrangements and understandings with respect thereto, provided however that this Disclosure Agreement shall be interpreted and construed with reference to and *in pari materia* with the Rule.

IN WITNESS WHEREOF, the Corporation has caused this Disclosure Agreement to be duly executed as of the day and year first above written.

PARKVIEW HEALTH SYSTEM, INC.

By: _____
Name. Jeanné Wickens
Title: Chief Financial Officer

EXHIBIT A

NOTICE TO MUNICIPAL SECURITIES RULEMAKING BOARD
OF FAILURE TO FILE ANNUAL REPORT

Name of Authority:	Indiana Finance Authority
Name of Bond Issue:	Hospital Refunding Revenue Bonds, Series 2017A (Parkview Health)
Name of Obligated Person:	Parkview Health System, Inc.
Date of Issuance:	August 10, 2017
CUSIP No.	*See Schedule 1*

NOTICE IS HEREBY GIVEN that Parkview Health System, Inc. has not provided an Annual Report with respect to the above-named Bonds as required by the Continuing Disclosure Agreement dated August 10, 2017 by and between Parkview Health System, Inc. and U.S. Bank National Association. Parkview Health System, Inc. anticipate that the Annual Report will be filed by _____.

Dated:

DIGITAL ASSURANCE CERTIFICATION, L.L.C., ON BEHALF OF PARKVIEW HEALTH SYSTEM, INC.

cc: Parkview Health System, Inc.

SCHEDULE 1

Maturity November 1	CUSIP

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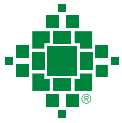

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